OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Oregon Department of Human Services
SELF-SUFFICIENCY PROGRAMS

DHS 2818 (07/2022)

Family Services procedure manual

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Chapter 1: Introduction to the Oregon Programs Eligibility Notebook

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Introduction to the manual

The Oregon Programs Eligibility Notebook (OPEN) was originally created as a tool to support the field through eligibility determination and family engagement. Originally called the Family Services Manual (FSM), it also provides additional guidance in a more practical and operationalized method.

This new version of OPEN has been organized to follow the work flow of staff as they determine eligibility. Information is no longer separated out by program. The information is arranged to mirror the Integrated Eligibility system. Guidance is separated into categories such as individual information, financial eligibility, non-financial eligibility and working with families.

OPEN is intended to be the initial resource location for staff looking for policy answers or clarity. The manual:

- Serves as a simplified explanation of federal and state regulations
- Includes examples of how policy is applied and affects families
- Links to Oregon Administrative Rules (OARs)
- Connects portions of policy that are closely interconnected.

Updates to OPEN will be made quarterly. The manual is a living document, which means information is changed and expanded to reflect current policies and practices.

Worker guides, previously located within the Oregon Programs Eligibility Notebook, are now housed on SSP Staff Tools. Staff Tools links:

- SSP Staff Tools: http://www.DHS.state.or.us/caf/ss_stafftools.htm
- SNAP Staff Tools: http://www.DHS.state.or.us/training/foodstamps/webtools.htm
- TANF Staff Tools: http://www.DHS.state.or.us/caf/ss/tanf/index.html
- ERDC Staff Tools: http://www.DHS.state.or.us/caf/ss/erdc/index.html
- Domestic Violence (TA-DVS) Staff Tools: http://www.DHS.state.or.us/caf/dv/index.htm
- Quality Assurance Staff Tools: http://www.DHS.state.or.us/caf/ss_quality.htm
- Aging and People with Disabilities (APD) Staff Tools: http://www.DHS.state.or.us/spd/tools/index.htm

Additional resources can be found on the SSP Training Unit webpage as well as the Policy Analyst Resources webpage.

To report errors or inconsistencies, please contact OPEN.TechAssist@dhsoha.state.or.us.

It is important to note that the Oregon Programs Eligibility Notebook should not be saved or downloaded under any circumstances. **Because OPEN is updated quarterly, past downloaded versions will not be correct and may result in policy errors.**

Additional resources and links

The following links may be helpful resources for staff determining eligibility.

Staff Tools by Program/Unit:

- Self-Sufficiency Programs
- SNAP
- TANF
- Child Care
- APD
- Domestic Violence
- Quality Assurance
- Self-Sufficiency Training Unit
- Policy Analysts

Other resources:

- Oregon Administrative Rule Search
- Transmittal database
- ODHS/OHA Publications and Forms
- Local offices
- DMAP Worker Guides
- Field Business Procedure Manual
- Self-Sufficiency field review process
- FSM Manual Letters
- Previous FSM Policies
- Oregon Trail (EBT) Card Replacement

Chapter 1:
Introduction to the Oregon Programs Eligibility Notebook

Section 1: Intent and overview of programs

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Intent and overview of programs

Overview of manual

The Oregon Department of Human Services and the Oregon Health Authority (ODHS|OHA) offer eight unique programs to help individuals and families. These programs are:

- Supplemental Nutrition Assistance Program (SNAP)
- Temporary Assistance for Needy Families (TANF)
- Employment-Related Day Care (ERDC)
- Refugee Programs (REF/REP)
- Temporary Assistance for Domestic Violence Survivors (TA-DVS)
- Medicare Savings Programs (MSP)
- Oregon Supplemental Income Program Medical (OSIPM)
- Health Systems Division (HSD) medical programs (MAGI Medicaid and CHIP)

Supplemental Nutrition Assistance Program (SNAP)

The SNAP program is there to help improve the health and well-being of low-income individuals, elderly individuals, people with disabilities, and other groups of people by providing them a means to meet their nutritional needs.

In Oregon, ODHS provides SNAP benefits to eligible persons based on the following expectations:

- People have the right to access SNAP as a safety net when they find themselves in a crisis such as homelessness, a domestic violence situation or lacking assets to obtain adequate nutrition.
- People receiving SNAP are personally responsible for and accountable for achieving their highest level of self-sufficiency.
- ODHS|OHA will provide supplementary information as needed to increase the likelihood that people will have adequate nutrition. These referrals can be to other food programs such as Women, Infants and Children (WIC), Meals on Wheels, and free/reduced school lunches. Other resources could involve referrals to access or information on nutrition education, managing a home budget or other food-related issues.

SNAP benefits provide not only support to families but also economic benefits to communities. SNAP is the largest program in the domestic hunger safety net. The U.S. Department of Agriculture Food and Nutrition Service (FNS) works with state agencies, nutrition educators and neighborhood and faith-based organizations to ensure those eligible for nutrition assistance can make informed decisions about applying for the program and access benefits. FNS also works with state partners and the retail community to improve program administration and ensure program integrity.

ODHS, in partnership with the Area Agencies on Aging (AAAs), provides SNAP benefits to Oregon residents. SNAP recipients include single individuals of all ages, couples, one- and two-parent families. SNAP is a program not only for those who have no money, but also for those who are working and still find themselves with limited resources to provide for their nutritional needs.

Individuals that become eligible for SNAP benefits in Oregon are able to participate in employment and training services. Employment and training (E&T) activities are offered in nearly every area of the state. All Oregon E&T programs help individuals receiving benefits obtain skills, training, work and/or experience. These activities' goal is increasing individuals' ability to obtain living-wage employment that leads to a gainful career path. Oregon has two voluntary SNAP E&T programs: SNAP Training and Employment Program (STEP), nationally called the SNAP 50/50 program, and the Abled-bodied Adults Without Dependents) program (ABAWD).

Temporary Assistance for Needy Families (TANF)

The TANF program provides cash assistance and family stability supports to low-income families with minor children. It is designed to promote personal responsibility for parents. The goal of the program is to help with employment services, family stability and community resources to reduce the number of families living in poverty.

TANF cash benefits are intended to help low-income Oregon families meet basic needs for daily living such as food, clothing, shelter and utilities.

The Administration for Children and Families (ACF), a division of the U.S. Department of Health & Human Services, sets regulations and monitors the TANF program for states that operate the program. In order to receive matching funds from the federal government, states must follow federal laws and regulations. The TANF program has undergone numerous changes since it officially began in 1937.

Under TANF, states are given the flexibility to design their own programs according to their own needs. With previously approved waivers from the federal government, Oregon has been making changes to the TANF program. Not only is the program able to help parents find employment; it also helps them work on family stability and long-term goal attainment.

Employment-Related Day Care (ERDC)

The Oregon Department of Human Services (ODHS) child care subsidy programs are intended as a dual generational support for parents and children. Families experience more success when their child care is stable and consistent, and they know their children are in a safe and healthy environment. Children can thrive when they have access to quality care that nurtures their learning and development and better prepares them to succeed in school and later in the workforce.

Central to ODHS child care programs is the principle that families assisted by ODHS have the same access to quality care as other families. ODHS child care assistance is more than a subsidy program for individual families who meet eligibility requirements; it is an investment in a child care system that makes access to quality care possible for these families. The ERDC program is designed to:

- Help educate parents and caretakers about quality child care and offer resources to help them find it
- Support parental choice by paying providers at a rate that gives parents access to a variety of child care options
- Assure eligible providers they will be paid for care they provide, receive timely payments, and know in advance what ODHS will pay
- Provide consistent support for families as their financial situation changes. The family may experience some

financial gain or temporary changes in employment during the certification. However, their child care will remain stable.

Several types of ODHS child care assistance are offered. Federal and state funding is used to create a payment system with uniform provider standards and health and safety requirements. The Direct Pay Unit (DPU) makes payments directly to the provider on behalf of the caretakers.

Refugee Programs (REF/REP)

Refugee Programs are designed to serve single adults and childless couples (and, in rare circumstances, emancipated minors) with cash assistance, medical assistance and employment services. The program is intended for those who do not meet the eligibility standards for other programs administered by the Oregon Department of Human Services. Individuals must have been admitted or paroled into the United States as refugees, asylees, Cuban/Haitian entrants, Amerasians from Vietnam, victims of trafficking, or with Iraqi/Afghan special immigrant visas (SIVs). The single adult or childless couple must be in the first eight months:

- Of arrival in the United States, or
- From the date in which one of these eligible statuses was granted.

For ease of use, when the Oregon Programs Eligibility Notebook refers to refugees, it includes all the non-citizen statuses mentioned above. When there is a need to discuss only those admitted specifically as refugees, it will be stated as such.

Refugee Programs are funded by the federal Office of Refugee Resettlement (ORR). ODHS uses these ORR funds to provide cash assistance, medical assistance and employment services to newly arriving refugees who do not qualify for other programs.

Temporary Assistance for Domestic Violence Survivors (TA-DVS)

Click here for the Temporary Assistance for Domestic Violence Survivors (TA-DVS) program.

In 1997, the Oregon Legislature passed HB 3112, now ORS 411.117, as Oregon's response to the Wellstone/Murray Family Violence Amendment of the 1996 federal welfare reform law. The Family Violence Option provides an opportunity for states to certify standards and procedures to screen for and identify individuals affected by domestic violence.

The Temporary Assistance for Domestic Violence Survivors (TA-DVS) program was created as a TANF funded program intended to provide temporary financial assistance and support to families affected by domestic violence during crisis or emergent situations when other resources are not available. TA-DVS is used to help the domestic violence survivor and their children address their safety concerns and stabilize their living situation, thus reducing the likelihood of the survivor returning to the abuser. The most common need for TA-DVS is when the domestic violence survivor flees the abuser.

The worker's role is to help determine eligibility for the TA-DVS program, help the survivor identify safety risks, refer them to domestic violence advocates and community resources that may address those needs, and provide

financial assistance to help the survivor and the children remain free from abuse.

The TA-DVS program supports domestic violence survivors by providing temporary financial assistance to flee from and remain free from domestic violence. Domestic violence is the occurrence of one or more of the following acts between family members, intimate partners or household members:

- Attempting to cause or intentionally, knowingly or recklessly causing physical injury or emotional, mental or verbal abuse
- Intentionally, knowingly or recklessly placing an individual in fear of imminent serious physical injury
- Committing sexual abuse in any degree as defined in Chapter 163 of the Oregon Revised Statutes
- Using coercive or controlling behavior.

Medicare Savings Programs (MSP)

Starting in 1988, the federal government created a group of programs called the **Medicare Savings Programs**. These programs provide Medicaid benefits that are related to the receipt of Medicare benefits.

Medicare is a federal medical benefits program that is administered by CMS (Center for Medicare and Medicaid Services), which contracts with intermediaries such as Blue Cross or Aetna; it is not administered by the state like Medicaid.

There are three types of Medicare:

- Medicare Part A which covers hospitalization;
- Medicare Part B which covers doctor bills and outpatient treatment;
- Medicare Part C which are the Medicare Advantage plans available in many areas. People with Medicare Parts A and B can choose to receive all their health care services through one of these provider organizations; and
- Medicare Part D which covers most prescription drugs.

Some recipients are required to pay a premium for Medicare Part A and there is always a premium for Medicare Part B.

Currently there are four Medicare Savings Programs in Oregon:

- **Qualified Medicare Beneficiary – QMB** is a program that offers limited medical coverage to individuals who are receiving Medicare Part A or who could be enrolled in Medicare Part A and whose income is at or below 100% of the federal poverty level (FPL). Eligible individuals will have their Medicare Part A and Part B premiums paid as well as co-insurance and deductibles for Medicare covered services, up to ODHS|OHA's fee schedule. This program does not cover any Part D costs.
- **Specified Low-income Medicare Beneficiary – SMB** is a Medicare Part A recipient who has income more than 100% but less than 120% of the FPL. Coverage is limited to payment of their Medicare Part B premium.
- **Qualified Individual – SMF** is a Medicare Part A recipient who has income from 120% to 135% of the FPL. Coverage is limited to payment of their Medicare Part B premium.

There is another group, the Disabled Workers (DWs), who can have income up to 200% of the FPL. However, there

aren't any DWs in Oregon currently and there won't be as long as Employed Persons with Disabilities (EPD) exists as a program. QMB-DW pays for the Medicare Part A premium only.

Oregon Supplemental Income Program Medical (OSIPM)

The Oregon Supplemental Income Program is a state and federally funded program that offers cash and medical assistance to low income aged and disabled individuals who qualify by meeting various financial and nonfinancial eligibility prerequisites.

The Oregon Supplemental Income Program Medical (OSIPM) is provided to several groups of individuals:

- Those **assumed eligible** for Medicaid due to receiving Supplemental Security Income (SSI) or being eligible for SSI through 1619(b) status as provided for under Section XVI of the Social Security Act.
- Those with **protected eligibility** as a Disabled Adult Child or through the Pickle Amendment.
- Those with income below the **SSI standard**.
- Those who receive **Behavioral Health services** and have income below 150% of the SSI standard.
- Those who receive **Long-Term Care** (LTC) services through Aging and People with Disabilities (APD) or through the Office of Developmental Disabilities Services (ODDS) Intellectual/Developmental Disability (I/DD) services program in a home or community-based setting, nursing facility or state institution and have income below 300% of the SSI standard.
- Working individuals with a disability who meet the requirements of the **Employed Persons with Disabilities** (EPD) program, such as income below 250% of the federal poverty level.
- Effective July 1, 2022; those who meet all financial and non-financial eligibility requirements, except for immigration status and are between the ages 19-25 or 55 and older are eligible for the Healthier Oregon medical program.

Note: Eligible CWM recipients with an active approved case status prior to July will be automatically transitioned to Healthier Oregon effective July 1, 2022.

OSIPM eligible individuals can receive cash payments (OSIP) called "special needs payments" if the individual meets the requirements of the rules. The individual may receive a one-time special need payment for a home repair or a monthly, ongoing special need payment for a laundry allowance, for example. To be eligible for OSIP, individuals must first be eligible for OSIPM.

This program is the basis under which Medicaid is granted under the Old Age Assistance, Aid to the Disabled and Aid to the Blind Programs whereby the individual receives medical assistance through a managed care provider. Depending on the individual's living arrangement, case management services are provided either by ODHS|OHA, Area Agencies on Aging (AAA), or county behavioral health or developmental disabilities programs. Eligible OSIPM individuals can be qualified for Medicare Savings Programs while receiving cash or medical benefits.

Other resources

Medicaid Long Term Care Services *includes screenshots: This QRG covers Medicaid Long Term Care (LTC) Services and how the programs function in ONE. Service TOA's include MSERV, NMAGISERV, and LTCSERV. This QRG is geared towards eligibility workers new to LTC services and ONE. Coordination with APD and AAA case managers is necessary to begin services for a participant because the service assessment is not done in ONE. This QRG references when and how that coordination should occur, and how eligibility is determined across the multiple systems.

Health Systems Division (HSD) medical programs (MAGI Medicaid and CHIP)

The intent of the Medical Assistance programs is to ensure low-income individuals and families in Oregon have access to medical care. The Oregon Health Authority (OHA) is the state Medicaid agency, but medical program eligibility determinations are generally made by the Oregon Department of Human Services (ODHS).

The Affordable Care Act (ACA) of 2010, which was implemented in Oregon in 2013, allowed states to expand Medicaid to cover more low-income adults under age 65 and children. The ACA also established the methodology of basing Medicaid eligibility on Modified Adjusted Gross Income (MAGI). This methodology uses taxable income and tax filing relationships to determine financial eligibility for Medicaid, CHIP, and premium tax credits and cost sharing reductions available through the health insurance marketplace. In addition to financial eligibility, applicants must also meet non-financial eligibility criteria, including Oregon residency. They must also be qualified non-citizens. Other non-financial eligibility requirements are specific to program type, such as pregnancy or age.

There are several different types of assistance available based on an individual's financial and non-financial information.

The following is a list of the HSD medical programs and includes program-specific information as needed:

- MAGI Child (CMO) is for children under the age of 19 with a household income at or below 133% of the federal poverty level or 185% of the federal poverty level for an infant under the age of 1.
  - Assumed eligible newborns (TP45) are newborns born to an individual who is eligible and receiving a Medicaid benefit in the month the child is born. Assumed eligible newborns are eligible until the end of the month of the newborn's first birthday, even if the data for the case changes; exceptions are death, loss of residency or the child's representative requesting a voluntary termination of the child's eligibility.
- MAGI Children's Health Insurance Program (CHIP) is for children less than 19 years of age who are not eligible for other programs. Their household income should be at or below 300% of the federal poverty level, and they should not be covered by minimum essential coverage.

When eligibility for a child less than age 19 is redetermined and would result in a loss of eligibility for any Medicaid/CHIP program administered by ODHS|OHA prior to the end of the renewal month, eligibility shall be maintained in the current program through the ended of the renewal month, unless the loss of eligibility is due to any of the following:

- The child is no longer an Oregon resident.

- The child dies.
- The child becomes incarcerated.
- The child turns age 19.
- Children in the CHIP program receive minimum essential coverage.
- An adult in the Eligibility Determination Group (EDG) requests the medical benefits be closed.
- The child begins receiving Supplemental Security Income (SSI).
- Eligibility renewal or redetermination cannot be completed because requested information is not submitted by ODHS|OHA's deadline.
- MAGI Parent or Other Caretaker Relative (PCR) program is for individuals with a dependent child in the home and income at or less than the income standard for the applicable family size.
- Pregnant individuals with a dependent child in the home who meet other financial and non-financial criteria for MAGI Parent or Other Caretaker Relative program are eligible for MAGI Pregnant Parent or Other Caretaker Relative (PCPR) program.
    - MAGI Pregnant Woman (PWO) is for pregnant women or women within two calendar months of their pregnancy ending who are at or below 185% of the federal poverty level.
        - » Pregnant individuals' eligibility is protected through the two calendar months following the month in which the pregnancy ends, regardless of most changes reported to their case with the following exceptions:
            - Loss of Oregon residency
            - Participant becomes deceased or is incarcerated, or
            - An adult in the household group requests the benefits close.
- Former Foster Care Youth Medical (FFCYM) is for individuals:
    - Between the ages of 18 and 26 who were in foster care under the responsibility of the Oregon Department of Human Services or Tribe, and
    - Enrolled in Child Welfare Title XIX Medicaid when they turned 18 or the age when Oregon Medicaid or Oregon Tribal foster care assistance ended under Title IV-E of the act. This includes children who were in Oregon Youth Authority (OYA) foster care.
- MAGI Adult (AMO) is for individuals 19 years of age or older and less than age 65 with a household income at or below 133% of the federal poverty level.

Healthier Oregon is full Medicaid coverage provided to adults aged 19 through 25 and 55 and older who meet all the financial and non-financial requirements eligibility requirements for an OHP Plus Program, except for citizen/non-citizen status.

CWM and Cover All Kids

- For adults who do not meet the citizenship and/or non-citizen status requirements, Medicaid coverage is available for emergency medical needs. This coverage is called "Citizen/noncitizen-Waived Emergency Medical (CWM)." Pregnant individuals who are CWM eligible will receive CWM Plus coverage for the duration of the pregnancy and Reproductive Health Equity Fund (RHEF) coverage through the end of the 60th

postpartum day.

- Children less than age 19 who meet all of the eligibility requirements for MAGI Medicaid/CHIP, except not meeting the citizen and non-citizen status requirements, are eligible for the Cover All Kids program. It is an OHP Plus equivalent benefit.

The following HSD medical programs are managed outside ONE:

- The Extended Medical Assistance Program (EXT) provides medical assistance for a time after a family loses its eligibility for the PCR program due to an increase in their spousal support or earned income.
- Substitute Care (SAC) medical coverage is for children less than age 21 who:
  - Lives in an intermediate psychiatric care facility for which an Oregon public agency is assuming at least partial financial responsibility
  - Is in Behavioral Rehabilitation Services (BRS), or
  - Is in a psychiatric residential treatment facility (PRTF).
- The Breast and Cervical Cancer Treatment Program (BCCTP) is for individuals in need of or being treated for breast or cervical cancer, including pre-cancerous conditions treatment.

Hospital Presumptive Eligibility (HPE)

- OHA approves and trains certain qualified hospitals to determine presumed eligibility for HSD medical programs based on a screening of basic eligibility information from the applicant. Hospitals document their determinations on an HPE Application (OHP 7260) and provide the applicable notice to the applicant. The hospital must submit copies of both the application and the notice within five days of its determination; this allows the applicant's eligibility to be entered in ONE. There is no verification process with HPE. ODHS|OHA will honor the hospital's presumptive determinations. If eligible, the participant is required to submit a full application no later than the last day of the month following the month in which the HPE was approved. HPE eligibility is based on the following attested information:
  - Family size
  - Household income
  - Receipt of other health coverage
  - Residency, and
  - U.S. citizenship, U.S. national or non-citizen status.

  Individuals must meet the program-specific financial and non-financial requirements and must **not**:
  - Receive Supplemental Security Income
  - Be a Medicaid/CHIP beneficiary, or
  - Have received an HPE approval start date within the year (365 days) prior to a new HPE period start date.

HPE coverage begins as of the hospital approval date (not the beginning of the determination month) and ends the last day of the month following the application approval month OR when a determination is made on a full medical application, whichever is earlier. HPE may start on the date an individual received a covered service from the qualified hospital as long as the HPE approval is submitted to ODHS within five days of the date of service.

The HPE period ends the last day of the month following the month in which the HPE period begins or the date the state makes an eligibility determination for MAGI Medicaid/CHIP and sends a basic decision notice.

Note: An HPE approval is not a full eligibility determination and does not entitle beneficiaries to the following:

- Children are not entitled to continuous eligibility during a period of HPE.
- Newborns born to an individual receiving benefits during a period of HPE are not assumed eligible.
- An individual receiving PCR during a period of HPE is not entitled to EXT.
- An individual whose HPE period is terminated due to incarceration is not entitled to automatic restoration of benefits.
- Individuals are not entitled to hearing rights for benefits received during HPE.

Other resources

Hospital Presumptive Eligibility 7260: Describes the process for Hospital Presumptive Eligibility

Crisis Response: Covers helpful tips and best practices for managers and workers when crisis situations arise

TOA Codes: Provides a table of all types of assistance (TOA) codes, the related category of assistance (COA) code, a description, and the MMIS code.

Oregon Supplemental Income Program – Medical (OSIPM) and Medicare Savings Programs (MSP): Contains overview of OSIPM and MSP programs, including Income and Resource Standards, Eligibility Criteria, and Medicare Part A/B/C/D breakdown and description.

Chapter 1
Introduction to the Oregon Programs Eligibility Notebook

Section 2: How to use the manual

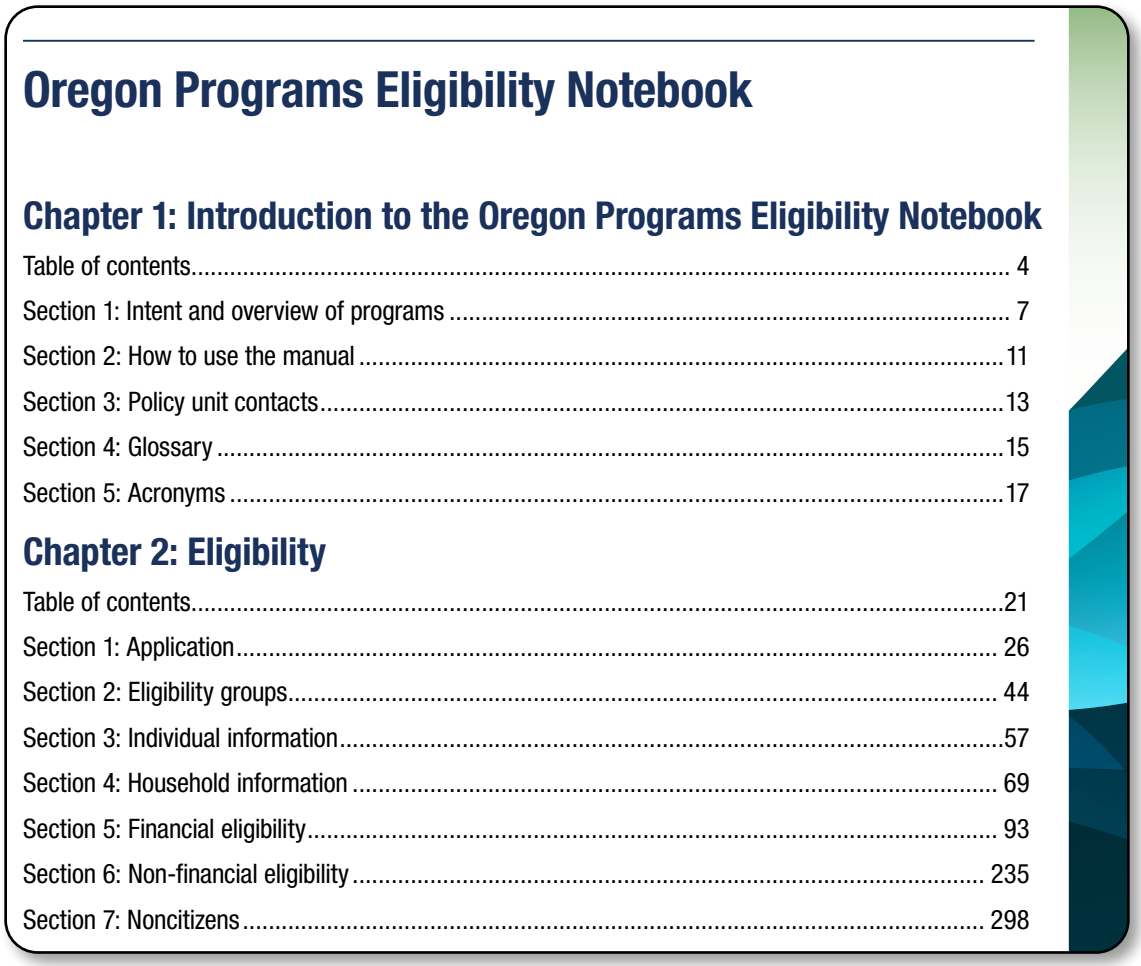
OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

How to use the manual

The Oregon Programs Eligibility Notebook is in a new format. It is now accessible as a PDF, which means that it functions like other PDF files. It is important to note that OPEN should not be saved or downloaded under any circumstances. **Because OPEN is updated quarterly, past downloaded versions will not be correct and may result in policy errors.**

The table of contents

In order to make navigation easier, OPEN includes an interactive table of contents (TOC). The TOC is located both within the first pages of the manual, at the beginning of each chapter and also in an expandable and collapsible field on the left side of the document. Either of the formats are “clickable” and easy to navigate.



Oregon Programs Eligibility Notebook

Chapter 1: Introduction to the Oregon Programs Eligibility Notebook

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The search features

In order to make using OPEN easier, the manual is enabled with search features. Search capability can find key words, specific chapters, rules, forms, links and exact phrases. To search, click on the magnifying glass on the top left of the document and enter your search term.

Navigation

Whether from the TOC or from within the document, users can navigate the manual in an intuitive and simple way. The TOC listed on the left-hand side of the manual includes all sections and subsections; it can be collapsed or expanded to suit the viewer's needs. Within the manual, each chapter has a TOC that is clickable to any section. Staff have the option of bookmarking pages if they would like to save a section for future reference.

The manual follows a flow to model the Integrated Eligibility (IE) system. Where past versions of OPEN were specific to each program, each chapter now is specific to a topic, with program-specific information listed within each chapter and section.

Information pertaining to all programs will be listed under each section, with program-specific information called out below. Programs will be called out by an icon, each in a different color:

- SNAP **Supplemental Nutrition Assistance Program**
- TANF **Temporary Assistance for Needy Families**
- ERDC **Employment-Related Day Care**
- REF **Refugee Program**
- TA-DVS **Temporary Assistance for Domestic Violence Survivors**
- MSP **Medicare Savings Programs**
- OSIPM **Oregon Supplemental Income Program Medical**
- HSD **Health Systems Division (HSD) medical programs (MAGI Medicaid and CHIP)**

Note: Temporary Assistance for Domestic Violence Survivors (TA-DVS) is not called out here. It has its own chapter (5).

Design key

There are four buttons at the top of each page of OPEN.

- **Previous page** — Go back one page in the manual (or use "Page Up" key).
- **Next page** — Go forward one page in the manual (or use "Page Down" key).
- **Jump back** — Return to the last page you viewed (or use "ALT + left arrow" keys).
- **Jump forward** — Go forward to pages you have recently viewed (or use "ALT + right arrow" keys).

Each section is laid out with colors to easily lead the reader through the text. The design key is as follows:

Section headers are colored in a darker blue.

Subsections are colored in darker blue with smaller size.

Subsections of subsections are colored in lighter blue. Occasionally there are subsections within a subsection rather than individual sections to cover each topic.

The lowest level of hierarchy within sections is colored black and bold. This guides readers to information that is important but supplements the above levels within sections.

Links

Within the manual, there are multiple types of links, each identified in a unique manner.

- OPEN references
- Forms
- Staff tools or other resources

OPEN references are listed as a blue hyperlink and will take the user to a different section within the manual. In order to navigate back to the original location, return to the TOC and find the original section. OPEN references within the manual look like this:

> Click here for Online application.

Forms are also linked to the manual. There are two different ways in which forms are referenced, based on the functionality of the form. Forms will be cited within the text and identified as a blue hyperlink for PDF forms or a link to the Forms server and the name of the form for Word documents. Links to PDF forms will appear like this:

> The information and referral services pamphlet, Information and Referrals for Low- income Households (MSC 3400). Liquid resources include bank accounts and cash on hand.

Staff tools or links to resources found outside the manual are also listed throughout. If the link is blue, the link is currently active; if the link is red, the document or referenced material is in development. They are a link to a location and should open in a new window, allowing the user to minimize that window when finished.

Rules

Although OPEN seeks to provide guidance in plain language, it is still essential that staff know and understand the Oregon Administrative Rules (OAR) relevant to eligibility and working with families. At the end of each subsection, any applicable rules will be listed and linked, allowing for rule citation on official ODHS|OHA notices. The link will open in another window, allowing staff to close and return to the manual once the rule has been reviewed.

Below is an example of what each OAR portion looks like within the manual.

> ### Oregon Administrative Rule(s)
>
> 461-115-0020 — Application Requirements
>
> 461-115-0071 — Who Must Sign the Application and Complete the Application Process
>
> 461-115-0090 — Authorized Representatives; General

Examples

Also found at the bottom of each subsection is a link to relevant examples. The examples are located in a separate chapter of the manual; links to them should open in another window. Chapters, sections and subsection organization for the examples mirrors the layout of the manual itself. In order to locate examples, users will find this text at the bottom of each section:

Click here for examples: Filing date.

In each examples link, there may be examples pertaining to multiple programs and/or to each program individually.

Any citation directly from Oregon Administrative Rule will be in grey font.

Other features

The Temporary Assistance for Domestic Violence Survivors (TA-DVS) program has its own chapter of the manual and, in most cases, will not be addressed within the primary OPEN. There are links to this section within the manual for easy navigation.

OPEN is a living document and will continue to be updated once per quarter. Staff can email any discrepancies found in OPEN for potential revision to OPEN.TechAssist@dhsoha.state.or.us.

OPEN now includes OHA's Health Systems Division (HSD) medical programs and ODHS's Aging and People with Disabilities (APD) programs. Future editions of OPEN will have additional information for these programs.

Other resources

Eligibility Transformation Operational Processes (ETOPs) Orientation: This process gives you an overview of how ETOPs are structured and how to use ETOPs.

Chapter 1

Introduction to the Oregon Programs Eligibility Notebook

Section 3: Policy unit contacts

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Policy unit contacts

The policy teams strive to be available and accessible to staff and to serve as a resource. Because the specific analysts vary from time to time, the most appropriate way to connect with the teams is through email. Below are the team and program-specific Outlook email boxes.

SNAP SNAP.Policy@dhsoha.state.or.us

TANF TANF.Policy@dhsoha.state.or.us

ERDC Childcare.Policy@dhsoha.state.or.us

REF Refugee.Policy@dhsoha.state.or.us

TA-DVS TADVS.Policy@dhsoha.state.or.us

MSP APD.MedicaidPolicy@dhsoha.state.or.us

OSIPM APD.MedicaidPolicy@dhsoha.state.or.us

HSD HSD.MedicalEligibilityPolicy@dhsoha.state.or.us

Staff who send questions to the policy email boxes can expect a response within two working days. Please keep in mind that the more specific your question, the more guidance and clarity the policy teams can provide in their response.

Other resources

Helpful links: Contains the following helpful links: System Training resources, training environment, training news, SSP staff tools, Real+D response matrix, Oregon Programs Eligibility Notebook, APD staff tools, MAGI Medical chapter from Oregon Programs Eligibility Notebook, Medicare Modernization Act Manual, APD transmittals, SSP transmittals, System Training QRGs, conversion resources, ETOPs, Troubleshooting, Known Issues and Interim Business Processes, Client Maintenance Unit (CMU), CMU Request QRG, Aging and Disability Resource Connection of Oregon (ADRC), and 211 info.

ETOPs Orientation: This process gives you an overview of how ETOPs are structured and how to use ETOPs.

Chapter 1

Introduction to the Oregon Programs Eligibility Notebook

Section 4: Glossary and acronyms

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Glossary and acronyms

Introduction

The following section is a glossary of frequently used terms within the Oregon Programs Eligibility Notebook. Not every term may be defined here unless it is used multiple times throughout the manual or is defined by Oregon Administrative Rule. Popular acronyms are also referenced here. This glossary will be updated as necessary with releases to the manual and applicable policy additions and changes.

Glossary and acronyms

Acronym	Term	Definition
1619 (b) Status	1619(b)	Section 1619(b) of the 1987 SSA legislation provides for continued Medicaid eligibility for disabled individuals whose incomes are too high to qualify for an SSI cash payment but are not high enough to offset the loss of Medicaid. These individuals received at least one month of SSI and are assumed eligible for OSIPM.
A Number	Noncitizen number	A unique seven-, eight- or nine-digit number assigned to a non-citizen by the Department of Homeland Security.
AAA	Area Agency on Aging	Area Agencies on Aging across Oregon that administer and support community-based care services, including Older American Act programs such as Oregon Project Independence and Home-Delivered Meals. AAAs advocate for older adults living in their area, develop community-based long-term care services to meet the needs of those adults and administer funds to implement services. Most services coordinated by AAAs are provided through community service providers at the local level. ODHS and OHA contracts with 16 AAA offices to administer non-MAGI, SNAP, and long-term care services.
ABAWD	Able-Bodied Adults Without Dependents	An ABAWD is an individual who is age 18-49 and when there are no persons under age 18 in the SNAP filing group. ABAWDs can be work registrant exempt or work registrant mandatory depending on circumstances.
ACA	Affordable Care Act	The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), as amended by the Three Percent Withholding Repeal and Job Creation Act (Pub. L. 112–56). The ACA established MAGI methodology and allowed states to expand Medicaid to non-disabled, non-aged adults without children.

ACCESS	Automated Computer Capture and Storage System	A computer system used by APD that automated the application and intake process from a paper-driven, manual process. Prior to ONE, Oregon ACCESS was used to capture all APD participant information. Integration was available between Oregon ACCESS and the following systems: Client Index (CI), Client Maintenance (CMS), and Service Eligibility (SELG).
ACP	Address Confidentiality Program	An Oregon Department of Justice program that provides a substitute mailing address and mail forwarding service for ACP participants who are victims of domestic violence, sexual assault, or stalking.
	Action	A termination, suspension, denial, or reduction of Medicaid or CHIP eligibility or covered services.
	Active renewal	The renewal process for cases that are not processed via passive renewal. The active renewal notice contains a renewal letter and case summary, with the most current case information relevant to renewal.
ADA	American with Disabilities Act	The Americans with Disabilities Act (ADA) prohibits discrimination against people with disabilities in several areas, including employment, transportation, public accommodations, communications and access to state and local government' programs and services.
	Adjusted income	Countable income minus allowable deductions for the program (461-001-0000)
ADL	Activities of daily living	Eating, dressing, grooming, bathing, hygiene, mobility (ambulation and transfer), elimination (toileting, bowel and bladder management), cognition and behavior. Individuals are assessed for their ability (or inability) to perform these tasks and are assigned a Service Priority Level (SPL) based on the results.
	Adoption assistance	Legal process of becoming a non-biological parent of a child or children
AEN	Assumed eligible newborn child	A child born to a mother who is receiving Medicaid or CHIP is assumed eligible for medical benefits until the end of the month in which the child becomes one year old, as long as the child lives with the mother. The mother does not have to be continuously eligible for benefits in order for the child to receive the benefits.
AFC	Adult Foster Care	A type of community-based care which provides room and board and 24-hour care and services for aged or disabled individuals 18 or older. The care is contracted to be provided in a home with five or fewer participants, See Chapter 411, Division 050 of the Oregon Administrative Rules for more information. Some providers can apply for a Limited Foster Care license, which contract to provide care to one specific individual.
	Agency	The Oregon Health Authority and Oregon Department of Human Services

AML	Authorized Medical Leave	May occur when a caretaker leaves work for a temporary period of time for medical reasons, they may be eligible to continue to use child care (ERDC) benefits.
APD	Aging and People with Disabilities	A division of ODHS that provides services to seniors and people with physical and intellectual disabilities. It is comprised of 52 local offices in 16 districts; 35 offices are administered by the state and 16 are administered by AAAs. Services and programs include Aging and Disability Resource Connection (ADRC); Adult Protective Services (APS); Disability Determination Services; Community Services and Supports Unit; Medicaid (including Medicare Savings Programs); General Assistance; Supplemental Nutrition Assistance Programs; Medicaid Long-Term Care Services and Supports; Older Americans Act; Oregon Home Care Commission (OHCC); Oregon Project Independence (OPI); Safety, Oversight and Quality Unit (SOQ).
	Applicant	An individual who is seeking an eligibility determination for themselves or someone for whom they are applying through an application submission or a transfer from another agency, insurance affordability program, or the FFM.
	Application number	ONE case term for the unique identification number assigned to an application received. Application numbers are converted to a Case number once the case has been created within ONE.
APS	Adult Protective Services	An APD agency that provides protection and intervention for older adults and adults with physical disabilities who are unable to protect themselves from harm and neglect.
APTC	Advance Premium Tax Credit	Advance payments of the premium tax credit, which means payment specified in section 36B of the Internal Revenue Service (IRS) that are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with sections 1402 and 1412 of the Affordable Care Act (ACA). For Oregonians, the FFM determines the amount, if any, of the APTC an individual is eligible for.
	Arrearages	Something unpaid and overdue.
ARU	Automatic response unit	Customer service unit for EBT where individuals can check their benefit balance and review their last 10 transactions; or transfer to a customer service representative to report a card lost, stolen or damaged or to request other assistance.
	Assumed eligibility	An individual is deemed to be eligible for a period of time based on receipt of another program benefit and condition, or because of another individual's eligibility. SSI recipients and those with 1619(b) status are assumed eligible for OSIPM. SSI recipients who are enrolled in Medicare Part A are assumed eligible for QMB.

AMT	Authorized military transition	ERDC program benefit that allows for child care usage (at the same level) for the purpose of family transition activities, work search, medical appointments and other activities needed for the caretaker returning from a military war zone to transition to civilian life.
	Authorized representative	Means an individual at least 18 years of age or organization that acts on behalf of an applicant or beneficiary in assisting with the individual's application and renewal of eligibility and other ongoing communications with the Agency (OAR 410-200-0111).
AWS	Authorized work search	ERDC program benefit that allows for continuation of child care assistance during temporarily or permanently loss of employment. During authorized work search, child care remains open to allow for the care taker to look for work.
	Automated renewal	A renewal of eligibility, initiated by the Agency, based on reliable information contained in the beneficiary's case record, using the Renewal and Redetermination Verification (RRV) service from the Federal Data Services Hub (FDSH) and automated electronic verification sources available to the agency to perform data matches for the sake of verifying eligibility criteria.
ATM	Automated teller machines	An electronic banking machine that allows customers to complete basic transactions without the aid of a bank representative.
	Basic decision notice	A written notice of a decision made regarding eligibility for benefits mailed no later than the date of action given in the notice or when suspending benefits due to Incarceration (OAR 410-200-0140), the effective date is the day following the date on which the individual became incarcerated.
	Basic living expenses	Basic living expenses are expenditures needed to maintain basic daily living and good health. They include but not limited to: housing, food, clothing, healthcare, and transportation.
BCCTP	Breast and Cervical Cancer Treatment Program	Eligibility criteria for medical assistance based on an individual's need of treatment for breast or cervical cancer, including pre-cancerous conditions (treatment). The authority administers the Oregon Breast and Cervical Cancer Treatment Program (BCCTP) by entering into agreements with qualified entities as approved by the Authority to provide screening services for BCCTP funded by the Center for Disease Control in support of the National Breast and Cervical Cancer Early Detection Program.
	Benefit group	A "benefit group" consists of the individuals who receive benefits.

	Benefit recovery	Benefit Recovery is a case term within ONE that is a process used to collect overpayments/over issuance on benefit amounts. An overpayment is defined as a benefit or service received by or on behalf of an individual, or a payment made on behalf of an individual, that exceeds the amount for which the individual is eligible. See Overpayment.
	Budget month	The calendar month from which financial and nonfinancial information is used to determine eligibility and benefit level for the payment month.
	Burial insurance	A type of whole life insurance that is specifically marketed to cover final expenses, including those for burial and cremation.
BWE	Blind work expense	These are costs that can be used as deductions in calculating adjusted income. These are defined by the SSA as expenses that can be used as reductions to earned income.
CA/PS	Client Assessment and Planning System	Client Assessment and Planning System (CA/PS) is in Oregon Access and is used for completing a comprehensive and holistic assessment to assess an individual's physical, mental, and social functioning. It identifies risk factors, individual choices and preferences, and the status of service needs. The CA/PS documents the level of need and calculates the individual's service priority level (SPL), calculates the service payment rates, and accommodates individual participation in service planning. An APD Case Manager will complete the assessment with the person who needs assistance. The person can invite family, friends and others.
	Cafeteria plan	"Cafeteria plan" means a written benefit plan offered by an employer in which: (a) All participants are employees; and (b) Participants may choose, cafeteria-style, from a menu of two or more cash or qualified benefits. In this context, qualified benefits are benefits other than cash that the Internal Revenue Service does not consider part of an employee's gross income. Qualified benefits include, but are not limited to: (a) Accident and health plans (including medical plans, vision plans, dental plans, accident and disability insurance); (b) Group term life insurance plans (up to $50,000); (c) Dependent care assistance plans; and (d) Certain stock bonus plans under section 401(k)(2) of the Internal Revenue Code (but not 401(k)(1) plans).

CAK	Cover All Kids	Refers to the OHP Plus-equivalent benefit provided to children who meet all eligibility requirements for MAGI Medicaid/CHIP, except they do not meet the citizen and non-citizen status requirements (OAR 410-200-0240).
	Caretaker	Individual who is responsible for the care, control and supervision of a child.
	Caretaker relative	An individual with whom the child is living who assumes primary responsibility for the child's care, and who is one of the following: (a) A relative of the dependent child, as follows: (A) A blood or half-blood relative, including parents, siblings, first cousins, nephews, nieces, and individuals of preceding generations as denoted by prefixes of grand, great, or great-great. (B) Stepfather, stepmother, stepbrother, and stepsister. (C) An individual who legally adopts the child and any individual related to the individual adopting the child. (b) The spouse of the parent or relative even after the marriage is terminated by death or divorce
	Cash surrender value	The accumulated portion of a permanent life insurance policy's cash value that is available to the policyholder upon surrender of the policy.
	Categorical eligibility	This applies specifically to the SNAP program. "Categorical eligibility" is a term used within the SNAP program. Categorical eligibility does not mean that a household is automatically eligible for SNAP benefits. What categorical eligibility means is that certain eligibility factors do not apply to the SNAP case when all individuals in the filing group are categorically eligible for SNAP.
CWM	Citizenship Waived Medical	Medicaid coverage for emergency medical needs for individuals who otherwise meet the financial and non-financial eligibility requirements for medical program, except they do not meet citizenship and/or non-citizen status requirements.
	CWM Plus	Medical services for pregnant CWM beneficiaries (OAR 410-200-0240) and includes: (a) CWM Plus coverage for the duration of the individual's pregnancy; and (b) Reproductive Health Equity Fund (RHEF) coverage through the end of the calendar month in which the 60th day following the last day of the pregnancy falls.

CBC	Community-based care	Community-Based Care settings include Assisted Living Facilities (ALF), Residential Care Facilities (RCF,) Adult Foster Home (AFH,) and Memory Care Communities. These facilities make a wide range of individualized services available in a homelike setting to older adults, people with disabilities and individuals with dementia or Alzheimer's disease.
CCB	Child care billing form	Billing form used by ERDC and JOBS program child care providers to submit for payment of services.
CEP	Client Employed Provider	Client employed provider system used for payments to homecare worker.
CES DMAP	Client Enrollment Services, Division of Medical Assistance Programs	Client Enrollment Services (the term DMAP is now obsolete and was replaced by Health Services Division (HSD))
CHIP	Children's Health Insurance Program	MAGI program for children, and to qualify the child must be under age 19. The income limit for this program is the highest of all medical programs at 305% of the FPL. In addition to the previous requirements, the child must not be enrolled in accessible minimum essential coverage (MEC).
CI	Client Index	Mainframe (DHR) system that stores demographic information for individuals across all programs. When an individual is added to a case, member match performs a check against CI to determine if the individual is already known.
	Claim	Means a legal action or a demand by, or on behalf of, an applicant or beneficiary for damages for or arising out of a personal injury that is against any person, public body, agency, or commission other than the State Accident Insurance Fund Corporation or Worker's Compensation Board.
	Claimant	Means a legal action or a demand by, or on behalf of, an applicant or beneficiary for damages for or arising out of a personal injury that is against any person, public body, agency, or commission other than the State Accident Insurance Fund Corporation or Worker's Compensation Board.
	Claimant	An individual who has requested a hearing or appeal.
CMS	Center for Medicare and Medicaid Services	A division of the federal Department of Health and Human Services that administers and oversees the nation's major healthcare programs, including Medicare, Medicaid, CHIP, and the federal health insurance marketplace.
CMU	Client Maintenance Unit	CMU provides customer service to State agencies who submit requests to assist with correction and/or maintenance in MMIS or other state systems to ensure program accuracy and integrity.

	Collateral contact	A form of verification received through oral or written statement from someone outside the EDG group.
	Combined eligibility notice	An eligibility notice that informs an individual, or multiple family members of a household when feasible, of eligibility for each program for which a determination or denial was made by the Authority.
	Commercial annuity	A contract or agreement (not related to employment) by which an individual receives annuitized payments on an investment for a lifetime or specified number of years.
	Community eligibility appointment	In-person meeting or interview with the customer at a Home or other location of their choosing. Will show in ONE office schedule with a "C."
	Coordinated content	Information included in an eligibility notice regarding the transfer of the individual's or household's electronic account to another insurance affordability program for a determination of eligibility.
	Copay	Applies to the ERDC program: a copay is the portion of a caretaker's child care costs they are required to pay before ODHS assist with the payment.
	Copay not met	ERDC program term for when a caretaker does not pay the required copay or make satisfactory arrangements to pay it. The Direct Pay Unit (DPU) will end benefits and send a closing notice as soon as timely notice requirements allow.
	Countable	An available asset (either income or a resource) that is not excluded and may be considered by some programs to determine eligibility.
CP	Community partner	For medical programs: Contracted with the Oregon Health Authority to assistance customers applying for health insurance. Community Partners are people in the local community who receive training and information that they use to assist in application and monitoring of medical cases for customers. If a customer applied through a community partner, it will show on their case summary screen.
CSIA	Community spousal income allowance	Allows the community spouse to a portion of their countable assets. Also known as Less Diverted to Spouse (LDS).
CSP/PSP	Child support passthrough/passthrough support	Child support intended for a TANF participant, up to $50 per dependent child or minor parent per financial group per month and not to exceed $200 per financial group per month. This amount is sent to the participant before any remaining amount of current child support is kept by the state. Pass-through includes current child support only.
CT Notice	Countable month notice	Notice sent to Able Bodied Adults without Dependents (ABAWDs) informing of the receipt of a countable month of SNAP benefits towards the SNAP time limit.

	Custodial parent	For children whose parents are divorced, separated, or unmarried, the parent with whom the child lives, with the following considerations: (a) If the child lives part-time with both parents, the parent with whom the child spends most nights is the custodial parent; or (b) If section (a) of this part cannot be determined due to the child spending equal nights with both parents, a court order or binding custody agreement establishing physical custody is used to identify the custodial parent.
DAC	Disabled adult child	An individual age 18 or older who was determined to be blind or disabled by SSA before age 22. DACs have certain protections from losing Medicaid coverage should they receive SSI and then lose it after being awarded SSA benefit from a deceased, disabled, or retired parent. Someone can be a DAC as defined by the SSA but not qualify for the OSIPM DAC category.
	Deactivated	An Electronic benefit transfer (EBT) card term where an EBT card is canceled and cannot be reactivated.
	Deeming	Deeming or sponsor deeming is the counting of a sponsor(s)' income and resources based on the amount on the affidavit.
	Disaster unemployment assistance	Disaster Unemployment Assistance is emergency assistance received by individuals who are unemployed as a result of a major disaster and cannot receive other unemployment compensation benefits.
	Disregard	Disregard means child support, up to $50 per dependent child or minor parent per financial group per month and not to exceed $200 per financial group per month, that is not counted as income of the individual. "Disregard" includes current child support only.
DND	Do not disclose	Used to indicate 'Do Not Disclose' address; If a person is in a domestic violence shelter and they don't feel safe, or there is a safety risk that a person may be identified to have, the physical address of the individual is marked as DND.
	Domestic violence shelter	Public or private nonprofit residential facilities providing services to survivors of domestic violence.
DOR	Date of request	The date on which an individual requests benefits, either orally or in writing. Determines the application processing time frame and start of benefits for medical and child care programs.
DPCS		DHR legacy screen that displays a list of all Direct Pay Unit child care provider claims paid, in suspense or denied status.
DPU	Direct Pay Unit	This unit facilitates the payment of childcare providers across the state.

DQ	Disqualification	There are different compliance requirements for each program. Failure to comply with these requirements may affect program eligibility and could result in disqualification from a program.
DSNAP	Disaster Supplemental Nutrition Assistance Program	Disaster Supplemental Nutrition Assistance Program (DSNAP) benefits are issued when a location experiences damage due to a natural disaster such as a storm, earthquake, or flood. After the President declares a disaster, the U.S Department of Agriculture's Food and Nutrition Service may approve an area of the state to accept applications for DSNAP.
EA	Emergency Assistance	Emergency cash to families without the resources to meet their emergent needs.
E & T Services	Employment and Training Services	For individuals in either the SNAP or TANF program, there are components designed to support participants by connecting them to employment, preparing them for employment and linking them to training. SNAP's E&T programs include ABAWD and STEP (see ABAWD and STEP for more info.) TANF's E&T program is the JOBS Program (see JOBS for more info.)
EBT	Electronic Benefits Transfer	Electronic Benefits Transfer card used for issuance of EB cash and SNAP benefits.
ECF	Electronic Case File	Where documents associated to a case/individual are stored.
ECLM		Oregon Employment Department interface showing weekly unemployment compensate payments to individual.
EDBC	Eligibility Determination & Benefit Calculation	Robust rules engine used to determine eligibility and benefit amount for applicants within integrated ONE. Reviews an individual's or a family's financial and non-financial criteria against program rules for multiple assistance programs.
EDG	Eligibility Determination Group	Eligibility Determination Groups are a grouping of individuals in a case based on the type of assistance they applied for, their relationships to each other, and their non-financial, income, asset, and expense information. Individuals are grouped into Eligibility Determination Groups for determining eligibility and benefits for each Type of Assistance based on the rules defined in decision tables. A case can contain multiple Eligibility Determination Group for the same Type of Assistance when allowed by the decision tables.
EDMS	Electronic Document Management System	An electronic database to house secured documents provided by Oregonians for verifications, etc. ONE will house documents once live. EDMS will continue to be used by Family Coaches for non-eligibility, case management documents such as attendance.
EFT	Electronic Funds Transfer	Occurs when benefits and payments are electronically deposited into a bank account.

	Emergency	An emergency is any occasion or instance for which the President determines that Federal assistance is needed to supplant State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe.
	Emergent need	The need for immediate action.
EML		Acronym based on legacy system coding for earned income generated from non-self-employed jobs.
	Employed	Employed means doing work that results in earned income.
EMPP or EP	Employment Payments	The intent of Employment Payments (EP) is to provide additional support up to three months after TANF closes for a family which has become employed and no longer eligible for TANF or SFPSS. The first month after TANF ends, they will receive $100; in the second month, $75; and $50 in the third month.
	Encumbrance	An encumbrance is a claim against a property by a party that is not the owner's.
	Endowment insurance	Endowment policies that pay the policy owner the face value plus dividends after a stated period of time. The face value of the policy is paid to the beneficiary upon the death of the insured if death occurs during the stated time period. This type of policy has a cash surrender value.
EPD	Employed Persons with Disabilities	The Employed Persons with Disabilities Program (EPD) is designed to help people who have a disability maintain their employment.
eSign	Electronic signature	A means of giving legal consent to electronic documents or forms.
ELI	Exit limit increase	The exit limit increase is designed to lessen the benefit cliff impact on families. The policy allows families to gradually phase off the TANF program when parents become employed, instead of experiencing an abrupt loss of benefits from their monthly cash assistance as they hit the income limit. A TANF benefit group that has countable earned income is eligible for an exit limit increase in the following situations: • An open TANF case with earned income to determine if the case is over the exit limit increase countable income limit, or • Restoring a TANF case within 30 days of closure when the case closed with earned income received by a member of the benefit group prior to closure. ELI serves as both the countable and adjusted income limit for the above two case types. ELI is only for individuals in the benefit group. If the TANF benefit group reports someone has moved into the home with income, the calculation to determine eligibility is based on the countable income limit (not the exit limit increase).

	Expedited appeal or expedited hearing	A hearing held within five working days of the Agency's receipt of a hearing request, unless the claimant requests more time.
	Expedited service	A situation where services are provided to a specific population that allows them to receive an eligibility determination within an expedited time frame.
EXT	Extended Medical Assistance	The Extended Medical Assistance program provides medical assistance for a period of time after a family loses its eligibility for the PCR program due to an increase in their spousal support or earned income.
F2F	Face to Face	An interview between an Eligibility Worker and the following: head of household, partner, spouse, any other responsible member of the filing group and/or an authorized representative. A F2F is used to resolve any unclear or incomplete information, and to determine eligibility.
	Face value or amount	The basic death benefit or maturity amount of the policy specified on its face. This amount may be decreased by loans. The face value does not include dividends or additional amounts payable because of accidental death or other special provisions.
	Family size	The number of individuals used to compare to the income standards chart for the applicable program. The family size consists of all members of the EDG (Eligibility Determination Group) and each unborn child of any pregnant members of the EDG.
FFM	Federally Facilitated Marketplace	The Federally Facilitated Marketplace (FFM) is an organized marketplace for health insurance plans operated by the U.S. Department of Health and Human Services (HHS).
FPL	Federal Poverty Level	The federal poverty level updated periodically in the Federal Register by the Secretary of the Department of Health and Human Services under the authority of 42 U.S.C. 9902(2) as in effect for the applicable budget period used to determine an individual's eligibility in accordance with 42 CFR 435.603(h).
FSMIS	Food Stamp Management Information System	Legacy system that contains all information for SNAP cases.
	Fugitive felon	A person fleeing to avoid prosecution or custody for a crime, or an attempt to commit a crime, that would be classified as a felony.
	Full equity rights	Asset value is transferred back to an individual in full.
GA	General Assistance	A program designed to help individuals with severe disabilities who are experiencing homelessness or who are at risk of homelessness. This program, inspired by the Housing First model, is administered by ODHS's Aging and People with Disabilities Collaborative Disability Determination Unit (CDDU).

	Gifts	Items given to or received by an individual on or for a special occasion, such as a holiday, birthday, graduation, or wedding. “Gifts” are not given or received on a regular basis.
	Hard pend	Occurs when eligibility cannot be determined and a Request for Information (RFI) must be fulfilled in order to process the application and determine eligibility.
	Health Systems Division Medical Programs	Means all programs under the Health Systems Division including: EXT, Substitute Care, BCCTP, FFCYM, MAGI Child, MAGI Parent or Caretaker Relative, MAGI Pregnant Woman, MAGI Children’s Health Insurance Program (CHIP), MAGI Adult.
	Heathier Oregon	Medical program effective July 1, 2022 that expands OHP Plus level of benefits to individuals between ages 19-25 and 55 and over who meet all financial and non-financial eligibility requirements, except for immigration status.
	Hearing request	A clear expression, oral or written, by an individual or the individual’s representative that the individual wishes to appeal an Authority or FFM decision or action.
HINQ	Voucher Issuance History	The Voucher Issuance History screen (HINQ screen) displays payment history of the Homecare Worker providing services.
	HIV positive	HIV positive is having had a positive result in a blood test for the AIDS virus.
HOH	Head of Household	Head of household is an adult in the filing group who is designated by the group to serve as the primary person. When there is no adult, the group can designate another responsible person in the filing group.
	Homeless or houseless	People who are living in a place not meant for human habitation, in emergency shelter, in transitional housing, or are exiting an institution where they temporarily resided. People who are losing their primary nighttime residence, which may include a motel or hotel or a doubled up situation, within 14 days and lack resources or support networks to remain in housing. Families with children or unaccompanied youth who are unstably housed and likely to continue in that state. People who are fleeing or attempting to flee domestic violence, have no other residence, and lack the resources or support networks to obtain other permanent housing.
	Household group	People who live in the same dwelling are in the same household.
HSD	Health Systems Division	Health Systems Division, Medical Assistance Programs (Division) under the Oregon Health Authority.

HSP	Housing Stabilization Program	A program that helps low-income families obtain stable housing. The program is operated through the Housing and Community Services Department through community-based, service-provider agencies. The department's rules for the program were repealed July 1, 2001
HUD	Department of Housing and Urban Development	A federal agency responsible for policy and programs that address shelter needs, improving and developing communities, and enforcing fair housing laws.
	Indian Country	"Indian Country" is a federally defined term that pertains to either specific communities defined by 18 USC 1151 or counties defined by the state and specific to tribal membership.

	Resident of a Public Institution	An individual that is: (a) Confined involuntarily in a local, state, or federal prison, jail, detention facility, or other penal facility, including being held involuntarily in a detention center awaiting trial or serving a sentence for a criminal offense; (b) Residing involuntarily in a facility under a contract between the facility and a public institution where, under the terms of the contract, the facility is a public institution; (c) Residing involuntarily in a facility that is under governmental control; or (d) Receiving care as an outpatient while residing involuntarily in a public institution. (e) An individual is not considered an inmate when the individual is: (A) Released on parole, probation, or post-prison supervision; (B) On home- or work-release, unless the individual is required to report to a public institution for an overnight stay; (C) Receiving inpatient care at a medical institution not associated with the public institution where the individual is an inmate. An individual is an inpatient when they've been admitted to a medical institution on the recommendation of a physician, and: (i) Expects to receive room, board, and professional services in the medical institution for a 24-hour period or longer; or (ii) Is expected to meet the criteria outlined in (i) of this part, but later dies, is discharged, or is transferred to another medical or extended care facility and does not actually stay in the medical institution for 24 hours.

		(D) Residing voluntarily in a detention center, jail, or county penal facility after their case has been adjudicated and while other living arrangements are being made for the individual; (E) Residing in a public institution pending other arrangements as defined in 42 CFR 435.1010; or (F) Residing in an Institution for Mental Disease (IMD), including the Oregon State Hospital and: (i) Is under age 21; (ii) Is 21 but was admitted to the IMD before their 21st birthday; or (iii) Is age 65 or older.
	Insurance affordability program	A program that is one of the following: (a) Medicaid; (b) CHIP; (c) A program that makes coverage available in a qualified health plan through the FFM with advance payments of the premium tax credit established under section 36B of the Internal Revenue Code available to qualified individuals; (d) A program that makes coverage available in a qualified health plan through the FFM with cost-sharing reductions established under section 1402 of the Affordable Care Act.
	Insured	A person whose life is insured against loss.
	Insurer-assurer	The company or association that contracts with the owner.
IPV	Intentional program violation	Based on ODHS|OHA investigation findings, knowingly providing untrue statements or withholding information needed to determine eligibility or participating in the illegal activity of transferring benefits between individuals.
IRS	Internal Revenue Service	A federal agency responsible for the collection of taxes and enforcement of tax laws.
IRWE	Impairment Related to Work Expense	Costs defined by the SSA that can be used as deductions in calculating adjusted income for OSIPM. To be allowed, the item/service must be related to the impairment and necessary to enable the person to perform their job.
ISS	In-Home Supplement Special Need	A special needs cash payment for individuals receiving SSI and some type of in-home services.

JOBS	Job Opportunity and Basic Skills	Activities that assist Oregonians in securing more stable and family-sustaining employment. It is a non-financial requirement for eligibility for all JOBS eligible adults or teen heads of household in the TANF need group. They agree to work on either employment, family or education goals. Goals include job search, life skills training, drug and alcohol treatment, getting a GED, and more. Oregonians work with their Family Coach to develop goals suited to their families' needs and desires. They are the experts in their lives.
	JOBS Plus	Through JOBS Plus, JOBS eligible participants are placed in subsidized employment. TANF and Supplemental Nutrition Assistance Program (SNAP) benefits are diverted. Net income for the participant must not be less than the combined income from TANF and SNAP. The intent of JOBS Plus is to enhance the employability of participants with limited skills. JOBS Plus provides an incentive to participants by increasing their skill level to help meet their short-term job goals. Participants are required to complete one day of job search each week after their fourth month of placement; the employer treats this as paid time.
JPI	Job Participation Incentive	Provides an additional food benefit to help increase the ability of parents with children to meet the nutritional needs of their families.
LDS	Less diverted to spouse	The amount of a service participant's countable income that they can give or "divert" to their community spouse.
	Legal argument	Has the meaning given that term in OAR 137-003-0008(c).
	Lethality assessment	Domestic violence evaluation tool that helps predict the likelihood of an abuser causing death to their victim.
LIHEAP	Low Income Home Energy Assistance Program	LIHEAP is a program that assists households with low incomes, particularly those with the lowest incomes that pay a high proportion of household income for home energy, primarily in meeting their immediate home energy needs.
LIS	Low Income Subsidy	Low income subsidy referral for Medicare Savings Programs from Social Security Administration and is referred to as extra help.
LOGI		ODHS legacy Notice Retrieval System used to retrieve notices sent through the Legacy system.
LPR	Lawful permanent resident	Lawful permanent residents (LPRs), also known as "green card" holders, are non-citizens who are lawfully authorized to live permanently within the United States.

LTC	Long-term care	An umbrella term encompassing K Plan (financial assistance to state to provide in home and community services), Developmental Disabilities (DD), nursing facility, and waivered services, or "a broad range of social and health services to eligible adults who are aged, blind, or have disabilities for extended periods of time" including "nursing homes and state hospitals" (OAR 461-001-0000). Other times, it specifically refers to nursing facility services (see OAR 461-001-0030). It is important to read the rule carefully in which this term appears to determine its meaning.
MAGI	Modified Adjusted Gross Income	Used in determining eligibility based on annual income as described in 410-200-0310(4). MAGI has the meaning provided at IRC 36B(d)(2)(B) and generally means federally taxable income with the following exceptions: (a) The income of the following individuals is excluded when they are not expected to be required to file a tax return for the tax year in which eligibility is being determined. This subsection applies whether or not the child or tax dependent actually files a tax return: (A) Children, regardless of age, who are included in the household of a parent; (B) Tax dependents. (b) In applying subsection (a) of this section, IRC § 6012(a)(1) is used to determine who is required to file a tax return.
	MAGI-based income	Income calculated using the same financial methodologies used to determine MAGI as defined in section 36B(d)(2)(B) of the Code with the following exceptions: (c) An amount received as a non-recurring lump sum, if taxable, is counted as income only in the month received. (d) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded; (e) Income from the following American Indian and Alaska Native sources is excluded: (A) Distributions from Alaska Native Corporations and Settlement Trusts; (B) Distributions from any property held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation or otherwise under the supervision of the Secretary of the Interior;

		(C) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest, including farming, from: (i) Rights of ownership or possession in any lands described in subsection (c)(B) of this part; or (ii) Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources. (D) (Distributions resulting from real property ownership interests related to natural resources and improvements: (i) Located on or near a reservation or within the most recent boundaries of a prior federal reservation; or (ii) Resulting from the exercise of federally protected rights relating to such real property ownership interests. (E) Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom; (F) Student financial assistance provided under the Bureau of Indian Affairs education programs.

MAGI Medical	Modified Adjusted Gross Income medical	MAGI Medicaid is a state and federally funded program which assists low-income Oregonians with medical coverage. The Oregon Health Plan (OHP) is our state Medicaid program. MAGI Medical Programs: • MAGI Parent or Other Caretaker Relative program (PCR) • MAGI Adult program (AMO) • MAGI Child program (CMO/CM1) • MAGI CHIP program (C21) • MAGI Pregnant Woman program (PWO) • Assumed Eligible Newborn (AEN) • Cover All Kids (CAK) • Citizen/Noncitizen Waived Emergent Medical (CWM) • CWM Plus – must not meet citizenship or immigration requirement, must be pregnant, and must be over the age of 19.
	Major disaster	A major disaster is any natural catastrophe such as a hurricane or drought, or, regardless of cause, any fire, flood or explosion, which the President determines causes damage of sufficient severity and magnitude.
	Mass update	ONE system functionality in which eligibility can be automatically re-evaluated for multiple cases without eligibility worker action. Mass updates occur nightly, weekly, monthly, annually, or as needed such as with a Cost of Living (COLA) increase.
MCI	Master Client Index	A central database that stores identifying information including the client's name, date of birth, gender, and Social Security Number (if available). Before assigning a new Individual ID to a client, the client's information gathered during Application Registration is compared against the Master Client Index (MCI) during File Clearance so that a duplicate record is not created for the client.

MEC	Minimum essential coverage	Medical coverage under: (a) A government-sponsored plan, including Medicare Part A, Medicaid (excluding CWM), CHIP, TRICARE, the veterans' health care program, and the Peace Corps program; (b) Employer-sponsored plans with respect to an employee, including coverage offered by an employer that is a government plan, any other plan or coverage offered in the small or large group market within the state, and any plan established by an Indian tribal government; (c) Plans in the individual market; (d) Health insurance plans in place on or before March 23, 2010; or (e) Any other health benefits coverage, such as a state health benefits risk pool, as recognized by the HHS secretary in coordination with the Treasury Secretary.
	Medicaid	Oregon's Medicaid program under Title XIX of the Social Security Act.
	Medicare	Medicare is the Federal Entitlement Health Insurance Program for people who meet at least one of the following criteria: • 65 years or older • Disabled or Blind receiving SSDI for 24 months • Diagnosed with ESRD (End Stage Renal Disease) or ALS (Lou Gehrig's disease) Medicare has 4 parts: • Part A – Hospital Insurance • Part B – Medical Insurance • Part C – Medicare Advantage (similar to an HMO or PPO) • Part D – Prescription Plan
MSP	Medicare Savings Program	These programs provide Medicaid benefits that are related to the receipt of Medicare benefits by paying the Medicare Part B premium for the customer. Depending on the benefit level, the customer may receive other benefits as well.
	Needy caretaker	A caretaker relative who either must or chooses to be included in the need group for TANF.
NIF	Nursing facility personal incidental fund	Personal incidental funds (PIF) are monies that service customers in a nursing facility allowed to use for personal items.
NNCR	Non-needy caretaker relative	A caretaker relative other than a parent who chooses not to be included in the TANF need group.

	Non-applicant	An individual not seeking an eligibility determination for themselves and is included in an applicant's or beneficiary's household to determine eligibility for the applicant or beneficiary.
	Non-citizen	Has the meaning given the term "alien" as defined in section 101(a)(3) of the Immigration and Nationality Act (INA), (8 U.S.C. 1101(a)(3)) and includes any individual who is not a citizen or national of the United States, defined at 8 U.S.C. 1101(a)(22).
	Non-citizen sponsor	A sponsor is a person who has helped an immigrant become a lawful permanent resident (green card holder) by signing an "affidavit of support."
	Noncustodial	Noncustodial parent is the parent who does not have primary custody of the child(ren).
	Nonexclusive	Not restricted to the person, group, or area concerned.
	Non-expedited service	A situation where the interview for benefits takes place as soon as possible but no later than the 20th day from the filing date. No requirement for speedy service.
Non-MAGI	Non-Modified Adjusted Gross Income Medical	Medical Programs for individuals who are aged, blind or disabled. Aging and People with Disabilities (APD) and Area Agency on Aging (AAA) are currently determining eligibility for the two Non-MAGI medical programs in Oregon. This will change when the state goes to ONE and all eligibility workers will be determining all programs. These programs are: • Medicare Savings Programs (MSPs) available to customers who are receiving Medicare Part A or eligible to receive it. • Oregon Supplemental Income Program Medical (OSIPM) available to customers who meet a Basis of Need (aged, blind or disabled.) Oregonians that eligible can receive one or both of these programs.

	Nonstandard living arrangement	Nonstandard living arrangement is defined as follows: (a) In the GA, OSIP, OSIPM, and QMB programs, an individual is considered to be in a "nonstandard living arrangement" when the individual is applying for or receiving services in any of the following locations: (A) A nursing facility in which the individual receives long-term care services paid with Medicaid funding, except this subsection does not apply to a Medicare recipient in a skilled-stay nursing facility. (B) An intermediate care facility for individuals with intellectual disabilities (ICF/ID). (C) A psychiatric institution, if the individual is not yet 21 years of age or has reached the age of 65. (D) A community-based care (see section (17) of this rule) setting, except a State Plan Personal Care (SPPC) setting is not considered a "nonstandard living arrangement".
NOTM		Legacy system used to generate notices.
	Numident	Numident or Numerical Identification System, is the Social Security Administration's computer database. It contains the names of applicants, places and date of births, and other information.
OAA	Older Americans Act	The Older Americans Act (OAA), originally enacted in 1965, supports a range of home and community-based services, such as meals-on-wheels and other nutrition programs, in-home services, transportation, legal services, elder abuse prevention and caregivers support. These programs help seniors stay as independent as possible in their homes and communities. In addition, OAA services help seniors avoid hospitalization and nursing home care and, as a result, save federal and state funds that otherwise would be spent on such care.
OAH	Office of Administrative Hearings	OAH is an agency that provides an independent and impartial forum for citizens and businesses to dispute state agency action against them.
OAR	Oregon Administrative Rules	Oregon Administration Rules defines the ODHS and OHA policy
	Obligee	The obligee is the obliged parent, who receives a child support payment from the noncustodial parent.
	Obligor	An obligor is the noncustodial parent that is required to pay the child support to the other parent who is caring for the child(ren).
OCC	Office of Child Care	
ODE	Oregon Department of Education	

ODHS	Oregon Department of Human Services	
OED	Oregon Employment Department	
OHA	Oregon Health Authority	
OHP	Oregon Health Plan	Oregon Health Plan, which is Oregon's Medicaid/Children's Health Insurance Plan (CHIP) program.
OPAR	Office of Payment Accuracy and Recovery	Consists of Overpayment Writing Unit (OWU) and Overpayment Recovery Unit (ORU).
OSIP	Oregon Supplemental Income Program	Cash supplements and special needs payments to individuals who are blind, disabled or 65 years of age and older.
OSIPM	Oregon Supplemental Income Program Medical	A Medicaid program which provides medical coverage (OHP Plus) for individuals who are aged, blind or disabled. APD administers OSIPM while the Oregon Health Authority administers all MAGI programs.
	Overpayment	An overpayment is defined as a benefit or service received by or on behalf of an individual, or a payment made by ODHS|OHA on behalf of an individual, that exceeds the amount for which the individual is eligible.
	Parent	Means a natural or biological, adopted or stepparent.
	Pass-through	Child support, up to $50 per dependent child or minor parent per financial group per month and not to exceed $200 per financial group per month, sent to the participant before any remaining amount of current child support is withheld by the state. Pass-through includes current child support only.
PDP	Personal Development Plan	Function in TRACS used to record activities, assigned hours, and attendance for TANF JOBS participants, along with some ABAWD and STEP participants using SNAP Employment and Training Services.
	Pend	Pend is the term used when ODHS needs to request more information from the individual or verification from a source other than the individual, to lend credence to the information the individual is providing. Individuals must provide verification when it is requested by ODHS|OHA.
	Personal injury	A physical or emotional injury to an individual including, but not limited to, assault, battery, or medical malpractice arising from the physical or emotional injury.
PHI	Protected health information	Individually identifiable information relating to the past, present, or future health status of an individual that is created, collected, or transmitted, or maintained by a HIPAA-covered entity in relation to the provision of healthcare, payment for healthcare services, or use in healthcare operations.

	Pickle Amendment	Under section 503 of Public Law 94-566, the "Pickle Amendment," Title II beneficiaries who would continue to receive SSI payments (or would continue to be eligible for benefits under section 1619(b)) but for their Title II COLAs continue to be considered SSI recipients for Medicaid purposes. If an individual's other income would not have precluded continuing SSI payments (or deemed payments under section 1619) without the title II COLAs, the State must continue to consider the individual to be an SSI recipient for Medicaid purposes.
PII	Personally identifiable information	Information that directly identifies an individual. Identifying information can include, but not limited to: name, address, social security number, telephone number, email address, etc.
POS	Point-of-sale	Point-of-sale refers to the place where a customer pays for goods or services. The transaction can take place in a physical store or be done virtually.
	Primary contact	Has the same meaning given "head of household."
	Primary person	Primary person for all programs except the SNAP program, means the filing group member who is responsible for providing information necessary to determine eligibility and calculate benefits. The ""primary person"" for individual programs is as follows: (a) In the TANF program, the parent or caretaker relative. (b) In the ERDC program, the caretaker. (c) In the SNAP program, see OAR 461-001-0015. (d) In the GA, OSIP, OSIPM, QMB, REF, and REFM programs, the participant or participant's spouse.
PRTF	Psychiatric Residential Treatment Facility	
	Public charge	Public charge or the public charge test is used by immigration officials to decide if a person can: enter the United States or get lawful permanent resident (LPR) status (i.e. a green card).

	Public institution	Means any of the following: (a) A state hospital (ORS 162.135); (b) A local correctional facility (ORS 169.005), a jail, or prison for the reception and confinement of prisoners that is provided, maintained, and operated by a county or city and holds individuals for more than 36 hours; (c) A Department of Corrections institution (ORS 421.005), a facility used for the incarceration of individuals sentenced to the custody of the Department of Corrections, including a satellite, camp, or branch of a facility; (d) A youth correction facility (ORS 162.135) (A) A facility used for the confinement of youth offenders and other individuals placed in the legal or physical custody of the youth authority, including a secure regional youth facility, a regional accountability camp, a residential academy and satellite, and camps and branches of those facilities; or (B) A facility established under ORS 419A.010 to 419A.020 and 419A.050 to 419A.063 for the detention of children, wards, youth or youth offenders pursuant to a judicial commitment or order. (e) As used in this rule, the term public institution does not include: (A) A medical institution as defined in 42 CFR 435.1010 including the Secure Adolescent Inpatient Program (SAIP) and the Secure Children's Inpatient Program (SCIP); (B) An intermediate care facility as defined in 42 CFR 440.140 and 440.150; or (C) A publicly operated community residence that serves no more than 16 residents, as defined in 42 CFR 435.1009.
	Pursuit of assets	An eligibility requirement that requires individuals to apply for or pursue income or resources to which they have a legal claim or right but don't currently receive or possess.
QC	Quality Control	The intent of QC is to provide information about eligibility and the correctness of benefits. The information gathered from the QC reviews may influence agency corrective actions, agency policy decisions and legislative actions.

	Qualified hospital	A hospital that: (a) Participates as an enrolled Oregon Medicaid provider; (a) Notifies the Authority of their decision to make presumptive eligibility determinations; (a) Agrees to make determinations consistent with Authority policies and procedures; (a) Informs applicants for presumptive eligibility of their responsibility and available assistance to complete and submit the full Medicaid application and to understand any documentation requirements; and (a) Are not disqualified by the Authority for violations related to standards established for the presumptive eligibility program under 42 CFR § 435.1110(d).
	Qualified non-citizens	Qualified non-citizens are individuals who are admitted to the United States with a lawful immigrant status. The person who is granted that status either enters the United States as a lawful permanent resident or will be eligible to become a lawful permanent resident in the future. A lawful permanent resident is eligible to be naturalized as a U.S. citizen usually after five years of lawful permanent residency in the U.S.
	Qualified victims' services program	A nongovernmental, nonprofit, community-based program receiving moneys administered by the Oregon Department of Human Services or the U.S. Department of Justice that offers safety planning, counseling, support or advocacy services to victims of domestic violence, sexual assault or stalking.
RCF	Residential care facility	Community-based facility which houses six or more aged or disabled adults and which provides 24-hour assistance with activities of daily living, health, and social needs. These are similar to an Assisted Living Facility (ALFs) except residents of RCFs can either reside in separate, individual living units or shared units. In general, RCF residents tend to require more care than those in an ALF.

	Reasonable opportunity period	May be used to obtain necessary verification or resolve discrepancy regarding US citizenship or non-citizen status; (a) Begins on and shall extend 90 days from the date on which notice is received by the individual. The date on which the notice is received is considered to be five days after the date on the notice, unless the individual shows they did not receive the notice within the five-day period; (a) May be extended beyond 90 days if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation or the Agency needs more time to complete the verification process.
	Redetermination	A review of eligibility outside of regularly scheduled renewal. Redeterminations that result in the assignment of a new renewal date are considered renewals.
REF	Refugee assistance	Cash assistance to low-income refugee singles or married couples, without children, who are not eligible for the TANF program.
	Renewal	A process by which the participant is assessed to continue receiving benefits such as medical coverage for a defined period of time based on the program.
	Renewal period	The period when a case must be submitted for renewal of benefits.
REP	Refugee Employment Program	Any self-sufficiency service, employment service or case plan available to or developed for individuals in the REF program.
RFI	Request for information	A notice sent by the agency to request additional information or verification of information. An RFI may be sent when attested information is not reasonably compatible with information obtained through an electronic data match, or when information or verification is needed that is not available through an electronic data match.
SAC	Substitute Adoptive Care	Medical coverage for children in Behavioral Rehabilitation Services (BRS) or Psychiatric Residential Treatment Facility (PRTF).
	Safe home	A private dwelling available for the temporary housing of victims of domestic violence, sexual assault and stalking to ensure safety of victims and any dependents until other housing arrangements can be made.
SAVE	Systematic Non-citizen Verification for Entitlements program	Web-based application that provides information on citizenship status for non-citizens.
SEBTC	Summer Electronic Benefits Transfer for Children	SEBTC is a grant from the Child Nutrition Program to provide extra food benefits during the summer months for school aged children.
	Self-alleged	Self-alleged father: claiming to be the parent of a child when paternity has not been established by law.

	Self-sufficiency activities	ODHS-approved activities while participating in an E&T program for either the SNAP ABAWD, STEP or TANF JOBS program.
SEN	Self-employment no cost	Self-Employment No Cost is a legacy system term used when determining countable income for state assistance programs. When as applicant states they have no cost associated with running their business, the full gross amount is used in determining benefit amounts.
	Service area	A geographical area where services are available.
	Service population	All people who receive services from a program.
SFDNP	Senior Farm Direct Nutrition Program	Food vouchers for low-income seniors, funded by a grant from the U.S. Department of Agriculture.
SFPSS	State Family Pre-Social Security (SSI)	The intent of the State Family Pre-SSI (SFPSS) program is to provide interim cash assistance, case management and professional level support to TANF eligible adults and their family in pursuing Supplemental Security Income (SSI). The TANF-eligible adult must have severe physical or mental impairment(s) that has been assessed and determined to meet the program impairment criteria by the program's disability analyst.
	Shared eligibility service	A common or shared eligibility system or service used by a state to determine individuals' eligibility for insurance affordability programs.
SLF	Specialized Living Facility	A facility which provides identifiable services designed to meet the needs of persons in specific target groups which exist as the result of a problem, condition or dysfunction resulting from a physical disability or behavioral disorder and require more than basic services of other established programs.
SLMB	Specified Low Income Medicare Beneficiary	These individuals are entitled to Medicare Part A, have income greater than 100% Federal Poverty Level (FPL), but less than 120% FPL and resources that do not exceed twice the limit for Supplemental Security Income (SSI) eligibility, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only.
SNAP NED	Supplemental Nutrition Assistance Program, No Earned Income, Elderly, or Disabled	Customers are eligible for 24-month certification if they are determined to have no earned income and all adults in the filing group meet the SNAP definition of elderly or disabled.
SNR	Special needs rate	Pertaining to ERDC and JOBS child care, special needs rate is for child(ren) who require a level of care over and above norm for age due to physical, behavioral or mental disability.
	Soft pend	A request for information when eligibility is determined, and benefits can be issued with conditions applying to the certification timeframe.

	Spark rating	Rating scale used to identify child care programs that either meet, exceed or excel in essential standards that support quality learning for children.
SPL	Service priority level	A system of measuring an individual's care needs based on their ability to complete activities of daily living (ADLs).
	Spouse	An individual who is legally married to another individual under: (a) The statutes of the state where the marriage occurred; (b) The common law of the state in which two individuals previously resided while meeting the requirements for common law marriage in that state; or (c) The laws of a country in which two individuals previously resided while meeting the requirements for legal marriage in that country.
SSA	Social Security Administration	The Federal agency which assigns social security numbers; administers the retirement, survivors, death and disability insurance programs known as Social Security. The SSA also administers the Supplemental Security Income (SSI) program for the aged, blind and disabled.
	SSA rep payee	Person authorized as a represented payee for someone else's Social Security benefits.
SSB	Social Security Benefits	Individuals who worked and paid taxes into the Social Security system can receive monthly benefits when they retire or if they become disabled (see SSDI below). Dependent children and spouses can receive benefits based on the individual's reported earnings. Surviving spouses and children can collect benefits when the individual dies.
SSD	Social Security Disability	Social Security Disability can also be referred to as Social Security Disability Insurance. Social Security Disability Insurance is one of the largest Federal programs that provides assistance to people with disabilities. SSD pays benefits to recipients and certain members of their family if the recipient is "insured," meaning that the recipient worked long enough and paid Social Security taxes.
SSDI	Social Security Disability Income	Monthly benefits paid to individuals with either severe impairments that will prevent one from doing "substantial" work for a year or more, or a condition that is expected to result in death per Social Security Administration. Recipients must have paid enough Social Security taxes while they were working to receive a benefit.
SSI	Supplemental Security Income	A federal income program administered by the SSA and funded by general tax revenues (not an individual's Social Security taxes). SSI provides support for aged, blind, and disabled people who have limited income and resources to meet basic needs.

SSN	Social Security number	A unique nine-digit number issued to U.S. citizens, permanent residents, and temporary (working) residents under section 205(c)(2) of the Social Security Act. The number is issued to an individual by the Social Security Administration.
SUP	Support	Legacy system acronym meaning child support paid by an obligor and/or child support received by obligee.
TA-DVS	Temporary Assistance for Domestic Violence Survivors	The program provides temporary financial help to support families whose safety is at risk due to domestic violence. Most often this is when the domestic violence survivor and the children are fleeing domestic violence or at risk of returning to an abusive situation. The program can help with up to $1200.00 over a 90-day eligibility period. Payments are usually given directly to the landlord or other service provider.
	Tax dependent	Has the meaning given the term "dependent" under section 152 of the Internal Revenue Code, as an individual for whom another individual claims a deduction for a personal exemption under section 151 of the Internal Revenue Code for a taxable year.
	Term insurance	A term life insurance policy is the simplest, purest form of life insurance: You pay a premium for a period of time – typically between 10 and 30 years – and if you die during that time a cash benefit is paid to your family (or anyone else you name as your beneficiary). Term life insurance does not accrue a cash surrender value like whole life insurance.
	Timely continuing benefit decision notice	Informs the participant of the right to continued benefits and is mailed no later than ten calendar days prior to the effective date of the change, except for individuals in the Address Confidentiality Program, for whom it shall be mailed no later than 15 calendar days prior to the effective date of the change. Commonly known as the 10 day notice.
	Title IV-E	Title IV-E of the Social Security Act (42 U.S.C. §§ 671-679b).
	Title IV-E subsidized guardianship payments	Ongoing financial assistance to eligible children who exit the child welfare system into the permanent care of a legal guardian.
TOA	Type of Assistance	Program code within ONE to identify a specific type of assistance for an individual or household program (SNAP, cash, ERDC, or medical).
TPL	Third party liability	Third Party Liability is the legal obligation of a third party to pay part or all of the medical costs. All available third-party resources must pay all claims that they are legally obligated to before the state Medicaid program can pay for the care of an individual.
TRACS	Transition Referral And Client Self-Sufficiency	TRACS is the SSP case management system for families receiving case management services via the SSP cash programs (TANF, TA-DVS and Refugee), and SNAP Employment and Training services.
UC	Unemployment compensation	Acronym used to represent weekly unemployment compensation payments to an individual.

UIB	Unemployment insurance benefit	Benefits given to unemployed individuals through the Oregon Employment Department.
	Unqualified non-citizen	Unqualified non-citizens are individuals who may be admitted lawfully into the United States but do not have immigrant status, i.e., they may stay here for a specific period of time but cannot stay in the country for longer than their travel visa allows them. Foreign students, tourists, diplomats, performers, artists, entertainers, certain private company employers, etc., are included in this category.
USCIS	United States Citizenship and Immigration Services	USCIS is a federal agency that regulates citizenship, employment in the U.S., humanitarian programs, adoptions, and lawful immigration into the U.S.
VA	Veterans' Affairs	A federal agency that provides healthcare services and non-healthcare benefits (disability compensation, vocational rehabilitation, education assistance, home loans, life insurance, burial/memorial benefits) to veterans and their family members.
VEC	Virtual Eligibility Center	A single, connected center that includes workers in different offices/ geographic areas that have a shared workload.
	Vested	To be fully and unconditionally guaranteed as a legal right, benefit, or privilege.
VHA	Veteran Health Administration	The Veterans Health Administration is the largest health care system in the United States. It provides a wide range of services to veterans in numerous health care facilities, VA Medical Centers and outpatient sites.
VLP	Verify Lawful Presence	An Integrated ONE interface that determines in real-time the status of a non-citizen applicants lawful presence in the United States for applicants requesting Medical assistance. Medical programs must be present for all other programs to use data provided by VLP.
WIA	Workforce Investment Act	The Workforce Investment Act is a program that enhances the workforce, minimizes welfare dependency, and enhances productivity and competitiveness.
WIC	Women, Infants and Children	WIC is a supplemental nutrition, education, and health referral program for pregnant, breastfeeding, and postpartum individuals, and children under the age of 5.
	Work Share	Oregon's Work Share program seeks to prevent layoffs by enabling employers to enter into a voluntary agreement with the Oregon Employment Department (OED) to temporarily reduce employee hours and wages and supplement those wages with partial unemployment benefits.

WP	Worker portal	Worker Portal is the worker or staff facing side of the ONE system. It will help staff complete intake on new applications, determine financial eligibility and benefit amounts, manage benefits, and process case changes. It will also support functions such as scheduling appointments, task management, and document management.
WSIT	JOBS Child Care Situation	DHR legacy screen. JOBS Child Care Situation screen used to add, modify, or close child care provider situations for JOBS child care payments.

Oregon Administrative Rule(s)

461-101-0010 — Program Acronyms and Overview

Chapter 2: Eligibility

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Chapter 2: Eligibility

Section 1: Application

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Application

Introduction

There are multiple ways an individual can submit an application to ODHS|OHA. Some procedures change depending on the type of form submitted, the method (printed or online) and if the application is new or a recertification/ renewal.

Every application contains information that helps determine the processing timelines and eligibility for the programs the individual is requesting.

The application process should not be a barrier to the people accessing benefits. It should be simple, efficient and responsive to the needs of persons seeking help. It should also consider the privacy and confidentiality of each applicant. Whenever possible, one application is used to determine eligibility under multiple programs.

Individuals can use the following paper applications:

- DHS 0415F Application (for SNAP, ERDC, REF, TANF, TA-DVS),
- DHS 7476 Employment Related Day Care and SNAP Application (for ERDC and SNAP only), and
- OHP 7210 Application for Oregon Health Plan (OHP) Benefits (for OSIPM, MSP, HSD programs and LTC services)

Other resources

Alternate Format Request: Process on how to handle alternate format request

Documents/Information Received - No Oregonian in Local Office: This process walks Support Staff through handling documents which are not received in person.

Documents/Information Received in Person: This process walks Support Staff, Eligibility Workers, Case Managers and Family Coaches through handling documents which are received in person.

Online application

The OregonONEligibility (ONE) system is an online application that gives Oregonians the option to apply for medical, cash, child care, food benefits and long-term care using a single online application.

Individuals may apply for assistance and update information through the ONE Applicant Portal using a secure login. Individuals may also apply and update information using a paper form, and an eligibility worker will enter the information into ONE using the Worker Portal.

If an individual requests child care assistance, this establishes a date of request (DOR) for ERDC.

Note: The Requesting ERDC During Interview form (DHS 0419) is not a required form as long as all pertinent information to determine eligibility is collected.

Other resources

Application Status *includes screenshots: Describes how to Quick Search for an Application, view an application number through Case Summary and conduct a Task Search for an unprocessed application.

Application Matrix QRG: This document is intended as a reference to guide you as applications are received to be processed in ONE.

Date of request

The date of request (DOR) is the date the request for benefits is received by ODHS|OHA. A DOR is established and documented by ODHS|OHA. Once a date of request is established, an Eligibility Worker must process the application within a certain time period. For ERDC, benefits begin the first of the month in which the DOR is established.

Program	How to establish DOR	Application processing time
SNAP	DOR does not apply.	See filing date.
TANF	DOR does not apply.	See filing date.
ERDC	The DOR is the date the caretaker or authorized representative requests ERDC benefits or child care assistance. This request can be made to ODHS|OHA via phone, letter, application or walk-in.	45 days, which can be extended due to situations beyond the applicant's control that require additional time to gather verification requested, up to an additional 45 days (a total of 90 days from the DOR).
REF	DOR does not apply.	See filing date.
MSP	The DOR is: 1. The date the applicant or someone acting on their behalf requests medical benefits. 2. The date medical services were received if the request for medical benefits is received by an ODHS|OHA representative no later than the next business day. 3. The date ODHS|OHA initiates a renewal. The request can be made via ONE, phone, in writing or in person.	45 days, which can be extended due to situations beyond the applicant's or ODHS|OHA's control which require additional time to gather the requested verification.

OSIPM	The DOR is: 1. The date the applicant or someone acting on their behalf requests medical benefits. 2. The date medical services were received if the request for medical benefits is received by an ODHS|OHA representative no later than the next business day. 3. The date ODHS|OHA initiates a renewal. The request can be made via ONE, phone, in writing or in person.	45 days, which can be extended due to situations beyond the applicant's or ODHS|OHA's control that require additional time to gather the requested verification. 90 days if the applicant has met all eligibility requirements, unless ODHS|OHA must determine whether the applicant is blind or has a disability. The processing time may be extended if: • ODHS|OHA cannot reach a decision because the individual or an examining physician or psychologist has not taken an action necessary for the decision to be made, or • There is an administrative or other emergency beyond ODHS|OHA's control that impairs its ability to make the decision.

HSD	The DOR is: 1. For new applicants, the DOR is established: (a) When the request for medical benefits is received by the Agency, the Federally Facilitated Marketplace (FFM), or a community partner, or (b) The date the applicant received a medical service, if the request for medical benefits is received by midnight of the following business day. 2. For current beneficiaries, the DOR is: (a) The date the beneficiary or someone authorized to act on the beneficiary's behalf reports a change requiring a redetermination of eligibility, or (b) The month an individual ages off a medical program. 3. For automated renewals which do not generate a Request for Information (RFI), the DOR is the date the Agency initiates the automated renewal. 4. For active renewals and for automated renewals which result in the generation of an RFI, the DOR is the date the ODHS|OHA receives a response to the active renewal or to the RFI.	45 days for initial request An eligibility determination will be made and a decision notice sent by the 45th calendar day after the date of request if: • All information necessary to determine eligibility is present, • An RFI is issued and a response has not been received by the deadline provided, or • A completed application is not received by the agency within 45 days after the date of request. The 45-day processing time may be extended if: • ODHS|OHA must request additional information or verification, and the due date of that request extends beyond the 45th day, or • If there is an administrative or other emergency beyond the control of the ODHS|OHA. 30 days for eligibility renewal If additional information or verification is required, the ODHS|OHA will provide the beneficiary at least 30 days from the date of the renewal form to respond and provide necessary information.

Click here for examples: Date of request.

Oregon Administrative Rule(s)

461-115-0030 — Date of Request
461-115-0010 — Application Process; General
461-115-0190 — Application Processing Time Frames; Not Pre-TANF or SNAP
410-200-0110 — Application and Renewal Processing and Timeliness Standards

Other resources

Third Month Application Processing: Program applications may run over into a third calendar month, this explains how some program time frames are extendable so we can consider whether the family will become eligible with upcoming, future changes.
Establishing DOR/Filing Date for Support Staff *includes screenshots
Extending the RFI Due Date for ERDC Cases *includes screenshots

Filing date

A filing date is the date ODHS|OHA receives a request for benefits from the applicant. A filing date is established when the applicant provides their name, address and signature to ODHS|OHA. For some programs, the filing date is the date benefits may begin once eligibility is determined.

A completed application is not needed or required to set the filing date.

Program	How to establish a filing date	Application processing time
SNAP	A request for SNAP benefits received by ODHS|OHA that includes the applicant's name, address and signature. This is true, even if the request is received after business hours or on a weekend or holiday.	• 7 days for expedited service. • 30 days for non-expedited service. 60 days if participant requests additional time to submit pended items.
TANF	The date a signed application for cash benefits (including the applicant's name, address and signature) is received by ODHS|OHA. If the request is received after business hours or on a weekend or holiday, the filing date will be the next working day.	In the TANF program, an application must be processed within 30 days or 45 days if eligibility information is expected to be received after the 30th day and the individual has no control of this information. When an Oregonian applies for TANF and is denied for the current month, we cannot use the same filing date and interview when evaluating for TANF eligibility in the following month. However, the same paper application, if within 60days of the original filing date can be used. When using the same application within the 60-day time frame, it must be amended to include the newly established filing date, update any information that has changed, and obtain a new signature.
ERDC	Filing date does not apply.	See date of request.

REF	The date a signed application for cash benefits (including the applicant's name, address and signature) is received by ODHS|OHA. If the request is received after business hours or on a weekend or holiday, the filing date will be the next working day.	An application is good for 30 days. If the application decision has not been made, the application is denied. A new filing date needs to be established.
MSP	Filing date does not apply, see date of request.	
OSIPM	Filing date does not apply, see date of request.	
HSD	Filing date does not apply, see date of request.	

Click here for examples: Filing date.

Oregon Administrative Rule(s)

461-115-0040 — Filing Date; REF, SNAP, TANF
461-115-0210 — Application Processing Time Frames; SNAP

Effective date of benefits

After an individual has completed the application process and is determined eligible for a program or programs, their initial month's benefits are approved. The date in which this occurs is called the effective date. Programs have different effective dates for when benefits can be authorized upon completing the application process.

SNAP In most situations, for a filing group making an initial application or applying at the end of a certification period, the effective date for starting benefits is the filing date, as long as all eligibility requirements are met within 30 days of the filing date. If all eligibility requirements are not met within 30 days of the filing date, the effective date is the date all eligibility requirements are met.

If a filing group applies for benefits during the last two months of their certification period, the effective date is the first of the month following the end of the certification period unless the filing group fails to complete the application process within the application time frames.

For migrant and seasonal farmworkers that received SNAP benefits in another state the month before applying for SNAP benefits in Oregon, the effective date for starting benefits is the first of the month.

TANF In the TANF program, when a filing group makes an initial application or applies after the end of their certification period, the effective date for starting benefits is the filing date, if all eligibility requirements are met within 30 days of the filing date, unless:

- If the only eligible child is an unborn, the effective date may not be earlier than the first day of the calendar month prior to the month in which the due date falls;
- For a JOBS support service payment, the effective date is the date the individual meets all eligibility requirements in OAR 461-190-0211.

ERDC In the ERDC program, the effective date for starting benefits is one of the following:

- The first day of the month in which the request for benefits is made, if all eligibility requirements are met in that month, and verification is provided within the application processing timeframes; or
- If all eligibility requirements are not met in the month of request, the effective date is the first day of the month in which they are met, if verification is provided within the application processing timeframes (generally 45 days from the date of request).
- For a benefit group that received TANF benefits within the 30 days before applying for ERDC, the effective date is the first of the month following closure of their TANF program benefits.

REF In the REF program, when a filing group makes an initial application, the effective date for starting benefits is one of the following:

- If all eligibility requirements (including an interview) are completed by the 30th day from the filing date, the effective date for starting benefits is the filing date; or
- If all eligibility requirements are not met by the 30th day from the filing date, a new filing date must be established.

MSP For all Medicare Savings Programs, the effective date is always the first of a month. This includes when an individual is currently receiving SMB (Specified Low-income Medicare Beneficiary) or SMF (Qualified Individuals) and is determined eligible for QMB (Qualified Medicare Beneficiary).

QMB

- The effective date for starting benefits the first of the month after the benefit group has been determined to meet all QMB eligibility criteria and ODHS|OHA receives the required verification.

SMB and SMF

- For individuals applying for benefits through ODHS|OHA, the effective date is the first day of the month in which the benefit group meets all eligibility criteria and ODHS|OHA receives the required verification.
- For individuals who are determined eligible based on a Social Security Administration (SSA) Low-Income Subsidy (LIS) application, the effective date is the first day of the month the LIS information is received by SSA if the application was an electronic transmission from SSA and the benefit group meets all eligibility criteria.

Retroactive medical benefits

Retroactive MSP benefits are only available for SMB and SMF. QMB eligible individuals are not eligible for retroactive medical. However, if they are also eligible for OSIPM, they may be eligible for retroactive medical under that program. If eligible for OSIPM retroactively, the individual's Part B premium will be paid with state general funds.

Retroactive medical may be requested at any time by the individual, their authorized representative, or assumed from the applicant's circumstances. A request for retroactive SMB or SMF benefits is assumed if the individual incurred or paid the cost of their Medicare Part B Premium during the retro period, whether they indicate they had a cost on the application or not.

If a benefit group currently eligible for SMB or SMF requests and is eligible for retroactive payment of Part B Medicare premiums, the earliest date they can be eligible is three months before the original date of request. This means that there can potentially be a gap in coverage. For example, if the DOR is 9/30 and the effective date of SMB is 10/1 (verification of income was needed and not received until 10/5), then the retroactive benefits cover June, July, and August (no benefits in September). An individual may be eligible in ANY one or ALL of the three months. To receive benefits, an individual must meet ALL eligibility factors for SMB or SMF other than pursuit of assets, which cannot be enforced until the applicant has been made aware of the requirement to pursue the asset.

Individuals are eligible for retroactive SMB and SMF even if they were not actually enrolled in Part B; however, if that is the case, they must be eligible to enroll and must have incurred Medicare Part B covered services in those months. The person can be enrolled in Part B retroactively and SMB and SMF will pay the premium if the individual is eligible for SMB or SMF in each of the retroactive month(s). This includes deceased individuals who would have been eligible for Medicaid-covered premiums if a person acting on their behalf completes an application for them.

Note: Individuals are not eligible for retroactive SMF in any month they were receiving OSIPM or HSD medical programs..

OSIPM Initial month

The initial month includes:

- When an individual is newly applying for medical, and
- When an individual is currently receiving medical and is determined eligible for a better program (for example, receiving MSP and becomes eligible for OSIPM).

The effective date for starting medical benefits for OSIPM is one of the following, whichever occurs first:

- If the applicant meets all eligibility requirements on the date of request, the effective date is the first of the month in which the date of request was established.
- If all eligibility requirements are not met in the month containing the date of request but are met within 45 days of the DOR, the effective date will be the first day of the month the requirements are met.
- If the 45-day processing period has been extended due to delays beyond the applicant's control, the effective date will still be the first of the month in which the individual established a date of request (if eligible). If not eligible on the date of request or on any day in the same month, the effective date will be the first day of the month in which the requirements are met. In other words, if an extension was granted, the applicant does not have to establish a new DOR.

Incarcerated individuals

If an individual has been released from a correctional institution and is determine eligible for OSIPM, the effective date for beginning the individual's medical assistance is the date the individual is released from the correctional facility or the date the individual begins a period of hospitalization outside of the correctional facility.

Retroactive medical benefits

If a benefit group requests and is eligible for retroactive medical benefits and has a Medicaid-covered cost prior to the month in which the date of request falls, the earliest date they can be eligible is the first day of the month that is three months before the date of request. For example, if the benefit group requests benefits on July 10th, eligibility may begin as early as April 1.

If an individual is deceased and a person acting on their behalf completes an application for them, that person may be eligible for retroactive medical.

After establishing the earliest date, determine eligibility on a month-by-month basis. The period starts on the earliest established date and ends on the date the benefit group requests benefits. For example, if the benefit group requests benefits on August 10th, the earliest effective date is May 1. Establish eligibility separately for May, June and July.

Renewal of benefits

The effective date for continuing eligibility at the end of the eligibility period is one of the following:

- If the renewal form is received before the end of the last month of the eligibility period, the effective date for an eligible benefit group is the first day of the month after the renewal period.
- If the renewal form is not received before the end of the individual's last month of eligibility, end benefits unless the filing group has contacted ODHS|OHA before the end of the last month of the eligibility period AND completed the renewal within the month following the last month of the eligibility period. If the renewal form is received later, determine the effective date as if it were a new application.

When a renewal is initiated, the filing group must be reviewed for other medical program eligibility prior to reducing or ending medical benefits. If additional information is needed to redetermine eligibility, the benefit group remains eligible from the date the review is initiated until ODHS|OHA determines eligibility in accordance with the application processing time frames.

Restored benefits

The effective date for restoring benefits that were underpaid (including erroneous collections of overpayments) or denied or closed in error is one of the following:

- If the error resulted from ODHS|OHA error, use the date the error was made. Restore benefits only for the preceding 12 months.
- If the error resulted from participant error, use the earliest of the following:
  - The first day of the month the benefit group notifies the branch office of the possible loss.
  - The month the branch office discovers the loss.
  - The date a hearing is requested.

The effective date for restoring benefits that have been suspended is:

- The first of the month after the suspension, if the suspension was for only one month, or

- The date the benefit group again becomes eligible, if benefits have been suspended for more than 30 days. Treat the month in which benefits are restored as an initial month.

Denial of benefits

The effective date for denying benefits is the date the decision is made that the individual is not eligible, including if the ineligibility results from failure to provide information or otherwise cooperate.

Closure and suspension of benefits

When the only individual in a benefit group dies, the effective date of closure is the date of death. If there is more than one person in the benefit group, the date of death is the date of reduction in benefits.

When using prospective budgeting, the effective date for closing or suspending benefits is the last day of the month in which the notice period ends.

For a pregnant person receiving OSIPM, the effective date for closing benefits is no earlier than the last day of the 12th calendar month after the last day of pregnancy falls, except at the individual's request.

Suspending benefits for incarcerated individuals: The effective date is the date the decision is made to suspend the benefits and the notice is sent.

Click here for more information on incarcerated individuals.

Click here for more on effective dates for long-term care (LTC) services.

Click here for more on effective dates.

HSD **New applicants:** The effective date of benefits is the earliest of the following:

- The first day of the month in which the date of request is established, or
- If ineligible in the month of the date of request, the first day within the following month the applicant is determined to be eligible.

Renewals: For all HSD medical programs except Extended Medical (EXT), eligibility shall be renewed every 12 months.

- The renewal date is the last day of the month established by counting 12 full months, including the DOR month.
- For ongoing eligibility, the renewal date is established by counting 12 full months following the current renewal month.

Retroactive medical requested: The effective date is the earliest of the following:

- The first day of the earliest of the three months prior to the DOR; or
- The earliest date of eligibility within the three months prior to the DOR.

Change is reported:

- If the change results in a reduction or loss of eligibility, the effective date for the change is:
  - The first of the next month, if the determination is made on or before the 15th of the month, or

  - The first of the month following next month, if the determination is made on or after the 16th of the month.
- If the change results in ongoing benefits with the same benefit level, the effective date is the first of the month following the date of processing.
- If an individual who is already receiving an HSD medical program benefit reports a pregnancy, the effective date of the pregnancy-related HSD medical program benefit is the first of the month in which the pregnancy is reported. For CWM beneficiaries who report a change that results in eligibility for Plus level benefits, the effective date of the new benefit is the first of the month it is reported.

Suspending or closing benefits:

- The effective date for closing HSD medical program benefits is the earliest of the following:
  - The date of a beneficiary's death,
  - The last day of the month in which a beneficiary becomes ineligible and a timely continuing benefit decision notice is sent,
  - The last day of the month ODHS|OHA receives a signed written request to end benefits,
  - The day prior to the start date for Child Welfare Programs and OSIPM for beneficiaries transitioning from an HSD medical program,
  - The date the program ends, or
  - The last day of the month in which a timely continuing benefit decision notice is sent if ongoing eligibility cannot be determined because there was no response to a request for information by the deadline provided.

Click here for examples: Effective date of benefits.

Oregon Administrative Rule(s)

461-180-0070 — Effective Dates; Initial Month Benefits
461-180-0080 — Effective Dates; Initial Month SNAP Benefits
461-115-0050 — When an Application Must Be Filed
461-190-0211 — Case Plan Activities and Standards for Support Service Payments; JOBS, Pre-TANF, REF, REP, SFPSS, TA-DVS, TANF
461-115-0210 — Application Processing Time Frames; SNAP
461-115-0190 — Application Processing Time Frames; Not Pre-TANF or SNAP
461-180-0090 — Effective Dates; Initial Month Medical Benefits
410-200-0115 — Effective Dates

Other resources

ERDC Application - Future Employment Date: Describes the process around ERDC applications if they are received with a future-effective employment start date.

Certification periods

When an individual is approved for benefits, their case remains open until they have to reapply. This amount of time is called a certification period, and it can vary depending on the program. Please note that some programs may allow for extension of certification periods, while cases may also close prior to the end of a certification period if the individual no longer meets program eligibility.

SNAP In the SNAP program, the certification is selected by ODHS|OHA, as well as the redetermination date, based on the individual's unique circumstances. The longest possible certification period is assigned while attempting to align the end date with companion benefits. It will not always be possible to align certification periods with other programs.

The length of the certification period depends on how far in advance the circumstances affecting the group's eligibility can be predicted, but cannot exceed 12 months in most scenarios, except:

- The certification period may be extended beyond 12 months in each of the following situations:
  - To the end of the TBA period, if the individual becomes eligible for transitional benefits. If eligibility for TBA ends early, the certification period is changed to end on the last day of the month; or
  - To include the month after the individual finishes working under a TANF JOBS Plus agreement. If the agreement ends early, the certification period is changed to end on the original recertification date, or on the last day of the month following the month in which the JOBS Plus agreement ends (whichever is later).

A certification period of less than 12 months can be extended before the certification period ends up to 12 months in the following situations:

- A one- or two-month certification period for expedited services when pending information is received, and eligibility and benefit level is determined based on the new information;
- An application or change report form is received and eligibility is reviewed; or
- The report system changes from CRS to SRS.

A certification period of 24 months may be assigned for a filing group in which all adult members are elderly or have a disability, and no one in the filing group has earned income (also called a NED household). 24-month certifications are placed in SRS and are required to complete a Periodic Report at month 12. If a NED household is certified for 24 months and then begins to receive earned income, the case is converted to SRS.

Click here for Special living arrangements.

Once assigned, SNAP certification periods cannot be shortened.

TANF A TANF grant is opened when an individual completes the application process All eligibility factors must be re-determined at least once every 12 months for families who have an open JOBS plan and are not participating or on an active JOBS disqualification. This includes a completed application and interview.

For some families, however, eligibility factors must be redetermined at least once every 6 months for

families who have an open JOBS plan and are not participating or on an active JOBS disqualification. This also includes a completed application and interview.

A redetermination may be done either at assigned intervals or whenever it is deemed necessary by the worker, so long as the interval between redeterminations does not exceed those listed above.

A TANF certification may be redetermined early in order to align the TANF certification with SNAP benefits as the certification period does not exceed the guidelines above.

ERDC In the ERDC program the certification period at initial application or recertification must be no less than 12 months.

The first month of the certification period starts with the effective date. If the effective date is in October, the certification period is October 1, YYYY through September 30, YYYY, of the following year.

The end certification date is the date used by the system to send the participant an ERDC re-application (DHS 7476) and closure notice if they do not re-apply.

The certification period can be longer in situations where an ongoing ERDC case is coded with authorized work search (AWS), authorized medical leave (AML) or authorized military transition (AMT), and the certification is extended past the end date.

A filing group that is determined to be homeless or requires child care for a current foster child may receive priority processing. For those families eligible for priority processing, the benefits can be opened for up to 3 months while the case is pending for verification of certain eligibility requirements.

Click here for Expedited service and priority processing.

Click here for Authorized work search.

Click here for Authorized medical leave.

Click here for Authorized military transition.

REF A REF or REFM case is opened when the individual completes the application process and provides the necessary verification within the processing time frames. If all eligibility is cleared, then the REF benefits will start from the filing date. REFM benefits begin from the date of request.

If ODHS denies an application in the initial month, a new filing date must be established for an application for the next month. If the family chooses to apply in the following month, all DHR and IEVS screens must be reviewed, an interview must be completed, and any changes must be narrated when eligibility is re-determined.

The maximum length of time an individual can receive REF and REFM is eight months from the time they received their immigration status. There is no redetermination of eligibility for REF and REFM after the initial eight months has been reached. Because of this, it is important that workers have a conversation with the refugee to discuss their options going forward. Workers should meet with refugees regularly to inform them of their limited eligibility, emphasizing the need to move forward and become self-sufficient.

MSP Certification periods do not apply to MSP. Benefits must be renewed at least every 12 months.

OSIPM Certification periods do not apply to OSIPM. Benefits must be renewed at least every 12 months.

HSD Benefits are renewed every 12 months via automated renewal or active renewal.

Automated renewal: Cases that are in Active/Approved status may be selected for automated renewal. ODHSIOHA shall redetermine eligibility using information found in the participant's electronic account and information that is available electronically. ONE will automatically attempt to renew participants about two and a half months prior to the end of their certification period by comparing existing data against the Federal Data Services Hub (FDSH). In the absence of discrepancies, ONE will automatically renew eligibility and send participants a notice to inform them of the renewal and a case summary showing the case data used to complete it. If there are discrepancies, cases will either pend for appropriate verification or be removed from automated renewal processes and sent to the active renewal process.

Active renewal: If a case cannot be processed through automated renewal, ONE will generate and send a pre-populated renewal form and a case summary containing current case information with instructions to return the form by a designated response date.

Oregon Administrative Rule(s)

461-115-0450 — Periodic Redeterminations; SNAP
461-170-0150 — Certification Period; ERDC
410-200-0110 — Application and Renewal Processing and Timeliness Standards

Other resources

ONE Renewals and Recertifications *includes screenshots: Provides an overview the renewals and recertifications process, including how to respond to renewal notices and how the method by which the renewal is returned impacts the way the renewal is processed.

Cold Caller and Outreach Pre-Call Process: Describes Cold Call and Outreach Pre-call process.

The application process

When individuals want to receive program benefits for themselves or others they are applying for, they must complete the application process. The application process is complete when the applicant, their authorized representative or, for all medical programs, a person acting responsibly on the applicant's behalf complete the following steps:

- Establish a date of request (DOR) or filing date.
- Submit a completed and signed application.
- Complete an interview, if one is required, as soon as possible after the DOR or filing date is established. (Some programs have requirements about how quickly the scheduled interview needs to occur to ensure there is enough time for verification and the eligibility decision.)

Note: There is no interview requirement for HSD medical programs.

- Provide any required verification.

ODHS|OHA accepts electronic applications as well. Click here for Online application.

ODHS|OHA has a Statewide Work Model to guide offices in the application process. All interviews for program benefits must be scheduled within 30 minutes of speaking with the applicant, either within the office or through the cold caller process.*

An application may be withdrawn at any time during the application process through oral or written request.

Program	Time frame to schedule the interview when an applicant is:	
	In the office	Not in the office (mail, email, phone, fax, drop off)
SNAP TANF	Scheduled for an interview within 30 minutes.	Goes through the cold caller process.*
ERDC REF MSP OSIPM		

*Cold caller process: The worker will attempt at least two calls to the applicant on the same business day the application was received or the next business day.

Click here for examples: The application process.

Oregon Administrative Rule(s)

461-115-0010 — Application Process; General
461-115-0020 — Application Requirements
461-115-0050 — When an Application Must be Filed
461-115-0210 — Application Processing Time Frames; SNAP

Other resources

Cold Caller and Outreach Pre-Call Process: Describes Cold Call and Outreach Pre-call process

Hand-off to Family Coach: This process walks Support Staff/Transfer Clerks, Eligibility Workers, and Family Coaches through the hand-off processes for CASH.

Case Actions: Performing case actions as an authorized user to update information on the case; note that this may affect case status/mode and program status/mode

When to use an application

An application is used to gather information about the applicant and their household as well as to determine eligibility initially and at recertification/renewal. The same application process is used for recertification/renewal for

some programs. See "Program-specific information" for specific program provisions and requirements regarding applications.

Printed or electronic applications are used when determining eligibility. The application must be complete, including a mailing address and a signature.

For all programs, a new application is not needed if a closure decision is reversed in the same calendar month. In addition, applications may be reused to determine benefits in certain circumstances. Some programs require a new signature on an existing application.

When an applicant is denied due to being over the income limits for a program, they may reapply in a subsequent month without completing a new application. A new budgeting period is established and income is recalculated.

Below are other situations that do not require an application.

SNAP An application is not needed to add a person, including newborns, to an open SNAP case.

If an application is denied, the same application can be reused. Unless one of the two below exceptions apply, the participant must review all information on the existing application, make changes where necessary, and re-sign and date the application. By doing this, the participant attests the information provided is accurate and correct.

SNAP has two exceptions to having an individual re-sign an application to establish a new filing date:

- If ODHS|OHA is denying benefits in the initial month and approving benefits for the second month (e.g., the participant was on another SNAP case or was over income in the month of application), the existing application may be used. The filing date does not change, but the approval date is the first of the second month. The participant does not need to re-sign the application in this instance. If the denial and approval actions are taken on different dates, Income Eligibility Verification System (IEVS) screens must be rechecked.
- When the participant submits pending items after the 30th day from the filing date and did not request more time to extend the filing date, the date the pending items are submitted sets the new filing date. The participant does not need to re-sign the application. IEVS screens must be rechecked.

When a case closes at the end of the certification/benefit period, a new application and eligibility determination is required. Unless there is an exception in rule, an application is also required at renewal and any time there is a break in benefits.

TANF An application is not needed or required when:

- Adding an individual to the case, and all information available is sufficient to determine eligibility
- Adding a newborn to the case, if the newborn was included on the original application as an unborn
- A case is closed because the case was over income and the case is reopened the month after closure
- Converting TANF to ERDC – however, if the TANF case closes and ERDC is requested after, an

application is required.

If an application is denied, the same application can be reused. If this is done, the applicant must review all information on the existing application, make changes where necessary, re-sign and date the application. By doing this, the applicant attests the information provided is accurate and correct.

If ODHS|OHA is denying benefits in the initial month (e.g., the applicant was over income in the month of application) and the applicant wants to apply the following month, the existing application may be used. The applicant would need to review, update and re-sign the application within the following month. The date this is done establishes a new filing date. IEVS screens must be rechecked.

When a case closes at the end of the certification/benefit period a new application and eligibility determination is required. Unless there is an exception in rule, an application is also required at renewal and any time there is a break in benefits.

ERDC

An application is not needed or required when:

- The caretaker requests to re-open their case within 30 days of case closure (if the case closes during the certification period). The case can be re-opened without an application if the caretaker still meets ERDC eligibility.
- The case closes for no provider connected, the case can be re-opened in the 30 days following the case closure if the caretaker locates an ODHS|OHA approved provider.

If an application is denied, the same application can be reused. If this is done, the applicant must review all information on the existing application, make changes where necessary, re-sign and date the application. By doing this, the applicant attests the information provided is accurate and correct.

When a case closes at the end of the certification/benefit period a new application and eligibility determination is required. Unless there is an exception in rule, an application is also required at renewal and any time there is a break in benefits.

REF

If an application is denied, the same application can be reused. If this is done, the applicant must review all information on the existing application, make changes where necessary, and re-sign and date the application. By doing this, the applicant attests the information provided is accurate and correct.

No new application is needed if a case is suspended for one month due to being over income and then reopened the month after the suspend month.

When a case closes at the end of the certification/benefit period a new application and eligibility determination is required. Unless there is an exception in rule, an application is also required at renewal and any time there is a break in benefits.

MSP

A new application is not required under the following circumstances:

- When a single application can be used for both a denial in the month of application and for determining eligibility the next month, if anticipated changes for the next month are within the processing time frame.
- When a case is suspended for one month because the case was over income and the case is

reopened the month after the suspended month.

- The individual's medical benefits were suspended during incarceration, the individual has been released and the release was reported within 10 calendar days. Eligibility must be redetermined prior to reopening benefits. See the Eligibility for residents of a public institution worker guide.
- The individual is currently receiving OSIPM, QMB, SMB, or SMF and eligibility is being redetermined:
  - Redetermination includes annual renewals, applicant-initiated requests for additional benefits, and reported or discovered changes that require redetermination of eligibility.
  - ODHS|OHA must have sufficient evidence using the existing application and be able to gather any additional information needed during the interview, if one is needed.
- The individual was receiving OSIPM or an MSP, was terminated for failure to provide requested information during a periodic redetermination, and the requested information was received within 90 days of the termination.
- When current MSP recipients request services.

OSIPM A new application is not required under the following circumstances:

- When a single application can be used for both a denial in the month of application and for determining eligibility the next month, if anticipated changes for the next month are within the processing time frame.
- When a case is suspended for one month because the case was over income and the case is reopened the month after the suspended month.
- The individual's medical benefits were suspended during incarceration, the individual has been released and the release was reported within 10 calendar days. Eligibility must be redetermined prior to reopening benefits. See the Eligibility for residents of a public institution worker guide.
- The individual is currently receiving OSIPM, QMB, SMB, or SMF and eligibility is being redetermined:
  - Redetermination includes annual renewals, applicant-initiated requests for additional benefits, and reported or discovered changes that require redetermination of eligibility.
  - ODHS|OHA must have sufficient evidence using the existing application and be able to gather any additional information needed during the interview, if one is needed.
- The individual was receiving OSIPM or an MSP, was terminated for failure to provide requested information during a periodic redetermination, and the requested information was received within 90 days of the termination.
- When current OSIPM recipients request services.

HSD A new application is not required in the following circumstances:

- The Agency determines an applicant is not eligible in the month of application and:
  - Is determining if the applicant is eligible the following month, or
  - Is determining eligibility for retroactive medical

- When benefits are closed and reopened during the same calendar month,
- When an individual's medical benefits were suspended because they were incarcerated and the individual reports their release within 10 calendar days of their release date,
- When an individual not receiving medical program benefits is added to an existing case where any case member is receiving medical program benefits,
- When ODHS|OHA has sufficient information to redetermine or renew eligibility for the same or new program,
- During the 90-day reconsideration period for eligibility following closure. The Agency will redetermine the eligibility of an individual who lost HSD medical program eligibility because they did not return the Active Renewal form or did not respond to an RFI if the renewal form or the RFI response is submitted within the 90-day reconsideration period. This will establish a new date of request.

Click here for examples: When to use an application.

Oregon Administrative Rule(s)

461-115-0050 — When an Application Must be Filed
410-200-0110 — Application and Renewal Processing and Timeliness Standards

Other resources

Rights and Responsibilities - Phone Applications: Covers options to capture signature for R&R including verbal signature

Signing an application and completing the application process

Each program requires an authorized person to complete the application process. For most programs, this requires a signature on a form designated by ODHS|OHA.

Applicants who are unable to write their name can sign their "mark." This mark must be witnessed by an ODHS|OHA employee. For incarcerated individuals, the mark may be witnessed by a correctional facility staff member.

An electronic application is signed electronically by the applicant typing their name and clicking the submit button; A telephonic signature can be used prior to the eligibility submission in ONE with the following process:

1. Notify the applicant their signature will be captured telephonically; and
2. Record the assurance that the rights and responsibilities have been read and understood by;
   - Playing the recording of the rights and responsibilities If they have not yet read and understood; and then
   (A) Start the Recording;
   (B) Read the script; "Do you understand the rights and responsibilities as explained, if so, state your full legal name and date of birth?"

3. Upload the recording to the electronic case file in ONE.
4. Print the application summary and mail it to the applicant.

To complete the application process, ODHS|OHA must capture a signature that;

- Attests to the accuracy of the information provided by the household; and
- Affirms the household has received information about their rights, responsibilities and penalties associated with program benefits received or applied for; and
- Permits ODHS|OHA to:
  - Access IEVS; and
  - Verify information used to determine a household's eligibility for program benefits.

SNAP The application must be signed by the head or household, the authorized representative or any other adult member of the SNAP filing group.

TANF A parent or caretaker relative of the dependent child(ren) must sign an application and complete the application process. An applicant who cannot do so unassisted may use an authorized representative.

ERDC The application must be signed by the caretaker of the child(ren) requiring care or an authorized representative.

REF The application must be signed by at least one adult in the filing group or an authorized representative. An adult from the filing group can either be the primary person or the primary person's spouse.

MSP Application must be signed by one of the following:

- Any member of the filing group 18 years of age or older,
- The authorized representative, or
- For someone who is incapacitated or for a child under 18 who has no parent or legal guardian to apply, we can accept an application signed by anyone 18 or older acting responsibility on the person's behalf.

OSIPM The application must be signed by one of the following:

- Any member of the filing group 18 years of age or older,
- The authorized representative, or
- For someone who is incapacitated or for a child under 18 who has no parent or legal guardian to apply, we can accept an application signed by anyone 18 or older acting responsibility on the person's behalf.

HSD The Agency will accept handwritten, electronic or telephonic signatures. The application must be signed by one of the following:

- The head of household,
- An adult in the applicant's Eligibility Determination Group (EDG),
- An authorized representative, or

- If the applicant is a child or incapacitated, someone age 18 or older acting responsibly for the applicant.

If the original signor of an application ceases to be a member of the case, a new signature is required.

The following can be determined without a signature:

- Hospital Presumptive Eligibility if no electronic data match with the FDSH will be performed,
- A renewal, if the ODHS|OHA is able to process an Automatic Renewal. If an Automatic Renewal cannot be processed, then a signature is required on the Active Renewal form.

Click here for examples: Who must sign the application and complete the application process.

Oregon Administrative Rule(s)

461-115-0071 — Who Must Sign the Application and Complete the Application Process
461-115-0090 — Authorized Representatives; General
461-115-0020 — Application Requirements
410-200-0110 — Application and Renewal Processing and Timeliness Standards

Other resources

Medical Asset Check via AVS *includes screenshots: Describes what benefit programs are eligible for the Medical Asset Check and the different types of assets that are checked by the AVS interface. Provides instruction for initiating the check and responding to discrepant and undisclosed resources.

Tracking Submitted Requests in the Asset Verification System (AVS) *includes screenshots of AVS software: Gives step-by-step process of how to check status of pending AVS requests via the Case Queue.

Call Center Software – Playing the Asset Verification System (AVS) recording & Capturing Verbal Signature *includes screenshots of AVS software: Walks through the process of having the Oregonian listen to the AVS recording, Capturing the verbal signature, downloading the recording, and saving the file in ONE at the individual level.

Federally Facilitated Marketplace Applications *includes screenshots: Processing steps for Federally Facilitated Marketplace applications in ONE.

Rights and Responsibilities - Phone Applications: Covers options to capture signature for R&R including verbal signature

Interviews

The purpose of the interview is to gather information, resolve any unclear or incomplete information, and determine eligibility. The person being interviewed may vary depending on the program the applicant applied for. An interview must be conducted for all programs, with some exceptions.

SNAP Click here for Expedited service and priority processing.

An adult, head of household or the authorized representative of the filing group is interviewed once every 12 months. A face-to-face interview must be granted if requested by the applicant.

For non-expedited service, an interview will occur as soon as possible and not later than 20 days after the filing date. An interview must be scheduled so the filing group has at least 10 days to provide any needed verification before the 30-day processing time frame.

When an applicant misses the first scheduled interview appointment, ODHS|OHA must inform the applicant by regular mail of the missed interview. An applicant who fails to attend a scheduled interview must contact ODHS|OHA no later than 30 days following the filing date to be eligible for benefits.

Regular service is used if an applicant misses their expedited service interview appointment without good cause.

TANF An eligibility interview is required at least every 12 months.

ODHS|OHA may conduct a required elgibility interview by telephone or home visit if:

- An authorized representative has not been appointed, and
- Participating in a face-to-face interview is a hardship for the household. A hardship needs to be documented in the case notes.

Hardships includes but are not limited to:

- Care of a household member
- An applicant's age, disability or illness
- A commute of more than two hours from the applicant's residence to the nearest branch office
- A conflict between the applicant's work or training schedule and the business hours of the branch office, and
- Transportation difficulties due to prolonged severe weather or financial hardship
- Individuals, due to their current health concerns are limiting their in-person interactions because COVID-19 still exists within the community.
- Individuals who live in multigenerational households who are limiting their public outings to protect their vulnerable family members.
- It is beneficial to the individual to complete the interview at the time of the call rather than delaying or requiring travel to complete the face-to-face at a later time.

Only one caretaker relative is required to attend the interview. Benefits are not delayed by requiring the second caretaker relative to attend.

ERDC An interview is required when determining eligibility for ERDC. Phone interviews are preferable to accommodate the caretaker's employment. A face-to-face interview must be granted if it can be arranged around the caretaker's work schedule and if the caretaker would prefer a face-to-face interview. An interview is not required when priority processing has been determined in ONE.

If the ERDC Reservation List is in effect, an interview is not required if the application will be denied due

to the family not meeting an exemption. It is a best practice to notify the family by phone, if possible, and send a denial notice to the applicant.

Click here for Expedited service and priority processing.

Click here for ERDC Reservation List.

REF A face-to-face interview is required at initial application unless there is a hardship. If a hardship is present, it should be narrated.

A hardship includes, but is not limited to:

- Care of a household member
- An applicant's age, disability or illness
- A commute of more than two hours from the applicant's residence to the nearest branch office
- A conflict between the applicant's work or training schedule and the business hours of the branch office, and
- Transportation difficulties due to prolonged severe weather or financial hardship.

MSP Any individual who is authorized to sign the application may also complete the interview.

An interview is required at initial application only. For all MSP applicants with the following exception:

- When someone is currently receiving OSIPM benefits and wants to apply for MSP benefits, an interview is not required if the individual completed an interview in the current OSIPM determination or renewal period and there has been no break in aid
- Individuals who are assumed eligible are still required to complete an interview at initial application.

OSIPM Any individual who is authorized to sign the application may also complete the interview at initial application. If the initial application was completed by someone acting responsibly on an incapacitated individual's behalf and that person is not the authorized representative, then they are not authorized to complete the interview at renewal.

Interviews must be completed at initial application for everyone except assumed eligible individuals who are not also applying for services (i.e. in a standard living arrangement).

Exception: When someone is currently receiving MSP benefits and wants to apply for OSIPM, an interview is not required if the individual completed an interview in the current MSP determination or renewal period and there has been no break in aid.

Interviews must be completed at renewal for everyone except assumed eligible individuals (with or without services).

Note: about incapacitated individuals and renewal interviews when there is no authorized representative: If it's clear that the individual cannot complete the interview process, the requirement can be waived. In ONE, this means that the interview must be marked as completed with a Case Note explaining the waiver.

While the interview requirement can be waived under certain circumstances, we must still utilize all available sources to verify eligibility requirements.

HSD An interview is not required for HSD medical program eligibility.

Click here for examples: Interviews.

Oregon Administrative Rule

461-115-0230 — Interviews

Other resources

Phone Contact: Describes the process for support staff and Eligibility Workers on how to serve Oregonians calling into local office and ONE Customer Service Center

Cold Caller and Outreach Pre-Call Process: Describes Cold Call and Outreach Pre-call process

Walk-in Contact: Describes the process for support staff and Eligibility Workers on how to serve Oregonians in local office

Crisis Response: Covers helpful tips and best practices for managers and workers when crisis situations arise

Community Eligibility Appointment: This process walks Eligibility Workers through conducting an Eligibility appointment in the community.

Rights and Responsibilities - Phone Applications: Covers options to capture signature for R&R including verbal signature

Complete Medicare - Medicaid Choice Counseling: Describes key data and processes involved in conducting an APD interview, including Income, Expenses, and Non-Financial Information.

APD Interview Guide *includes screenshots: Describes key data and processes involved in conducting an APD interview, including Income, Expenses, and Non-Financial Information.

Appointment Checklist: Describes information to review prior to or during an appointment with an Oregonian

ADRC Community Resources: Describes resources available to Aging and Disability Resource Connection staff with a particular focus on 211 info.

Capturing a Verbal Signature for the 457D for Medical Only *includes screenshots: This QRG walks through the process of obtaining, recording, and saving the verbal signature for waiving timely notice rights for Medical

Head of household

Head of household means a “primary person.”

SNAP A primary person means an adult in the filing group who is designated by the group to serve as the primary person. When there is no adult, the group can designate another responsible person in the filing

group.

Once the primary person has been designated, the filing group cannot choose a different individual to be the primary person during the same certification period or during an Oregon Food Stamp Employment Transition (OFSET) program or job quit disqualification period, unless there is a change in the composition of the household group.

TANF A primary person means the filing group member who is responsible for providing information necessary to determine eligibility and calculate benefits.

ERDC A primary person means the filing group member who is responsible for providing information necessary to determine eligibility and calculate benefits.

REF A primary person means the filing group member who is responsible for providing information necessary to determine eligibility and calculate benefits.

MSP A primary person means the filing group member who is responsible for providing information necessary to determine eligibility and calculate benefits.

OSIPM A primary person means the filing group member who is responsible for providing information necessary to determine eligibility and calculate benefits.

HSD A primary person is the individual the ODHS|OHA shall communicate with and is listed as the case name, or is the individual named as the primary contact on the application.

Click here for examples: Head of household.

Oregon Administrative Rule(s)

461-001-0000 — Definitions for Chapter 461
461-001-0015 — Definitions; SNAP
410-200-0015 — General Definitions

Other resources

Add or Remove Member / Change Head of Household *includes screenshots: Adding and removing household members; changing the head of household (HoH)

Authorized representative

This does not apply to the TA-DVS program.

An authorized representative (AR) is an individual or organization that may act on behalf of an applicant or beneficiary during:

- The application process
- Renewals or redetermination of eligibility, and
- Ongoing communications.

An AR designated for one program is the AR for all programs and benefits with the same head of household, primary person or primary contact except in the:

- Temporary Assistance for Domestic Violence Survivors (TA-DVS) program, and
- Long-term care service provider for the individual designating the AR.

ODHS|OHA may accept a designation or termination of an AR via any of the following methods, which must include either a handwritten or electronic signature of both the individual and the AR:

- Internet
- Email
- Mail
- Telephonic recording
- In person, or
- Other electronic means.

If the designated AR:

- Is in the eligibility determination group, all individuals whose financial and non-financial information is considered when determining eligibility do not need to complete the Authorized Representative and Alternate Payee form (MSC 0231)
- Is outside the eligibility determination group, the MSC 0231 needs to be completed.

The following individuals can designate an AR:

- The head of household, primary person or primary contact of any age,
- Any individual age 18 and older included in the eligibility determination group, and
- An individual given legal guardianship or power of attorney who is included in the eligibility determination group.

An AR cannot be any of the following, though exceptions can be made at the discretion of ODHS|OHA when there are no other available AR options:

- An individual serving a disqualification for an intentional program violation (IPV)
- A person who may cause harm
- A person who may have a conflict of interest including:
  - Landlords and other vendors of goods or items who deal directly with the individual, including retailers who accept SNAP benefits or are authorized to accept electronic benefit transfer (EBT) cards
  - ODHS|OHA employees and any employee of a contractor involved in the certification and issuance process for benefits. An exception can be made only with the written permission of the SNAP program administrator or designee, and
- Meal providers for homeless SNAP recipients.
- An individual included in the EDG for HSD medical programs solely because they are part of a tax-filer's tax group.

The AR may do any of the following:

- Complete, sign and submit any applications, renewals or documents on the applicant's or recipient's behalf
- Receive copies of notices and other communications from ODHS|OHA, and
- Act on behalf of the applicant or recipient by reporting information and submitting requests to ODHS|OHA.

The AR must maintain the confidentially of any information provided by the ODHS|OHA regarding the represented individual. An AR can be terminated when:

- The represented individual requests the designation be terminated
- The represented individual appoints a new AR
- The AR requests the designation be terminated
- ODHS|OHA determines the AR is no longer permitted, or
- There is a change in the legal authority upon which the individual or organization was based.

When ARs have been determined to knowingly misrepresent the eligibility determination group or misuse SNAP benefits, the ARs are disqualified. ODHS|OHA can disqualify them for one year after sending written notification of the disqualification to the individual and the AR 45 days prior to the disqualification. The notice must specify the reason for the disqualification, the disqualification period and the individual's right to request a hearing.

Click here for examples: Authorized representative.

Oregon Administrative Rule(s)

461-115-0090 — Authorized Representatives; General
410-200-0111 — Authorized Representatives

Other resources

Authorized Representative Verbal Signature *includes screenshots: Describes the process of obtaining, recording and saving the verbal signature of the Authorized Representative and Oregonian.

Authorized Representative and Alternate Payees *includes screenshots: Describes the role of Authorized Representative and Alternate Payees, programs for which these roles are available, and forms like MSC 0231 related to them

Authorized Representative Verbal Signature QRG *includes screenshots

Alternate payee

An alternate payee (AP) is an individual or organization authorized by another individual to obtain and use benefits for and in the best interest of the benefit group. When an AP is designated, ODHS|OHA may issue an electronic benefit transfer (EBT) card or other program benefits to the alternate payee.

The following individuals may appoint an AP in writing on an Authorized Representative and Alternate Payee (MSC 0231) form:

- The head of household, primary person, primary contact or authorized representative of any age, or
- An individual given legal guardianship or power of attorney for an individual age 18 and older.

An AP cannot be any of the following. Exceptions can be made at ODHS|OHA's discretion when there are no other available AP options:

- An individual serving a disqualification for an intentional program violation (IPV)
- A person who may cause harm
- A person who may have a conflict of interest including:
  - Landlords and other vendors of goods or items who deal directly with the individual, including retailers who accept SNAP benefits or are authorized to accept electronic benefit transfer (EBT) cards;
  - ODHS|OHA employees and any employee of a contractor involved in the certification and issuance process. An exception can be made only with the written permission of the SNAP program administrator or designee, and
- Meal providers for homeless SNAP recipients.

An AP can be terminated when:

- The represented individual requests the designation be terminated
- The represented individual appoints a new AP
- The AP requests the designation be terminated
- ODHS|OHA determines the AP is no longer permitted, or
- There is a change in the legal authority upon which the individual or organization was based.

SNAP No additional program-specific information.

TANF No additional program-specific information.

ERDC There are no alternate payees within the ERDC program. This is because payments are made directly to child care providers rather than the caretaker or family.

Click here for Child care provider requirements.

REF No additional program-specific information.

MSP No additional program-specific information.

OSIPM No additional program-specific information.

HSD HSD medical programs do not use Alternate Payees

Click here for examples: Alternate payee.

Oregon Administrative Rule(s)

461-115-0090 — Authorized Representatives; General

Other resources

Authorized Representative and Alternate Payees *includes screenshots: Describes the role of Authorized Representative and Alternate Payees, programs for which these roles are available, and forms like MSC 0231 related to them

Authorized Representative Verbal Signature QRG *includes screenshots

Assistance with applications

Individuals may ask for help to complete their applications. These requests are honored by ODHS|OHA as part of Oregon's commitment to equity and access. There are a variety of ways in which ODHS|OHA helps individuals complete their applications for benefits.

Alternate formats

As part of ODHS|OHA's ongoing commitment to diversity and inclusion for all Oregonians, applications and notices can be delivered in alternate formats. These formats may include audio, Braille, electronic formats, large print or oral presentation (over the phone or in person).

Alternate formats are documents made available through anything other than standard print. The Americans with Disabilities Act (ADA) is intended to protect persons with disabilities from discrimination in the services, programs or activities of all state and local governments. This includes accessing information about these services, programs or activities. ODHS|OHA must ensure communications with applicants, participants and members of the public with disabilities are as effective as communications with others. When an individual asks to receive information in an alternate format, the request provides ODHS|OHA staff an opportunity to learn more about and better serve that individual.

Benefits should not be delayed until the appropriate alternate format is available. If necessary, ODHS|OHA staff can read the application aloud to the applicant to help them to complete the form(s).

ODHS|OHA will not assess whether an individual requesting material in an alternate format is entitled to them under law; rather, as a matter of customer service, ODHS|OHA shall provide materials in alternate formats upon request.

For ONE, update the Contact Information Screen with Oregonian's alternate format request.

Community partners

Community partners are all external entities that enter into formal agreements with OHA to conduct outreach or enrollment assistance to Oregonians. They may or may not be funded or compensated by OHA to provide application assistance. It is the agency's responsibility to ensure that community partners or ODHS|OHA workers are available to assist applicants in completing the application process.

To associate a community partner to an individual's case, the agency must receive a signed Community Partner Consent Form OHP 6610. However, if a community partner enters an application for the applicant via the ONE Applicant Portal, they can complete the association and will not have to provide a copy of the signed consent form to ODHS|OHA. The community partner must keep a copy of the consent form on file for six years.

Interpreters

The Civil Rights Act of 1964 prohibits discrimination on the basis of race, color or national origin. This act requires services and benefits be provided in a consistent manner to all individuals; no person shall be denied an opportunity to participate in a program administered by ODHS|OHA because of their race, color or national origin.

In Oregon, individuals do not have to speak English, have good hearing or be sighted to apply for or receive public assistance programs. ODHS|OHA is responsible for ensuring a limited-English-speaking applicant or an individual who has difficulty hearing, seeing or reading is communicated with in a way they can understand. Oregon employs bilingual employees and contracts with Language Link to provide language-appropriate services to all individuals.

In branch offices with 35 or more limited-English speaking households with the same language, ODHS|OHA employs individuals able to provide bilingual services and translated materials to any individuals to whom English is not their first language or to whom English is not their preferred language; these employees' interpretation ability varies based on their own statement as well as bilingual exams. ODHS|OHA is committed to providing communication services to anyone within the blind or Deaf and hard of hearing communities as well, whenever communication needs exist that affect the individual's ability to apply for or receive benefits offered through ODHS|OHA. Central office maintains a list of employees available to provide bilingual services to limited-English-speaking individuals. Please call central office at 503-945-5600 for help.

Other resources

Community Partner Verification: Describes the process of how to work with a Community Partner (AKA Active Assistor)

Translations

Written documents used by applicants and individuals are also translated and available in Bosnian, Cambodian, Hmong, Laotian, Mien, Romanian, Russian, Simplified Chinese, Somali, Spanish and Vietnamese.

Most ODHS and OHA forms can be found in the above listed languages on the FORMS file server located at https://aix-xweb1p.state.or.us/es_xweb/FORMS/. Translated versions of these forms can be requested by contacting your policy analyst.

Click here for examples: Assistance with applications.

Other resources

ADRC Community Resources: Describes resources available to Aging and Disability Resource Connection staff with a particular focus on 211 info.

Service Guide for Language Access *includes screenshots: Provides overview of language services and interpreter resources available to staff, including DHS interpreters and Voiance software as well as deaf/hard of hearing resources.or a Request for Information (RFI). The notice informs them they will not receive further benefits until they provide the requested verification. In addition, if the verification they provide causes a change in eligibility or benefits, the change will be made without further notice.

Expedited service and priority processing

SNAP and ERDC have processes that identify specific populations who must receive an eligibility determination within an expedited time frame. This process is called SNAP Expedited Service and ERDC Priority Processing.

These processes do not apply to the TANF and REF programs.

SNAP Expedited service

To be eligible for expedited service, the filing group must be without SNAP and meet one of the following criteria:

- Have countable income of less than $150 a month and resources in the form of cash and bank accounts of $100 or less, or
- Have combined gross monthly countable income, cash and bank account balances less than the group's total monthly housing and utility costs (using the dollar value of the appropriate utility standard), or
- Be destitute. "Destitute" means the filing group contains a migrant or seasonal farm worker who has met certain criteria during the month of application.

When participants apply for SNAP before the end of their certification period, SSP does not use expedited service processing time frames. Expedited processing is used any time there is a break in benefits.

When applicants qualify for expedited service, they must have the benefits by the seventh calendar day following their filing date, which is called seven-day processing. This applies even if the in-office interview is waived for a phone interview. The seven-day processing includes screening, intake interview, identity verification, other verification readily available, the decision that the participant meets all eligibility requirements, and issuance of benefits.

- Under expedited service, participant statements and limited verification are used to determine eligibility for SNAP for a short period of time. The only eligibility factor absolutely required to be verified under expedited service is the identity of the applicant. A reasonable effort is made to verify all factors, but only those that will not cause a delay in issuing benefits are required. The rest of the verification can be postponed.

  If the application is approved for more than one month and verification is postponed, SSP provides the applicant a Notice of Pending Status (DHS 0210) or a Notification of Pending Status (SDS 0539H). The notice informs them they will not receive further benefits until they provide the requested verification. In addition, if the verification they provide causes a change in eligibility or benefits, the change will be made without further notice.

  There is no limit to the number of times a participant may receive expedited service. However, all eligibility factors from the previous expedited service must be verified before they are entitled to seven-day processing again.

  - **Application filed on or before the 15th:** Benefits approved using expedited service may be certified for one month only. The due date listed on the request for information is the end of the month or no later than 30 days from the filing date. The verification must be provided by the

end of that month for the participant to get continued benefits the next month. If the verification is provided before the end of the filing month, the certification period is extended. If verification is provided within 30 days of the filing date but after the end of the one-month certification period, the case is recertified for a full 12 months without requiring a new application. No further action is taken if the verification is not provided.

- **Application filed after the 15th:** Benefits approved using expedited service may be certified for two months only. The verification must be provided by the end of the 30-day processing period following the filing date so continued eligibility can be determined. To receive further benefits, the applicant must provide the requested verification within 30 days. If the verification is provided by the end of the 30-day processing period, the certification period is extended. No further action is taken if the verification is not provided.

Offices must have a seven-day expedited service process in place to screen applicants for expedited service to issue benefits within the seven-day time frame for eligible individuals. Pages one and two of the Application for Services (DHS 0415F) or the Food Benefit Filing Form (SDS 0539F) are used for this screening.

- Sometimes the initial screening does not identify a group that qualifies for expedited service. When this was due to worker error, benefits must still be received by the seventh day following the filing date. When this was due to the applicant withholding information or providing misinformation, benefits must be received as soon as possible, but no later than seven calendar days following the date the error was discovered or the date the information was provided.
- The applicant will not lose eligibility for expedited services due to missing their interview. When the applicant misses the appointment, a Notice of Missed Interview (NOMI) is sent.

If an applicant specifically requests expedited service and is denied, they are entitled to an expedited hearing. A Notice of Decision and Action Taken (DHS 0456) or Notification of Planned Action (SDS 0540) is sent to the individual when their request is denied. A Notification of Pending Status (APD 0539H) is given to verify income and SSN.

TANF This does not apply to the TANF program.

ERDC Priority processing

Some families may be eligible to receive child care benefits through ERDC immediately even if they do not yet have any proof of income. Families with homeless youth or foster children may qualify for priority processing.

To qualify for priority processing, families must meet **one** of the criteria listed below:

- **Homeless families:** Homeless is defined as an individual who is lacking a fixed, regular and adequate nighttime residence. This includes living in an emergency shelter or shared housing with others due to loss of housing or economic hardship; or staying in motels/hotels, cars, parks, public places, tents, trailers or other similar settings.
- **Families with foster children:** The caretaker must indicate they need child care for a child receiving foster care to be eligible for priority processing; older children ages 12 through 17 may

still be eligible by applying special needs age (SNA) coding.

At intake, if a family does not have sufficient income verification to approve their ERDC case, it is critical for ODHS|OHA to determine if the family qualifies for priority processing.

If the family is eligible for priority processing, the case is opened based on the family's best estimate of their ongoing income; a notice should be given to the family letting them know their ERDC case will close 45 days from their date of request (DOR). An interview is not required when priority processing has been determined by ONE.

- The ERDC case should be opened with a 12-month certification. This is a requirement for ERDC. However, the family has 45 days from the DOR to submit their ongoing anticipated income or their ERDC case will close in two to three months (based on the DOR).
  - If the family does not submit their proof of income, the case should be closed. No notice is required.
  - If the family does submit proof of income, the case should be adjusted based on the new verification, and timely notice should be sent if it will result in an increased copay amount.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Click here for examples: Expedited service and priority processing.

Oregon Administrative Rule(s)

461-001-0000 — Definitions for Chapter 461
461-110-0350 — Filing Group; ERDC
461-110-0630 — Need Group
461-115-0210 — Application Processing Time Frames; SNAP
461-115-0690 — Verification for SNAP Expedited Services; Time Limits
461-155-0150 — Child Care Eligibility Standard, Payment Rates, and Copayments
461-120-0510 — Age Requirements for Clients to Receive Benefits
461-135-0575 — SNAP Expedited Services
461-170-0150 — Certification Period; ERDC
461-175-0300 — Notice Situation; Prior Notice

Chapter 2: Eligibility

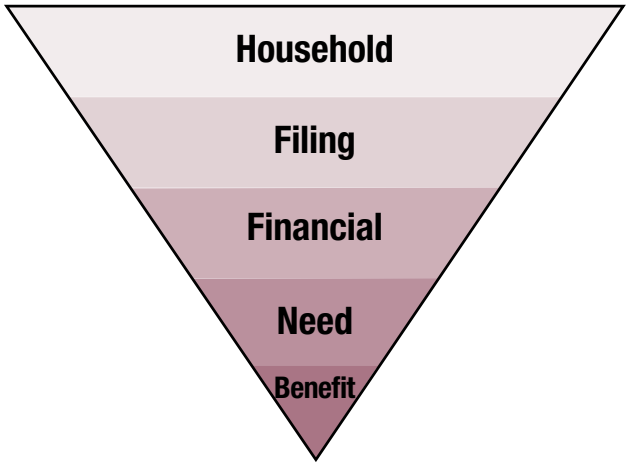
Section 2: Eligibility groups

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Eligibility groups

Introduction

There are five eligibility determination groups (EDGs): household, filing, financial, need and benefit.



Who is included in each of these groups may affect program eligibility, whose assets are considered, whose non-financial criteria are reviewed and who receives benefits.

Household group

The household group is usually the people who live together, with or without a dwelling. For a residence to be considered separate, it has to have access to the outside that does not pass through another residence. It also must have a sleeping area, bathroom and kitchen facility. The household group forms the basis for determining who is in the remaining eligibility groups.

"Homeless" means lacking a fixed regular and adequate nighttime residence and includes living in an emergency shelter; shared housing with others due to loss of housing or economic hardship; and staying in motels, cars, parks, public places, tents, trailers or other similar settings.

For homeless applicants, the household group consists of the individuals who consider themselves living together.

ONE uses information entered on the living arrangement screen to determined who is included in the household for each program.

SNAP Individuals who live in the same dwelling or share the same living space are considered to be in the same household group. A dwelling is defined as a living space, separate from other dwellings, with access to the outside that does not pass through another dwelling. It must contain a sleeping area, bathroom and kitchen facility. The individuals residing together in a dwelling are considered a household group.

A landlord tenant relationship does not create a separate household group.

Individuals living in multiple household groups in one month

When participants live in more than one household during a calendar month, the individual is in the household group that provides the individual with more than half of their 21 weekly meals.

To determine who is credited with providing meals to a child, the home the child left from for school is credited with providing breakfast and lunch on that day.

During the month in which a resident of a domestic violence shelter enters the shelter, the resident may be included both in the household group they left and in a household group in the shelter.

Individuals gone for 30 days or more

Individuals gone from the household for 30 days or more are no longer in the household.

Homeless youth

An individual under the age of 18 is considered a youth. Youth who may be considered homeless:

- Are those who meet the definition of homeless
- May be residing with an adult who is not their parent, and
- Are not considered to be under the care, control and supervision of the adult.

Care, control and supervision means that the adult is providing significant and sustained financial assistance. The adult may also function in a parental role by establishing rules and curfews and participating in schooling or health decisions.

Information may be needed to determine financial dependence on the adult. Important considerations include:

- Is the adult responsible for medical, dental and other health care needs?
- Does the youth rely on the adult to pay for ongoing needs such as clothes, personal items or school fees?

There is no minimum age requirement to apply for SNAP. Eligibility for homeless youth is the same as other homeless individuals. The following are some considerations to keep in mind:

- Homeless youth commonly share housing with others in temporary, informal conditions.
- Youth may often move between temporary living situations. Non-parental adults in these situations have no legal responsibility or authority to control the youth.
- Verification requirements are the same for homeless youth as for other individuals. This includes accepting collateral contact to verify identity and helping the youth gather required verification, if needed.
- The youth is not required to provide information or verification from their legal guardian or parent, if they are outside their household unless information points to a different situation.
- Temporary living arrangement refers to an arrangement that will last less than 90 days.

TANF Individuals living in multiple household groups in one month

Individuals who live in more than one household group during a calendar month are members of the

household group in which they spend more than half of their time, except as follows:

- Parents who sleep in the household of the dependent child(ren) 30 percent or more of their time during the calendar month
- A dependent child living with the caretaker relative who usually has the major responsibility for care, control and supervision.
- The dependent child lives with two household groups in the same calendar month for at least one of the following reasons:
  - Education
  - The usual caretaker relative is gone from the household for part of the month because of illness or a family emergency.

Individuals gone for 30 days or more

Individuals are in the same household even if they are gone for 30 days or more, if one of the following is true:

- They are absent because of employment. Employment includes looking for work outside the area of their residence, or their employment takes them out of their residence. Employment such as long-haul truck driving, fishing or active duty in the U.S. Armed Forces normally takes an individual out of their household for a period of time.
- Caretaker relatives are gone for up to 90 days in a residential alcohol or drug treatment facility.
- Caretaker relatives enter a general hospital (unless they enter some other living arrangement).
- Child(ren) are in foster care but are expected to return to the household within the next 30 days.
- Children are gone for:
  - Illness, such as general hospital or drug and alcohol treatment (unless they go into a long-term care title XIX facility)
  - Social service, or
  - Educational reasons such as Job Corps or boarding school.
- IWhen a filing group includes more than one caretaker relative, a caretaker relative in the household group is absent for up to 60 days solely due to the regulations of a homeless or domestic violence shelter or other circumstances beyond the individual's control but who would otherwise be included in the household.

In the TANF program, ODHS may approve one or more 30-day extensions of this time period if ODHS receives sufficient information to assure the absent individual will return within the extension period.

Correctional facilities

The following people are considered living in correctional facilities. They are not considered part of the household group:

- People who are legally confined to a correctional facility such as jail, prison, penitentiary or juvenile detention center

- People temporarily released from a correctional facility to perform court-imposed community service work
- People on short-term leave (less than 30 days) from a correctional facility
- People released from a correctional facility for the sole purpose of obtaining medical care.

ERDC

Landlord and tenants

A household includes all the individuals who live in the same dwelling, except for those who have a landlord/tenant relationship. A landlord/tenant relationship means that:

- The tenant lives independently from the landlord,
- The landlord charges a fair market value for the housing, and
- The tenant has separate sleeping, bathroom and kitchen facilities from the landlord. If they do not, it is within a commercial establishment that offers room and board, or both, for fair market value compensation.

Individuals living in multiple household groups in one month

People who live in more than one household during a calendar month are members of the household where they spend 51 percent or more of their time. An exception to this rule is when a child who lives with different caretakers during the month may be considered a member of both households.

Click here for Shared custody.

Gone for 30 days or more

Individuals gone from the household for 30 days or more are no longer part of the household unless there is a reasonable expectation they will return within 90 days. Examples of this include members who are hospitalized, in a residential alcohol and drug treatment program, or children placed in temporary foster care.

Parents or caretakers who are gone for 30 days or more are still considered part of the household if they have left due to:

- Employment (includes long-haul truck driving, fishing, job search or active duty in the U.S. Armed Forces)
- Education
- Training
- Caring for an individual's emergent need related to illness, injury or death.

Parents or caretakers are still considered available to care for children if they leave to care for an individual's emergent need due to illness, injury or death. This will typically affect eligibility for two-parent households.

Returning within 90 days

An individual is still considered part of the household when they are:

- Out of the household for any reason, and
- Reasonably anticipated to return within 90 days.

REF Individuals are in the same household if they state they intend to reside in the household, i.e., this is their primary residence. Individuals are considered in the same household when they share their dwelling:

- Living together in the same house
- Sharing the same address, or
- Sharing sleeping, bathroom and kitchen facilities that are not in a commercial establishment that provides room, board or both for fair market value compensation.

Additionally, individuals are considered in the same household even if:

- An individual is gone for 30 days or more due to employment
- An individual is in an acute care medical facility that is not considered long-term care
- An individual is gone for 30 days or more due to days to care for an individual's emergent need related to illness, injury or death
- An individual is gone for 30 days or more due to education or training
- An individual is gone for up to 90 days while in a residential alcohol or drug treatment facility
- An individual is gone for up to 60 days due to the regulations of a domestic violence shelter or other circumstances beyond the individual's control.

Remember, ODHS|OHA may extend the absence time period for 30 days if it receives sufficient information to ensure the absent individual will return within the extension period.

The following people are considered living in a public institution; therefore, they are not household members and are not eligible for benefits:

- Individuals who are involuntarily confined to a public institution such as jail, prison, penitentiary or juvenile detention center
- Individuals temporarily released from a public institution to perform court-imposed community service work
- Individuals on short-term leave (less than 30 days) from a public institution
- Individuals released from a public institution for the sole purpose of obtaining medical care.

MSP A separate household group is established for people who live in the same dwelling as another household group if a landlord/tenant relationship exists.

Applying for or receiving services has no effect on Medicare Savings Program eligibility groups whatsoever, it's all about who lives with whom.

Note: Notice that the MSP HH group for nonstandard living arrangements is different from that of OSIPM. If you have an applicant who is in the same building as their spouse, even if they are receiving services, they are in the same HH group as their spouse for MSP.

Individuals living in multiple household groups in one month

People who live with more than one household group during a calendar month are members of the household group where they spend 51 percent or more of their time.

Gone for 30 days or more

Individuals gone from the household for 30 days or more are no longer part of the household, including individuals receiving benefits who enter an acute care hospital or nursing facility and are expected to remain for 30 days or more. Leave the individual in their original household group until the 31st day, then re-run eligibility for that person as a household of one.

OSIPM

The people in the household group who apply for benefits are called applicants. A separate household group is established for people who live in the same dwelling as another household group if there is a landlord/tenant relationship.

Individuals living in multiple household groups in one month

People who live with more than one household group during a calendar month are members of the household group where they spend 51 percent or more of their time.

Gone for 30 days or more

Individuals gone from the household for 30 days or more are no longer part of their original household group, including individuals receiving benefits who enter an acute care hospital or nursing facility and are expected to remain for 30 days or more. Leave the individual in their original household group until the 31st day, then re-run eligibility for that person as a household of one.

If a new applicant is or will be absent from the household because they are in the hospital or a nursing facility, then consider them in their own household group prior to the 30 days if they will be evaluated under the Acute Care Setting (ACS) rule or long-term-care/services rule.

Note: The following individuals who are not otherwise eligible in a standard living situation are considered to be in their own household group (i.e. household group of one):

- Individuals receiving or applying for home and community-based care or nursing facility care,
- Individuals being evaluated under the ACS rules,
- Individuals residing in 24-hour mental health residential care settings, and
- Individuals applying for or receiving Employed Persons with Disabilities (EPD).

HSD

Household information is used to determine whose financial and non-financial information is considered and will be used to determine eligibility and who will receive benefits. This information establishes the household size and family size for each applicant. HSD medical programs only use household group.

- Household group:
  - A household group consists of every individual whose information is considered for determining each medical applicant's eligibility.
  - If a deceased individual still being claimed on a household member's taxes and the year of death is within the year of evaluation, they should be included in the household group.

- Family size is:
  - Used to compare to the income standards chart for the applicable program.
  - Equal to the household group unless there is a pregnant individual in the household. If someone is pregnant, the family size consists of all members of the household group and each unborn child of any pregnant members of the household group.

When establishing eligibility for HSD medical programs, each applicant or beneficiary shall have their own Eligibility Determination Group (EDG) determined based on the EDG rules below. You can use the MAGI EDG Formation flow chart to assist you when determining an individual's EDG.

For individuals determined eligible based on the monthly income test:

- Tax filer EDG: If individuals intend to file a federal income tax return and are not claimed as a tax dependent by another individual, their EDG consists of:
  - The tax filer
  - The tax filer's spouse if:
    - Tax filing status is 'Married Filing Jointly'; or
    - They live in the same household, regardless of tax filing status.
  - Individuals the tax filer claims as tax dependents
- Tax dependent EDG: If individuals expect to be claimed as a tax dependent by a tax filer, their EDG:
  - Is the same as the tax filer that claims them as a dependent except when any of the below apply:
    - An individual is claimed as a tax dependent by someone other than a parent or spouse,
    - The individual is a child living with both parents and is claimed as a tax dependent by one parent (such as when a parent's tax filing status is 'Married Filing Separately'), or
    - The individual is a child living with one parent and is claimed as a tax dependent by the non-custodial parent.

      If any of these exceptions apply, the tax dependent's EDG is determined based on non-filer rules.
- Non-Filer EDG: If an individual does not intend to file a federal income tax return or meets a tax dependent exception outlined above, their EDG consists of the individual and, if living together, the following:
  - The individual's spouse,
  - The individual's children (if less than age 19), and
  - If the individual is a child (less than age 19), the child's parents and the child's siblings.

For individuals determined eligible based on the monthly income test:

- The following individuals cannot be determined eligible using the 100% annual income test (thus there is no annual income EDG formed for them):
  - Tax filers who plan to file "Married Filing Separately,"

  - Individuals who are not filing taxes and who are not claimed as a tax dependent; or
  - Individuals who are claimed as a tax dependent, but do not live with the person who is claiming them.
- Tax filer EDG: If individuals intend to file a federal income tax return and are not claimed as a tax dependent by another individual, their EDG consists of:
  - The tax filer,
  - The tax filer's spouse if status is "Married Filing Jointly," and
  - The individuals the tax filer claims as tax dependents.
- Tax dependent EDG: If individuals expect to be claimed as a tax dependent by a tax filer, their EDG is the same as the tax filer that claims them as a dependent.

Individuals are still considered EDG members if they are temporarily absent from the household with intent to return to the household when the purpose of their absence is complete. This is true regardless of the time the person will be temporarily absent. Some reasons include:

- Education,
- Military,
- Work or training,
- Incarceration, or
- Hospitalization.

Individuals are no longer considered members of an EDG when:

- An individual is removed from a case or marked as permanently out of household (found on the case composition screen in ONE),
- An individual is marked as not living in the household, unless they should be included in the EDG due to being a part of a targeted individual's tax filing group, or
- An individual is deceased and the year of death is prior to the year of evaluation or the deceased individual is a non-filer.

Click here for examples: Household group.

Oregon Administrative Rule(s)

461-110-0210 — Household Group
461-135-0950 — Eligibility for Inmates and Residents of State Hospitals
410-200-0305 — Eligibility Determination Group—MAGI Medicaid/CHIP

Other resources

Forming a MAGI-based EDG: Flowchart to follow when forming a MAGI-based or MAGI EDG using either the monthly income test or 100% annual income test.

Filing group

The filing group consists of individuals from the household group whose circumstances are considered in the eligibility determination process. The filing group includes participants from the household group who choose to apply for benefits and those who must apply together because of their relationship or circumstance.

When an individual is in more than one filing group for the same program, the filing groups must be combined, unless specified otherwise in rule. If the filing group does not include at least one person who meets all non-financial eligibility requirements, the filing group is ineligible for benefits. Participants must provide any information or verification needed to determine who must be in the filing group.

SNAP Most situations

The filing group is the people in the household who:

- Choose to apply together, and
- Must apply together because of relationship or other circumstances (such as purchasing and preparing their meals together) that make them ineligible to apply separately from others living there.

When all people living together purchase and prepare meals together, they are all in the same filing group, unless they meet an exception due to a special living arrangement (see below).

Additionally, some people who live together must be in the same filing group, even if they purchase and prepare their food separately. These people are:

- Spouses, and
- Parents and their children, unless the child is 22 or older.
  - When a child under the age of 22 is living with their parents and applying for benefits separately from their parents, the application should not be denied. Instead, the child's application is pended for the parent's information using a DHS 0210.
- Children under age 18 who live with an adult who is not their parent, but the adult has parental control.
  - Parental control means the adult is responsible for the care, control and supervision of the child, or the child is financially dependent on the adult.

A person who received SNAP benefits in the month of application in another benefit group is excluded from the new filing group. If necessary, they can be excluded for a maximum of two months due to notice requirements unless the person was head of household in the other case. Even if the head of household received SNAP in another state, this is considered an ongoing case. If the person received SNAP this month as head of household, benefits are denied for the entire filing group.

Higher education students

Higher education students who do not meet the eligible student criteria cannot be in the filing group. Only higher education students who meet special student eligibility criteria or who are under age 18 or are age

50 or older can be included in the filing group.

Higher education students residing in dorms or other group college living situations with meal plans that provide for 51 percent or more of their daily meals are not eligible for SNAP.

Click here for Students of higher education.

Residents of institutions

Overview

Residents of institutions that provide more than 50% of daily meals are ineligible for SNAP benefits unless they meet one of the following five exceptions:

1. Residents of federally subsidized housing for the elderly built under either Section 202 of the Housing Act of 1959 or Section 236 of the National Housing Act,
2. Residents of a facility or treatment center with the purpose of regular participation in a drug and alcohol treatment and rehabilitation program,
3. Residents of a Group Living Arrangement (GLA) who are blind or disabled and receiving benefits under Title I, Title II, Title X, Title XIV or Title XVI of the Social Security Act (SSI, SSB, SSD),
4. Residents of a domestic violence shelter, and
5. Residents of public and private nonprofit homeless shelters if otherwise eligible.

information on 5 exceptions

1. Residents of federally subsidized housing for the elderly built under either section; 202 of the Housing Act of 1959 or Section 236 of the National Housing Act.
   (a) Check the list of known properties built under Section 202 of the Housing Act of 1959 or section 236 of the National Housing Act. If the reported residence address matches one of the sites listed additional verification is not required to apply this exception.
   (b) If the reported residence address does not match one of the sites listed, verification is required to determine if the residence was built under either Section 202 of the Housing Act of 1959 or Section 236 of the National Housing Act.

   Note: Applicants may not know if their residence meets the criteria for this exception. The housing office or administrator can verify if the building meets the criteria for this exemption.

2. Residents of Drug and Alcohol Treatment and Rehabilitation Programs

   Residents of a facility or treatment center that are participating in a drug and alcohol treatment and rehabilitation program may be eligible for SNAP benefits.

   Not all facilities meet the requirements for their residents to receive SNAP.

   The facility must meet the following criteria:

   - The drug and alcohol treatment and rehabilitation program is conducted by a private, nonprofit

organization or institution, or a publicly operated community mental health center, under part B of title XIX of the Public Health Service Act to receive funds, even if it does not actually receive funding under part B of title XIX. (https://findtreatment.samhsa.gov/); or

- The treatment center or facility is an authorized retailer by FNS (https://www.fns.usda.gov/snap/retailer-locator); and
- Designate an employee to serve as authorized representative on behalf of residents.

Note: Residents residing in facilities that do not meet these requirements or who have lost FNS authorization are ineligible for SNAP benefits while a resident of the institution.

3. Residents of a Group Living Arrangement (GLA) who are blind or disabled and receiving benefits under Title I, Title II, Title X, Title XIV, or Title XVI of the Social Security Act (SSI, SSB, SSDI).
   - GLA is defined as a community-based residential facility operated by a public or private nonprofit organization or institution authorized to serve no more than 16 residents.
4. Residents of shelters for battered persons and their children.
5. Residents of public and private nonprofit homeless shelters if otherwise eligible.

If an applicant is a resident of a Group Living Arrangement or Drug or Alcohol Treatment and Rehabilitation Program, click here for SNAP worker guides.

Elderly persons who have disabilities

An elderly person and their spouse (if any) may apply separately from others they live with who purchase and prepare meals for them. This is true only if the elderly person is unable to purchase and prepare their own food because of a severe and permanent disability, and the income of the other household group members managing the food does not exceed this limit:

Gross monthly income eligibility standards for households where elderly are disabled are a separate household	
Others living in the dwelling	**Monthly countable income**
1	$1,771
2	$2,396
3	$3,020
4	$3,644
5	$4,268
6	$4,893
7	$5,517
8	$6,141
+1	+$625

Elderly and disabled; no earned income

A household in which all members of the filing group are age 60 or older, or meet the SNAP definition of individuals with disabilities, and no one has any earned income is exempt from some eligibility

requirements. These are also referred to as NED (No earned income, Elderly or Disabled) households.

NED households can be certified for 24 months. The individual must be contacted by ODHS|OHA during month 12 of their certification period to report changes in income, shelter and utility costs, and medical deductions. As long as this contact is made, the individual will receive the second 12 months of their certification period.

Foster care/guardianship assistance

Persons in foster care or receiving guardianship assistance cannot form their own filing group. Because their meals are provided as part of their foster care/guardianship assistance, they do not have a food need.

The familial relationship ties regarding spouse and child under age 22 are not broken, even when a person is in foster care. If the caregiver applies for benefits, the caregiver can choose to include or exclude from the filing group the person(s) in foster care/guardianship assistance, their spouse or child under age 22.

For SNAP, treat residents of adult foster care (AFC) as follows:

- Residents of nonrelative AFC not licensed by the state are not eligible for SNAP benefits.
- Residents of AFC and relative AFC facilities licensed by the state must apply with their caregiver to be eligible for SNAP per OAR 461-110-0370.

Proctor care administered by or under contract to a state agency is a form of foster care. These situations and income are treated the same as foster care.

Live-in attendants

A live-in attendant is a person living in the household and paid to provide medical, housekeeping or similar personal services for a person with disabilities or elderly person. They are not considered a member of the elderly person's or person with disabilities' household unless they are related as specified in "Most situations" above. When live-in attendants are not related as specified above to the person they are caring for, they may apply with their minor children (if any) separately from the people for whom they are providing services.

A paid live-in attendant provides essential supportive services in:

- The individual's home, or
- The home of a relative or others with whom the individual lives, or
- The home where the individual lives with a relative or others who provide paid care services, and the living situation does not meet foster care licensing requirements. The services range from assistance with household tasks to assistance with activities of daily living.

Residents of domestic violence shelters or safe homes

These individuals can be in two filing groups the month they enter the shelter if they recently left a household containing a person who abused them. These individuals may receive SNAP benefits twice

that month if they:

- Were not issued an Oregon Trail card
- Are unable to access the benefits, or
- The original benefits remain in control of the abuser.

The two filing groups are the one they just left and the one they are in the month they enter the shelter. Once in the shelter/safe home, residents can choose to apply together or form filing groups as specified above.

Lodgers

A lodger is someone who pays someone else in the household for their meals.

Lodgers cannot form their own filing group. This is because they do not purchase and prepare their meals. The meal provider can choose to include or exclude a lodger when applying for the household, if the lodger is paying a reasonable amount to their meal provider.

The meal provider must include a lodger when applying for the household, if the lodger is not paying a reasonable amount to their meal provider.

To determine if the lodger is paying a reasonable amount, compare the amount they are paying to the Thrifty Food Plan (TFP). Include the lodger and any member that would be in their filing group if they were not purchasing and preparing with the meal provider.

If paying for more than two meals a day, the amount is not reasonable when it is less than the TFP.

If paying for two or more meals a day, the amount is not reasonable when it is less than two-thirds of the TFP.

Residents of commercial boarding houses are not eligible. A person operating the commercial boarding house and their filing group may receive benefits separate from the residents paying board.

Click here for Boarder/lodger.

TANF

The filing group is all the individuals from the household group whose circumstances are considered in the eligibility determination process. The filing group consists of individuals from the household group who choose to apply for benefits and who meet non-financial eligibility requirements; and people who must apply for benefits because of their relationship to those people.

If the filing group does not include at least one applicant who meets all non-financial eligibility requirements, the group is ineligible.

Applicants must provide any information or verification needed to determine who must be in the filing group.

When a household member is in more than one filing group for the same program, the filing groups must be combined, unless specified otherwise in administrative rule.

Who must apply together?

The following household group members must be in the filing group:

- Dependent child or unborn
- Parents of a dependent child in the group, including stepparents
- Parents of an unborn
- Siblings of a dependent child. The sibling must be:
  - Under age 18, or
  - 18 and attending school full time.
- Caretaker relatives of the dependent child, their spouse and children.

Who is not in the filing group?

The following individuals are excluded from the filing group:

- A dependent child receiving:
  - Foster care payments, or
  - Adoption assistance, or
  - Title IV-E subsidized guardianship payments
- Minors who are married, married and legally separated or legally emancipated
- Parents of a minor parent if:
  - The parents of the minor parent are in the household but not applying for TANF for the minor parent or any siblings of the minor parent, or
  - The minor parent does not live with their parents.

A caretaker relative who does not meet the definition of a parent of the dependent child may apply for TANF as a needy or non-needy caretaker if the caretaker relative is given the care, control and supervision of the child. Needy caretaker relatives need to meet all eligibility requirements to qualify. Non-needy caretaker relatives need to only meet income eligibility requirements to qualify.

Pregnant women

Pregnant women who have no other children must have reached the first of the calendar month before their due date. For filing groups in which the only eligible child is an unborn, the father of the unborn must be in the filing group if he is in the household with the mother. If there is another dependent child in the household, the father of the unborn is included in the filing group, even when the mother's pregnancy has not reached the calendar month before the month in which the due date falls.

Caretaker relatives and children on duplicate TANF cases

If a needy caretaker relative applies for TANF and meets all eligibility requirements except that their dependent child received benefits on another case, the caretaker relative cannot receive TANF for themselves until the dependent child(ren) are removed from the other case. The child(ren) may not receive

TANF on both cases in the same month. Prior to issuing TANF for the caretaker relative, it needs to be determined that the child(ren) are in the caretaker relative's household and the filling group meets all other eligibility requirements for TANF.

ERDC The ERDC filing group includes all household members whose incomes and circumstances are considered in determining the family's need for child care assistance.

The following household members are included in the filing group for ERDC:

- The caretaker of the child(ren) for whom ERDC benefits are requested — A caretaker is the person responsible for the care, control and supervision of the dependent child. This does not apply to a child care provider caring for the child of a member of the National Guard, U.S. Armed Forces or Reserve unit who has been called to active duty away from the child's home for more than 30 days. The caretaker does not have to be related to the child.
- Unmarried children in the care and custody of the caretaker who are under age 18 or 18 and attending secondary school or vocational training at least half time
- The parent(s) of any of the above children or of an unborn child in the same household — This includes both parents and any common children in the filing group.
- Foster child(ren) only if the caretaker wants to include them in the filing group
- The spouse of the caretaker
- Minor parents who are children of the caretaker — Minor parents who are employed may request a separate ERDC case. In this situation, the minor parent is now considered the caretaker. The minor parent and their child(ren) can form a filing group separate from the others in the household. Once the minor parent applies as a caretaker, their income becomes countable. A minor parent who is not applying as the caretaker is considered a child and their earned income is not counted.

REF The filing group is the people from the household group whose circumstances are considered in the eligibility determination process.

The filing group consists of people from the household group who:

- Choose to apply for benefits, and
- Meet non-financial eligibility requirements, and
- Must apply for benefits because of their relationship to those people.

If the filing group does not include at least one applicant who meets all non-financial eligibility requirements, the group is ineligible.

In the REF and REFM programs, the filing group consists of:

- A single adult refugee with no dependent children in the household, or
- A legally married couple who have no dependent children in the household.

Unlike TANF, an unborn child does not connect two single adults together in a filing group. When a REF filing group contains a single pregnant female, remember to revisit eligibility for TANF once the pregnancy has reached the month before the due date, or in cases involving TA-DVS. If the woman is receiving REFM,

remember to have them revisit Medicaid eligibility as soon as you become aware of the pregnancy. If they are determined ineligible for Medicaid, they may continue to receive REFM until the end of the eight months.

MSP

The filing group is the people from the household group whose circumstances are considered in the eligibility determination process. A person's circumstances must be considered either because they request assistance or because of their relationship to household members who request assistance. You cannot add people at this point (or at any other). If an individual isn't in the household group, they will never be in the filing group.

The filing group consists of each applicant and the following household group members:

- The spouse of each applicant. Remember that if a couple is separated (legally or otherwise) and living apart, the spouse would not be in the filing group because they are not in the household group. On the other hand, if they are separated (legally or emotionally) but still cohabitating, then the spouse is in the filing group. Again, applying for or receiving services has no effect on Medicare Savings Program eligibility groups whatsoever, it's all about who lives with whom.
- Each parent of each child, if the children are applying and are not assumed eligible.
- Children of the applicant if the applicant wants to include these children in the filing group. The applicant can choose to include one child and not another based on the income of each child (i.e. applicant can pick and choose amongst children).

  Note: Applicants would want to include a child if the child had no or little income and the parent was over the income standard without them.

OSIPM

The filing group is the people from the household group whose circumstances are considered in the eligibility determination process. A person's circumstances must be considered either because they request assistance or because of their relationship to household members who request assistance. When a household member is in more than one filing group for the same program, the filing groups must be combined, unless specified otherwise in administrative rule.

The filing group consists of the following (except EPD, IC and ACS):

- For applicants who are children living in a standard living arrangement and are not assumed eligible, the filing group consists of applicants and each parent of these applicants who live in the household.
- For all other applicants who live in a standard living arrangement, the filing group consists of each applicant and the spouse of each applicant as long as the spouse is included in the household group.

HSD

Filing group does not apply for HSD medical programs. Please refer to the household group section for EDG formation.

Click here for examples: Filing group.

Oregon Administrative Rule(s)

461-001-0015 — Definitions, SNAP
461-110-0310 — Filing Group; Overview
461-110-0370 — Filing Group; SNAP
461-110-0330 — Filing Group; TANF
461-110-0350 — Filing Group; ERDC
461-110-0410 — Filing Group; MSP, OSIPM
461-115-0145 — Responsibilities of a Facility or Group Living Arrangement Acting as Authorized Representative; SNAP
461-135-0070 — Specific Requirements; TANF
461-135-0570 — Eligible and Ineligible Students; SNAP
461-135-0510 — Residents of Institutions; SNAP
461-135-0530 — People in Adult Foster Care (AFC) and Boarding Houses; SNAP

Financial group

The financial group includes all individuals in the filing group whose income and resources count in determining eligibility and benefits. Everyone in this group will have their income and resources reviewed to determine whether they are countable or excluded, unless otherwise specified in rule.

SNAP The financial group is individuals from the filing group whose income and resources count in determining eligibility and benefits.

TANF The financial group is individuals from the filing group whose income and resources count in determining eligibility and benefits.

The TANF financial group consists of all the people in the filing group except:

- A caretaker relative (other than a parent), their spouse and dependent children who choose not to be included in the need group and who have income less than the non-needy countable income limit standard for their filing group, and
- An individual who is eligible for and receives an SSI cash payment.

ERDC For ERDC, the financial group consists of all people in the filing group.

REF For REF, the financial group consists of all the people in the filing group except people who are eligible for and receive an SSI cash payment. All income and resources attached to the SSI recipient are not counted.

MSP All the members of the filing group are also members of the financial group. The financial group determines whose income counts in determining eligibility and benefits.

OSIPM Remember, you don't have to try and figure this out for anyone receiving SSI or 1619b as they are assumed eligible.

The financial group is the same as the filing group for the following individuals:

- Unmarried adults,
- Adults married to someone receiving SSI or TANF,
- Children, and
- Individuals receiving or applying for services or being evaluated under the acute care setting rule.

For everyone else, the first step is determining whether or not the individual would be under the OSIPM income standard as an individual. If the adjusted income is above the standard, then the person is not eligible, even if their own income is below the two-person income standard and the spouse has no income. The process is outlined below:

- When the term "ineligible" appears in this rule, it means an individual not eligible to receive either SSI or TANF program benefits.
- When an individual is married to an ineligible spouse, if the individual's adjusted income is greater than the OSIPM program adjusted income standard for one, the individual is in their own financial group and not eligible for OSIPM.
- For individuals being evaluated under the protected groups, first determine how much of the individual's Social Security benefits are countable before proceeding to the next step.
- If the individual's adjusted income is less than the OSIPM adjusted income standard for one, then figure out if the spouse is in the financial group using the de3510 OSIPM Income Allocation and Deeming worksheet. It is more complicated if there are children, but either way, the process is outlined below:
  - If there are children in the home, the ineligible spouse is included in the financial group if that spouse's countable income after allocation to each ineligible child is more than the difference between the couple and individual SSI standard amount of $420 (in 2022). If it is equal to or less than $420, the spouse is not in the financial group when determining income eligibility, but their resources are still counted when determining resource eligibility.
    - » The maximum amount allocated to each ineligible child is the difference between the couple and individual SSI standard minus any other countable income of each ineligible child.
  - If there are no children in the home, the spouse is included in the financial group if the spouse's countable income is more than $420 (in 2022). If it is equal to or less than $420, the spouse is not in the financial group when determining income eligibility, but their resources are counted when determining resource eligibility.

HSD Financial group does not apply for HSD medical programs. Please refer to the Household Group section for EDG formation.

Click here for examples: Financial group.

Oregon Administrative Rule(s)

461-110-0530 — Financial Group
461-135-0780 — Pickle Amendment; OSIPM
461-135-0830 — Disabled Adult Children; OSPIM
461-135-0820 — Widows and Widowers; OSIPM
461-135-0771 — Individuals with blindness or disability eligible for SSI in December 1973; OSIPM
461-135-0790 — People in an Institution since 1973; OSIPM
461-135-0800 — 1972 COLA; OSIPM
461-160-0551 — Income Deductions; OSIPM (except EPD) in the Community When There Are Children in the Household Group

Need group

The need group includes individuals from the financial group whose basic and special needs are used in determining eligibility and benefit level, unless otherwise specified in rule.

SNAP The need group are individuals whose basic and special needs are used in determining eligibility. The need group consists of the financial group members except any member who:

- Does not meet the non-financial eligibility requirements
- Is an ineligible able-bodied adult without dependents (ABAWD) due to exceeding the SNAP time limits
- Is disqualified for an intentional program violation, or
- Is considered a fleeing felon or violator of parole, probation and post-prison supervision per rule.

Although individuals are not included in the need group because of the above reasons, their income and resources are still included in the eligibility decision. This is because they are still members of the financial group. Individuals who are not eligible for SNAP benefits due to the above reasons are not included when determining the group size of the payment standard to calculate benefits.

TANF The need group consists of individuals from the financial group whose basic and special needs are used in determining eligibility and benefit level. The need group consists of the financial group members except as follows:

- Parents who are in foster care and for whom foster care payments are being made. This includes:
  - Teen parents who are in foster care but whose children are not covered by foster care, and
  - Individuals receiving independent living subsidies, including payments under the Chafee Housing Program.
- Unborn children.

ERDC For ERDC, the need group consists of all individuals in the filing group.

REF The need group consists of individuals from the financial group whose basic and special needs are used in determining eligibility and benefit level with the exception of unborn children.

MSP The need group consists of each member of the financial group. Think of the need group as the "income standard group." The number of individuals in the need group determines what income standard you will use (1-person, 2-person, etc.). Some need group members may not be in the benefit group.

OSIPM The need group is the people whose basic and special needs are used in determining eligibility and benefit level. Some need group members may not be in the benefit group.

If a child is applying, the need group consists of the child.

In all other situations, the need group consists of all members of the financial group.

HSD Need group does not apply for HSD medical programs. Please refer to the household group section for EDG formation.

Click here for examples: Need group.

Oregon Administrative Rule(s)

461-110-0630 — Need Group

Benefit group

The benefit includes all individuals in the need group who receive benefits.

SNAP People from the need group who pass all resource and income requirements and have requested SNAP are in the benefit group and receive SNAP.

If a mandatory member of the filing group opts out of receiving SNAP benefits, explain to the group what this means. We will use all that person's income to determine the amount the benefit group is eligible to receive, but we will issue less food benefits. Be sure to code the person who opts out on the SNAP case as a DH, DP or IA and do not include them in the benefit number

If the group does not have at least one eligible person in the benefit group, deny the application.

TANF The benefit group also consists of individuals from the need group who meet all non-financial eligibility requirements, except:

- Individuals serving a disqualification penalty
- Individuals disqualified for an intentional program violation
- Individuals who have exceeded the 60-month time limit and do not meet any of the time limit exemptions or any hardship extensions
- A fleeing felon
- Individuals violating a condition of state or federal parole, probation or post-prison supervision
- Individuals who do not meet citizen/non-citizen status, and/or
- Individuals who choose not to receive benefits.

No-adult cases

When there is no adult in the benefit group, benefits are based on the adjusted number in the household group compared to the number in the benefit group.

In no-adult TANF cases, the adjusted number in the household is determined by taking the total number of individuals in the household, minus the following individuals (unless they are included in the benefit group):

- Unborn child
- Children who receive foster care payments for more than 30 days
- Children receiving Adoption Assistance
- Landlords and tenants
- Live-in attendants who live with the filing group solely to provide necessary paid medical or paid housekeeping services
- Individuals receiving long-term care or waivered home and community-based care.

ERDC For ERDC, the filing and benefit groups are the same. The number of members in this group determines which number to use in the copay calculation.

When the benefit group includes children who are not eligible for child care, they are still counted. This could include:

- Children ages 13 through 17 who do not have special needs
- Children who do not need child care, and
- Non-citizen children, unless they meet an exemption.

Adult siblings are not counted in the benefit group. This includes:

- Siblings age 19 or older, or
- 18-year-old siblings who are no longer in high school.

REF The benefit group are the people from the need group who receive benefits. The benefit group consists of the people from the need group who:

- Meet all non-financial eligibility requirements
- Have resources below the resource limit, except the following:
  - Individuals serving a disqualification penalty
  - Individuals disqualified for an intentional program violation (see OAR 461-195-0601)
  - A fleeing felon under OAR 461-135-0560
  - Individuals violating a condition of state or federal parole, probation or post-prison supervision under OAR 461-135-0560
  - Individuals who choose not to receive benefits.

Non-refugee spouse

If a refugee is married to someone who does not meet the immigration requirements for REF or REFM, that person is not included in the benefit group for either REF or REFM.

MSP For individuals not assumed eligible, the benefit group consists of the people from the need group who meet all the following:

- All non-financial eligibility requirements, and
- Have income below the income limits.

OSIPM For individuals not assumed eligible, the benefit group consists of the people from the need group who meet all the following:

- All nonfinancial eligibility requirements,
- Have resources below the resource limit, and
- Have income below the income limits/payment standards.

HSD Benefit group does not apply for HSD medical programs. Please refer to the household group section for EDG formation.

Click here for examples: Benefit group.

Oregon Administrative Rule(s)

461-110-0750 — Benefit Group

Chapter 2: Eligibility

Section 3: Individual information

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Individual information

Introduction

When applying for benefits, individuals must provide certain information about themselves and others who are in their household. The information required depends on which household members are requesting benefits and what program benefits are being applied. They have the right for this information to be treated with respect and confidentiality; they have the responsibility to provide true, complete, legal and accurate information.

Some information must be verified and other information can be accepted as stated by the applicant. If safety is a concern, arrangements can and should be made to provide an extra level of protection for individuals and their information in ODHS|OHA systems.

Oregon Administrative Rule(s)

461-105-0010 — Rights of Clients
461-105-0020 — Responsibilities of Clients

Other resources

Alternate Format Request: Process on how to handle alternate format request.

Name/identity

All benefit applications request the name(s) of the applicant and any other person for whom benefits are being requested. Applicants need to provide their true legal identity/name(s), which for ODHS|OHA purposes is the name registered with the Social Security Administration (SSA). ODHS|OHA calls this the person's "Primary name." This name is used in the system to identify the person. Identity must be verified during the application process.

Persons may want to use a name other than their primary name. If the individual believes a risk would be created by their name being linked to their information in ODHS|OHA systems (e.g., safety risk is connected to an employee's family member), the local branch can follow the process to create a unique T number and "created name" for that person. The branch will keep record of the T number, the created name(s) and the legal name(s). If there is no safety risk, a preferred or nickname can be recorded as an alias name, but these names are not to be entered as the primary name.

If an individual has legally changed their name through Oregon courts, but SSA is showing a different name, ODHS|OHA will continue using the primary name and refer the person to the SSA to complete the name change. Changing a name through Oregon or other state courts does not change the person's name registered with the SSA.

Other resources

Remote Identity Proofing (RIDP): Discusses the purpose of the RIDP check. Discusses the normal RIDP process, and steps for workers to troubleshoot and verify user identity if RIDP is unable to confirm their identity.

Date of birth (DOB) and age

Recipients must provide their date of birth for themselves and all other household members. Age is important for many programs and can affect who is considered when determining eligibility, as well as for which program(s) they may be eligible.

SNAP There is no age restriction for SNAP applicants; however, an applicant's age and relation to others in their household can greatly affect with whom they must apply.

TANF To be eligible for TANF, the dependent child must be under age 18, or age 18 and regularly attending high school or an equivalent program full-time (per the school's definition of full-time). The caretaker relative(s) may be any age.

Minors who are married, married and legally separated or legally emancipated do not qualify as a dependent child.

If the caretaker relative is under age 18, ODHS|OHA needs to determine there are no other adult relatives to care or be responsible for the well-being of the applicants and they are living in a safe environment.

ERDC For ERDC, children must be younger than 13 to be eligible for child care payments. However, older children ages 13 through 17 may be given an exception called the "special needs age" (SNA) or the "special needs rate" (SNR) to qualify for ERDC benefits under the following situations:

- ODHS|OHA determines the child should not be left unsupervised during the hours the parent is working or participating in authorized program activities. This determination is verified by one of the following:
  - A verbal or written statement from a physician, nurse practitioner, psychologist, social worker or another qualified professional who is familiar with the child
  - Eligibility for SSI
  - Supervision by a court
  - Receipt of foster care payments, or
  - Other unique circumstances where the child's safety or the caretaker's ability to work or participate in authorized activities will be significantly compromised if child care is not approved. (For example, child care might be necessary for an older child whose parent works an overnight shift.)

To authorize payment for an older child (up to the school age rate), the worker would indicate that a special need is required and select the verification source on the ERDC Questions page. Eligibility for the special needs age or special needs rate exception must be reviewed to determine if there is a continued child care need at reapplication. SNA will pay at the school age rate and SNR will pay at the infant rate.

Click here for Special needs rate (SNR).

Note: Children eligible for SNR may benefit from the High Needs rate. For more information, click here for ODHS|OHA provider rates: supplementing for very high needs.

REF For REF, an applicant must be an adult (at least 18 years of age or older). The only exceptions are legally emancipated minors. If the applicant is part of a TANF filing group, they are not eligible for REF.

MSP To be eligible for QMBP, SLMB, QSMF programs, an individual may be any age.

OSIPM Use the person's actual date of birth in determining their age. If the month of birth is unknown, use July. If the day of birth is unknown, use the 1st of the month.

OSIPM-AB: May be any age.
OSIPM-AD: Must be under 65 years of age.
OSIPM-OAA: Must be age 65 or older.
OSIPM-EPD: Must be at least 18 years of age. There is no upper age limit.

HSD The applicant's date of birth helps determine the programs for which an applicant should be evaluated:

- Applicants for MAGI Child and MAGI CHIP programs must be under age 19.
- Applicants for Former Foster Care Youth Medical Program must be an adult at least age 18 and under age 26.
- Applicants for MAGI Adult must be 19 years or older and under age 65.

Social Security number (SSN)

Not all programs require applicants to provide SSNs. The SSN is used to verify income and other assets. It is also used to match with other state and federal records such as the Internal Revenue Service (IRS), Medicaid, child support, Social Security benefits, unemployment benefits and identify any individual receiving benefits in more than one household.

Social Security number table

Program	SSN required?	Exceptions?

SNAP	Yes. To be included in the need group, individuals must provide their SSN or apply for one if they don't have a number.	Yes. See OAR 461-120-0210 for details. **Expedited:** May receive their first full month's allotment without meeting the SSN requirement. **Newborns:** May be included in a benefit group for six months following the date the child is born or until the benefit group's next recertification, whichever is later. **Religion:** May not be required to apply for or provide an SSN if the individual is a member of a religious sect or division of a religious sect and meets the following criteria: • The religious sect that has continuously existed since December 31, 1950; and • The individual adheres to its tenets or teachings that prohibit applying for or using an SSN.
TANF	Yes. If an individual does not have an SSN, they must provide verification of application and provide the SSN within six months of the initial TANF approval or by the end of the certification period, whichever is sooner.	Yes. **Newborn:** A child born in an Oregon hospital is eligible for TANF benefits for six months following the date of birth or until the next redetermination of eligibility, whichever is sooner.
ERDC	No. A member of a need group or a benefit group is not required to provide or apply for an SSN.	ODHS|OHA may ask a member of the filing group or need group to voluntarily provide an SSN.
REF	No. A member of a need group or a benefit group is not required to provide or apply for an SSN.	ODHS|OHA may ask a member of the filing group or need group to voluntarily provide an SSN.
MSP	To be included in the benefit group, an individual must provide a valid SSN or apply for a number if the individual does not have a valid one and provide the SSN when it is received. **Note:** ODHS|OHA must not deny, delay or end benefits pending receipt of an SSN after a person has applied for a number with the SSA.	Yes. An individual is not required to apply for or provide an SSN if the individual: 1. Does not have an SSN and may only be issued an SSN for a valid non-work reason in accordance with 20 CFR 422.104, or 2. Is a member of a religious sect or division of a religious sect that has continuously existed since December 31, 1950 and adheres to its tenets or teachings that prohibit applying for or using an SSN.

OSIPM	To be included in the benefit group, an individual must provide a valid SSN or apply for a number if the individual does not have a valid one and provide the SSN when it is received. **Note:** ODHS|OHA must not deny, delay or end benefits pending receipt of an SSN after a person has applied for a number with the SSA.	Yes. An individual is not required to apply for or provide an SSN if the individual: 1. Does not have an SSN and may only be issued an SSN for a valid non-work reason in accordance with 20 CFR 422.104, or 2. Is a member of a religious sect or division of a religious sect that has continuously existed since December 31, 1950 and adheres to its tenets or teachings that prohibit applying for or using an SSN. In the **CWM** program, a member of a need group or a benefit group is not required to provide or apply for a social security number (SSN). ODHS|OHA may request that a member of the filing group or need group provide an SSN on a voluntary basis.
HSD	The SSN is used to verify identity, income and other assets, and to match with state and federal records. With a few exceptions, each applicant, including children, requesting medical benefits shall provide a valid SSN or, if the individual does not have one, to apply for an SSN and provide it when it is received.	Yes. An individual is not required to apply for or provide an SSN if the individual: 1. Is a member of a religious sect or division of a religious sect that has continuously existed since December 31, 1950 and the individual adheres to its tenets or teachings that prohibit applying for or using an SSN, 2. Is a newborn that is assumed eligible based on the eligibility of the mother of the newborn and who is under one year of age, 3. Is a non-citizen and they: (a) Do not have an SSN and may only be issued an SSN for a valid non-work reason, or (b) Are not eligible to receive an SSN, including because they do not have a documented status. A non-applicant may provide an SSN on a voluntary basis.

Oregon Administrative Rule(s)

461-120-0210 — Requirement to Provide Social Security Number (SSN)
410-200-0210 — Requirement to Provide Social Security Number

Address

Addresses are an important part of communicating with participants. If a mailing or physical address is out of state, it is essential to review residency in depth during the interview.

Although individuals are not required to have a fixed mailing address, they must provide a location to get notices from ODHS|OHA. This mailing address cannot be a branch address. A mailing address may be General Delivery or the address of a shelter or a friend. If an unacceptable address is provided on an application, OHDS|OHA accepts this for establishment of a filing date and collects a useable address during the interview. For medical programs, the county listed in the physical address section is used to determine which coordinated care organization(s) are available to the participant. Therefore, both a mailing address and at least the state, zip code and county where the applicant physically resides needs to be collected.

Address fields for all programs should be reviewed and updated when a change of mailing or physical address is reported. The HZIP system or USPS Look Up a ZIP Code can be used to verify the address and ZIP code.

Some individuals will have special address coding that ODHS|OHA will use due to their unique situation. These specific situations are:

- TEMP — "temporary"
  - **As of 2/1/2020**, TEMP will no longer be used for participants who state they do not have a "fixed address." This would be for anyone who claims they are homeless, staying in a shelter (this includes domestic violence shelters), living with a friend, couch surfing, living in an RV, or living any place they feel is not their permanent home address. Workers will answer the question "Has No Fixed Address" as YES in ONE. This will eliminate the need for data in the residential street line. Workers will then code the zip code and county the individual has provided for where they spend their time. The mailing address will be the address where they want their mail delivered.
- DND — "do not disclose"
  - DND is for safety purposes only and not for individuals who, for reasons other than safety, simply do not want to provide an address.
  - DND will only be used for cases with a safety concern, including but not limited to domestic violence and trafficking.
  - Workers will code the physical address line with DND, the city and ZIP code of current residence, and the mailing address will continue to be the address where they want their mail delivered.
  - Below are the reasons why a worker would code DND:
    - The abuser is an employee of ODHS|OHA,
    - The abuser is a community partner or contractor and has access to ODHS|OHA systems,
    - The abuser is a member of the household (or "EDG" in ONE) and has access to case information, or I

information

» The survivor believes the abuser may have or may be able to "hack" into our systems and gain access to case information in ODHS|OHA systems.

Note: Domestic violence shelters are all confidential. Within any system, we should never enter the DV business name or shelter location.

- ACP — "address confidentiality program"
  - ACP is only used for individuals who participate in ACP, which is a program determined and administered by the Department of Justice. More information about the program can be found on their website, here.
  - Participants will have an ACP ID card issued to them with the ACP post office box and their recipient number.
  - Workers will choose 'Yes' to "Participating in Address Confidentiality Program" and input the ACP number.
    - » All ACP participants will prepopulate Salem as their city and Marion as their county.
    - » If the ACP Number is only 5 digits, best practice is to input a zero before the number.
  - It is best practice to view the ACP card to ensure accuracy of the ACP number. Whenever possible, view the card when adding an ACP address, and case note that the card was viewed.
    - » We can email or call to verify ACP enrollment at acp@doj.state.or.us or via phone at 503-373-1323. This is also helpful if the survivor does not know their participant number.
  - Important: Delivery of mail to ACP addresses takes additional time. While the ONE system ensures enough time is given when notices are generated, if mailing timely notices outside the system, allow an additional 5 business days (see OAR 461-175-0050 and OAR 461-175-0206).

Reminder for medical benefits: Immediately following an authorized approval or reported change to add ACP, workers must request an enrollment exception, known as a service area exception (SAE), for anyone who does not physically reside in Marion County.

The email should be sent to DMAP CES and include the following information in the email:

Subject line: 'Medical Exception Needed – ACP Program'

In the body of the email include:

- Participants' names
- Case number
- Prime numbers for all individuals
- County (and zip code, if known) of physical residence
- Managed care plan the participant chose in their residential county
- Reason why the exemption is needed

If these steps are not completed, individuals will be enrolled in Marion County CCOs and will experience access-to-care issues. Once CES adds the SAE in MMIS, they will manually enroll the person in their CCO choice in their

residential county. You must also send a SAE extension request to CES at every subsequent renewal, as long as the ACP remains in effect. SAEs are only applied in MMIS for up to one year at a time. Always check MMIS to confirm an active SAE is in place for any ACP individual (Recipient Panel > Recipient Maintenance > Managed Care > MC Special Conditions).

Note: If the individual has a tribal status (HNA) and is requesting to remain on an open card, no communication to CES is required.

Other resources

Address Confidentiality Program (ACP) and Do No Disclose (DND) Address Coding *includes screenshots: Includes guidance on when to use Address Confidentiality Program (ACP) and Do Not Disclose (DND) and provides address coding options for Oregonians who have safety concerns and meet the criteria for ACP and DND

Client Enrollment Services (CES) & Client Services Unit (CSU): OHP Client Services Unit is the customer service center for all OHP/Medicaid recipients who assist with general questions about OHP medical and refer to Coordinated Care Organizations (CCO) as needed. OHP Client Services Unit (CSU) and Client Enrollment Services (CES) are partners within member services, which manages all member CCO enrollment/disenrollment requests.

Citizenship/non-citizen status

Click here for Non-citizens.

Different programs have different United States citizen and/or non-citizen status requirements. ODHS|OHA has discontinued use of the federal term “alien” in rules as ODHS|OHA is aware this term can feel offensive. ODHS|OHA also uses different terminology during interviews, narrations and conversations.

An amnesty non-citizen is a person with permanent or unexpired temporary status who was admitted under either of the following provisions:

- Section 245A of the Immigration and Nationality Act (referred to as 1/1/82 Residents); OR
- Section 210 or 210A of the Immigration and Nationality Act (referred to as SAWs).

Amnesty non-citizens and family unity cases meet the non-citizen status requirement only if they qualify per rule 461-120-0125.

Effective July 1, 2006 all Medicaid applicants are required to declare AND provide documentary evidence that they are U.S. citizens or U.S. nationals. Applicants who state that they are not U.S. citizens or nationals, and who indicate they have a status that would allow them to be eligible for OHP Plus level benefits, are required to provide documentary evidence of their citizen or non-citizen status, **even if receiving SSDI, Medicare, or Title IV payments**. Non-citizen SSI recipients are exempt from this requirement.

Oregon Administrative Rule(s)

461-120-0110 — Citizenship and Noncitizen Status Requirements
461-120-0125 — Noncitizen Status Requirements
461-135-1070 — Specific Requirements; Citizenship-Waived Medical (CWM)
410-200-0215 — Citizenship and Non-Citizen Status Requirements

Race, ethnicity, language and disability (REAL+D)

ODHS|OHA applications have a place for individuals to self-report their racial and ethnic information. If the applicant has not answered these questions on the application, please cover this during the interview.

Note: Some medical applicants are not required to have an interview. If there is no interview, and an OHA 7210 form is received, and these questions are left blank, indicate "did not answer" for these questions. This is the only time this answer should be used.

It is important that these questions are addressed as they are required from Oregon legislation. These questions are asked in an effort to ensure all participants received the highest quality of care, ensure the best services possible, and address health disparities. These questions do not impact eligibility.

Individuals may change how they self-identify and the computer system needs to be reviewed and updated to reflect what participants report on the most recent application.

For more information, see Transmittal SS-AR-15-010.

Other resources

REALD Desk Guide: This QRG provides information on the policy requirements surrounding the REaL+D demographic data. It also provides scripts for responding to common customer questions.

Basis of need

This applies specifically to OSIPM programs.

OSIPM To be eligible for OSIPM, a person must be one of the following:

- Blind at any age (AB),
- Age 65 or over (OAA), or
- An individual with a disability (AD).

Note: Determine eligibility for OSIPM in the following order of priority: AB, OAA, AD. When OAA or AD individuals become blind, workers must verify an official determination of their blindness and update accordingly.

Blindness as the basis of need

Individuals meet blindness as the basis of need if any of the following is true:

- They are receiving SSDI or SSI benefits based on blindness. Eligibility continues as long as their SSDI or SSI eligibility continues.
- They were eligible for and received AB in Oregon in December 1973. These individuals continue to be eligible as long as they are continuously blind as defined by Oregon requirements that were in effect in 1973.
- They are found by ODHS|OHA to meet the following OSIPM blindness criteria:
  - Vision of 20/200 or less in the better eye with a corrective lens, or
  - A limitation in vision field to an angle of 20 degrees or less.

Old age as the basis of need

Individuals meet old age as the basis of need if they are age 65 or over.

Disability as the basis of need

An individual meets the requirement to have a disability if one of the following requirements is met:

- The individual is receiving SSDI or SSI based on disability. Eligibility continues as long as the individual remains eligible for SSDI or SSI.
- The individual was eligible for and received Aid to the Disabled benefits in Oregon in December 1973. These individuals continue to be eligible as long as they are continuously disabled as defined by Oregon requirements that were in effect in 1973.
- ODHS|OHA has determined the individual meets the SSA listing of impairments, meets the SSA medical vocational guidelines, or meets the SSA definition of disability. Individuals are referred to the Presumptive Medicaid Disability Determination Team (PMDDT) for disability determinations. Refer to PMDDT for more information.
- SSA has determined the individual meets the listing of impairments, meets the medical vocational guidelines for SSI, or meets the definition of disability.

If ODHS|OHA finds the individual eligible for OSIPM in the absence of a disability determination by SSA, the individual remains eligible, provided that the individual continues to meet the disability criteria for eligibility for OSIPM, until SSA denies the disability claim in a final administrative decision.

If a binding SSA disability determination is not in place, the determination of disability to qualify for OSIPM is made by PMDDT. Refer to PMDDT for more information.

Note: If a non-EPD individual lost SSDI due to earning over the SGA limit, they may still be considered medically disabled by the SSA. In this situation, workers may contact PMDDT to check whether a new referral and evaluation is needed.

Refer here for information on EPD.

SNAP This does not apply to the SNAP program.

TANF This does not apply to the TANF program.

ERDC This does not apply to the ERDC program.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

HSD This does not apply to HSD medical programs.

Oregon Administrative Rule(s)

461-125-0330 — Blindness as the Basis of Need
461-125-0350 — Old Age as the Basis of Need; OSIPM
461-125-0370 — Disability as the Basis of Need

Highest grade completed in school

Many programs request information regarding the highest grade participants completed in school. This information can help ODHS|OHA identify barriers to employment, consider eligibility for older children in a TANF group, consider whose income does and doesn't count against benefits and more. This field should be updated as it may affect eligibility and case planning.

Oregon Administrative Rule(s)

461-120-0510 — Age Requirements for Clients to Receive Benefits
461-145-0130 — Earned Income; Treatment
461-190-0171 — Education Requirements for Teen Parents; JOBS
461-190-0181 — Basic Education for Nonteens; JOBS

Residency

To be eligible for benefits, an individual must be a resident of Oregon. An individual is a resident of Oregon if the individual lives in Oregon. If an individual is in Oregon solely for a vacation, that individual is not a resident. An individual continues to be a resident of Oregon during a temporary period of absence if the individual intends to return when the purpose of the absence is completed and the absence is evaluated and approved by ODHS|OHA. For example, participants can still meet residency while "snow-birding" in Arizona or Southern California as long as the individual plans on returning when the purpose (getting away from the Oregon winter) for their absence is completed as long as the individual is not receiving benefits in Arizona or California.

Not all programs require participants to be physically living in Oregon when they apply to be considered an Oregon resident for program benefits. If a non-Oregon physical or mailing address is listed on an application and residency is questionable, ODHS|OHA can address this with the participant and add a case note.

When an individual maintains their Oregon residency, ODHS|OHA will still review whether the individual is considered part of the household group.

SNAP There is no minimum amount of time an individual must live in Oregon to be a resident. The SNAP program does not require intent to remain in Oregon to establish residency.

TANF There is no minimum amount of time an individual must live in Oregon to be a resident. However, the individual must intend to remain in Oregon. Exceptions can be made for the following situations:

- An individual is considered a resident if the individual entered Oregon with a job commitment, or
- An individual is looking for work and is not receiving benefits from another state.

ERDC There is no minimum amount of time an individual must live in Oregon to be a resident. However, the individual must intend to remain in Oregon.

REF There is no minimum amount of time an individual must live in Oregon to be a resident. However, the individual must intend to remain in Oregon. Exceptions can be made for the following situations:

- An individual is considered a resident if the individual entered Oregon with a job commitment, or
- The individual is looking for work and is not receiving benefits from another state.

MSP There is no minimum amount of time an individual must live in Oregon to be a resident. However, the individual must intend to remain in Oregon.

People are considered a resident if they have entered Oregon with a job commitment or are looking for work, as long as they are not receiving benefits from another state.

Residency does not require a permanent dwelling or a fixed mailing address.

Incapable of stating intent to reside

A person is considered incapable of stating intent to reside if any of the following is true:

- The person's IQ is 49 or less.
- The person has a mental age of 7 or less as determined by tests used to establish IQ.
- The person is judged legally incompetent by a court of law.
- Other acceptable medical documentation supports a finding that the person is not capable of indicating intent. Acceptable sources are a physician, a psychiatrist or a psychologist.

OSIPM There is no minimum amount of time an individual must live in Oregon to be a resident. However, the individual must intend to remain in Oregon.

People are considered a resident if they have entered Oregon with a job commitment or are looking for work as long as they are not receiving benefits from another state.

Residency does not require a permanent dwelling or a fixed mailing address.

SSI-eligible people who attend school out of state continue to meet residency requirements and can receive OSIPM while attending school as long as they intend to return to Oregon at the end of the school year or claim Oregon as their legal residence.

Incapable of stating intent to reside

A person is considered incapable of stating intent to reside if any of the following is true:

- The person's IQ is 49 or less.

- The person has a mental age of 7 or less as determined by tests used to establish IQ.
- The person is judged legally incompetent by a court of law.
- Other acceptable medical documentation supports a finding that the person is not capable of indicating intent. Acceptable sources are a physician, a psychiatrist or a psychologist.

HSD There is no minimum amount of time a participant must live in Oregon to be a resident. The individual is a resident of Oregon if any of the following are true:

- The individual intends to remain in Oregon,
- The individual entered Oregon for a job, or is looking for work, or
- The individual is out of Oregon for a temporary absence but intends to return. The individual continues to be an Oregon resident during a temporary period of absence if they intend to return when the purpose of the absence is completed.

An individual is not a resident if:

- The individual is in Oregon solely for a vacation,
- The individual is 21 years of age or older and is placed in a medical facility in Oregon by another state. The individual is considered a resident of the state that makes the placement if:
  - The individual is capable of indicating intent to reside, or
  - The individual became incapable of indicating intent to reside after turning 21.
- If the individual is less than 21 years of age and is incapable of indicating intent to reside or became incapable prior to age 21, the individual's residence is:
  - The state of residence of the individual's parent or guardian,
  - The state of residence of the party who applies for benefits on the individual's behalf if there is no living parent or their whereabouts are unknown, and there is no legal guardian, or
  - Oregon, if the individual has been receiving medical assistance in Oregon continuously since November 1, 1981 or is from a state with which Oregon has an interstate agreement that waives the residency requirement.

  An individual is presumed to be incapable of indicating intent to reside if the individual falls under one or more of the following:
  - The individual is assessed with an IQ of 49 or less based on a test acceptable to OHA,
  - The individual has a mental age of seven years or less based on tests acceptable to OHA, or
  - The individual is judged legally incompetent.

Oregon Administrative Rule(s)

461-110-0210 — Household Group
461-120-0010 — Residency Requirements
461-120-0050 — Incapable of Stating Intent to Reside; OSIPM, QMB, and REFM
461-165-0300 — Concurrent and Duplicate Program Benefits
410-200-0200 — Residency Requirements

Student status

Student status affects participants in many ways across multiple programs. It is important to ask many follow-up questions if there is any unclear information about school grade, the school(s) attended, the credits taken, enrollment status, if the individual has already started classes, and expected graduation dates (if known). This information can help create an informative conversation with the applicant, decrease the likelihood of an eligibility error and help guide ODHS|OHA regarding work requirements.

SNAP Student status affects how income is treated, general SNAP eligibility, the SNAP ABAWD program, and work registrant status. Individuals attending higher education at least half time who are 18 years of age or older but not yet 50 may not receive SNAP unless they meet additional criteria.

- "Higher education" for this rule means:
  - Public and private universities, colleges and community colleges that offer degree programs regardless of whether a high school diploma is required for the program.
    - » Exclusion: GED, ABE, ESL and high school equivalency programs at those institutions are not considered higher education.
  - Vocational, technical, business and trade schools that normally require a high school diploma or equivalency certificate for enrollment in the curriculum or in a particular program at the institution.
    - » Exclusion: Programs at those institutions that do not require the diploma or certificate are not considered higher education.

Eligibility due to student status is reviewed during initial application, renewal/recertification, as well as when ODHS|OHA receives a report requiring action due to it meeting SRS action criteria or affecting ABAWD status. If such a report indicates the person no longer meets the additional criteria, the student has lost their SNAP eligibility.

Students of higher education

Who is subject to student eligibility criteria?

This policy addresses eligibility for students enrolled in higher education. An individual is considered a student when they are age 18 through 49 and enrolled in an institution of higher education at least half-time.

- Enrollment status of a student begins on the first day of the school term.
- A student is considered enrolled through normal periods of class attendance, vacation and recess. This applies unless the student graduates, is suspended or expelled, drops out, reduces credit hours to less than half-time or does not intend to register for the next normal school term (excluding summer school).

An institution of higher education is any public or private educational institution that:

- Admits persons beyond the age of 16, or
- Normally requires a high school diploma or equivalency certificate for enrollment. The institution

must be legally authorized to provide an educational program beyond secondary education or to provide a training program that will prepare students for gainful employment.

Institutions of higher education include but are not limited to:

- Public or private colleges, universities or community colleges
- Correspondence schools
- Online schools
- Business or technical schools, or vocational programs.

A student of higher education with a meal plan intended to provide 51 percent or more of the student's meals is ineligible for SNAP.

Who is not subject to student eligibility criteria?

Student eligibility does not apply to individuals who are:

- Under age 18 or age 50 or older
- Attending high school, adult basic education (ABE) or a GED program
- Participating in a training program provided by an employer
- Enrolled in schools and training programs that are not institutions of higher education such as vocational, technical, business or trade schools that do not require a high school diploma or equivalency for enrollment in the program of curriculum
- Enrolled for the exclusive purpose of obtaining training in English as a second language (ESL), provided that the courses are not taken for credit as part of a total program
- Attending school less than half-time
- Physical or mental health reasons that create a barrier to employment
- New students who have enrolled but will start classes after the month the eligibility decision occurs.

To be eligible for SNAP, a student must meet at least one of the following exemptions:

- Be employed:
  - For a minimum of 20 hours per week (averaged monthly) and be paid for such employment (verify with pay stubs or employer), or
  - If self-employed, be working for a minimum of 20 hours per week averaged monthly and receive weekly earnings at least equal to the federal minimum wage multiplied by 20 hours (verify with current income after allowable costs).
    - » The self-employment income is at least $1,247 SEC and $623.50 SEN.
- Participate in a federally or state-funded work-study program (accept statement on funding)
  - Student must be assigned federal work study as part of their school's financial aid offer at the time of application for SNAP; the work study must be approved for the school term; and the student must anticipate actually working during that time.

- Once begun, the exemption shall continue until the end of the month in which the school term ends, or it becomes known that the student has refused an assignment.
- The exemption shall not continue between terms when there is a break of a full month or longer unless the student is participating in work study during the break.

- In a one- or two-parent home, be responsible for the care of a dependent child in the filing group under the age of 6
- In a one- or two-parent home, be responsible for the care of a child in the filing group who has reached the age of 6 but is under age 12 when the state agency has determined that adequate child care is not available to enable the student to attend class and work at least 20 hours a week
- Be a single parent enrolled in an institution of higher education on a full-time basis (as determined by the institution) and be responsible for the care of a dependent child in the filing group under age 12.
  - This provision applies in those situations where only one natural, adoptive or stepparent (regardless of marital status) is in the same food stamp filing group as the child.
  - If no natural, adoptive or stepparent is in the same SNAP household as the child, another full-time student in the same SNAP household as the child may qualify for eligible student status under this provision if they have parental control over the child and are not living with their spouse.
- Be receiving TANF
- Be assigned, placed or voluntarily enrolled in an institution of higher education through or in compliance with one of the following programs:
  - A program as a result of participation in the Jobs Opportunities and Basic Skills Program (JOBS)
  - Workforce Innovation Opportunities Act (WIOA) (A complete list of approved training providers can be found at https://www.wioainoregon.org/eligible-training-providers.html.)
  - A program under Section 236 of the Trade Act of 1974
  - An employment and training program or course of study that would lead to employment under the Food and Nutrition Act. To qualify under this criteria, the employment and training program or course of study:
    - » Needs to have placed the individual in the higher education program or accepted the placement when the individual self-initiated enrollment, and
    - » Must not be a post-baccalaureate program, and
    - » Must be intended to be completed in not more than four years.
- Be enrolled in school because of employer-sponsored on-the-job training
- Be receiving unemployment compensation (UC)
- Be participating in at least one of the following Employment Department training programs. These can be identified with a code of 066, 067, 068, 070 or 088 on the ECLM screen and include the following programs:

- The Trade Readjustment Allowance (TRA) program serving displaced workers under the Trade Act
- The Training Unemployment Insurance (TUI) program
- The Self-Employment Insurance (SEA) program
- The Apprenticeship Program (APT).

Eligible students

If the student meets the eligible student criteria, they:

- Are included in the filing group and must meet all other eligibility criteria
- Must be placed or voluntarily enrolled in a career and technical education program (CTE) or referred by a government employment and training program such as STEP or ABAWD. For these students, work reg code "2" is used.
  - If the student is eligible but does not meet the above criteria, they are exempt from the SNAP work program; work reg code "2" is used.
- Have income and resources counted when determining eligibility.

Ineligible students

If the student does not meet an exemption:

- They are excluded from the filing, financial, need and benefit groups. The student is coded as an SH or ST.
- Any costs they pay for the household are not allowed as deductions.

Changes in student status

When a student reduces their credit hours to less than halftime (by dropping or withdrawing from classes) in a term or report that they are no longer attending, the students of higher education rules no longer apply to them. Verification of withdrawal or reduction in classes/hours is only needed if questionable.

For individuals who no longer meet the SNAP requirements for students of higher education, it is important to consider if this person is now subject to ABAWD time requirements or is no longer exempt from work registration.

Student eligibility needs to be reviewed to determine if the student meets any eligible student eligibility criteria. If so, a conversation may be needed to determine if there is countable educational income; all countable income must be verified.

If a SNAP recipient reports starting higher education, ODHS|OHA staff should explain reporting requirements. An individual who meets the SNAP eligibility requirements of a student of higher education is exempt from work registration. This would also exempt them from ABAWD time limits.

When processing an application or DHS 0852 ffor a student before they have received an expected financial aid award, processing should not be delayed while waiting for verification of future income. Staff should explain reporting requirements and ways to report changes, and provide the student with a

change report form.

If an eligible student reports a change that indicates that they are no longer eligible under the original student eligibility criteria, past narrations should be reviewed to determine if any other student eligibility criteria were identified. If they are still not eligible, timely closure notice to close the case should be sent.

- The student will need to reapply with a new application and is required to meet an exemption to continue to meet eligible student eligibility requirements for SNAP.
- If the student contacts the branch and student eligibility criteria is identified, an ROP action must be taken on the case to prevent it from closing at the end of the month. It is important that action and student eligibility criteria are narrated clearly, and the case is allowed to continue in the current certification period.

TANF Eighteen-year-olds who are not regularly attending school full-time as defined by the school are not eligible to receive cash benefits. Regular school attendance means attending high school, a GED program, vocational or technical training, or the Oregon School for the Deaf or Blind/Visionally Impaired Regional Program Services. Home schooling is an acceptable venue for schooling if the educational plan is approved by the local school district and the child is meeting the district standards.

ERDC Working students may be eligible to have some or all their class time covered for child care assistance. A request for student hours can be made at any time including during initial certification, recertification and the certification period. Working student hours can be approved for in-person and online classes. When a caretaker is approved for additional student hours, they must be coded with the STU case descriptor.

Click here for Child care hours.

REF For REF and REFM, an applicant must not be a full-time student of higher education, unless such education is part of a cash assistance case plan. Any education or training allowable under an approved case plan must be less than one year in length. GED, ABE, ESL and high school equivalency programs at these institutions are not considered “higher education.”

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD Student status is only used to determine whether an individual who is 18 is a dependent child for the Parents and Caretaker Relative (PCR) program. To be considered a dependent child, an individual who is18 years of age must be a full-time student in a secondary school, or equivalent vocational or technical training, if the individual may reasonably be expected to complete the school or training before turning 19.

Oregon Administrative Rule(s)

461-135-0570 — Eligible and Ineligible Students; SNAP
461-135-0400 — Specific Requirements; ERDC
461-135-0900 — Specific Requirements; REF, REFM
461-130-0310 — Participation Classifications: Exempt, Mandatory, and Volunteer
410-200-0015 — General Definitions

Relationship

The relationship (responsibility, age, legal and biological) between individuals in the same household can affect eligibility in many ways.

It is important to gather each person's relationship to every other person on the application and in the home. During the interview, ODHS|OHA will inquire about roommates or significant others. It is important that ODHS|OHA knows who is living together; this can be important in the future, if not now, especially if there is a pregnancy or common children.

If there are minor children in the home, it is important to determine who has care and control.

Living arrangements

Click here for Eligibility groups.

Purchasing and preparing together

This is specifically relevant to SNAP.

SNAP When individuals purchase and prepare meals together, they are considered in the same filing group for SNAP. For more information, click here for Filing group.

TANF This does not apply to the TANF program.

ERDC This does not apply to the ERDC program

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Oregon Administrative Rule(s)

461-110-0370 — Filing Group; SNAP

Tax filing status

This screen is specifically relevant to HSD medical programs.

ONE asks applicants how they file their taxes. HSD medical programs use tax filing status to determine program eligibility

SNAP This does not apply to the SNAP program.

TANF This does not apply to the TANF program.

ERDC This does not apply to the ERDC program

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD For HSD medical programs, tax filing status is required for all individuals on a case, even if not applying for medical or living in the same household. Tax filing status is used in combination with relationships and household status to calculate the Eligibility Determination Group (EDG).

Oregon Administrative Rule(s)

410-200-0305 — Eligibility Determination Group – MAGI Medicaid/CHIP
461-145-0915 — Self-Employment; General; OSIPM, QMB

Minor parents

A minor parent is an individual under the age of 18 who is the parent of a child.

SNAP This does not apply to the SNAP Program.

Click here for Eligibility groups.

TANF To be eligible for TANF, a minor parent applying for benefits for their child must live with the minor's parent, parents or legal guardian unless it is unsafe or impractical for the minor parent to live with those individuals.

The expectations regarding minor parents are as follows:

- A safe and supportive living situation is critical to the well-being of any individual, particularly minor parents and their child;
- Minor parents learn to cope and function better when there is extended family support and parental/adult guidance;
- A safe and secure home environment provides a better opportunity for minor parents to become successful and self-reliant;
- Attainment of a high school diploma or its equivalent contributes to economic success and better functioning in the world of work.

Definitions

Minor parent: A minor parent is any parent under the age of 18.

Minor parent head of household: A minor parent head of household is an individual applying for benefits for themselves and their child(ren).

Major parent: A major parent is a parent in the same household with their minor parent child.

Teen parent: A teen parent is a parent age 19 or younger who does not yet have their high school diploma or equivalent.

Eligibility for minor parents

A minor parent filing for TANF benefits cannot be both a dependent child and a caretaker for their own child. If they are considered a dependent child, they must file for benefits with their parent or caretaker relative. Minor parents and teen parents need to meet all TANF eligibility requirements to be eligible for TANF.

Minor parent living with a parent or other legal adult

Minor parents are not eligible for benefits if they are not living with their parent(s), legal guardian, or another adult relative. This is true unless the worker determines that it is unsafe or impractical for the minor parent to live with the aforementioned individual(s).

A minor parent will be ineligible for benefits if they refuse to live with their parent(s), legal guardian, or another adult relative when the worker determines that it is an appropriate option.

If the worker determines that it is in the best interest of the minor parent to live on their own, the minor parent must attend high school (or equivalent) full-time, or participate in JOBS or other training programs to develop employment or self-sufficiency skills to qualify for benefits.

Note: Sexual abuse or other physical or emotional abuse is grounds for the worker to waive the requirement that a minor parent live with their parent(s), legal guardian, or other adult relative in order to receive benefits. The worker's decision to waive that requirement may also be based on the unavailability of the parent(s), legal guardian, or other adult relative in providing the minor parent's care, control, and supervision. This is true when they are not living in the same state, or when the minor parent has been living on their own for over 12 months before or since the birth of their last child.

Minor parents living with their major parents

When a minor parent returns to live or lives with their parents, eligibility for the minor parent will be determined as follows:

- If the major parents are receiving benefits, the minor parent and their child will be added to the filing group. Thus, the minor parent will be treated as one of the dependent children in the family;
- If the major parents are not receiving benefits and do not want to apply for the minor parent, the parents' income (this includes earned and unearned income) will be used to determine if the minor parent is eligible.

Deeming of major parents' income for minor parents

If the minor parent has been married or legally emancipated, ODHSIOHA does not deem the major parent's income.

The major parents' income will be deemed as follows:

- Allow the $90 earned income deduction;

- Deduct the needs of the parents and their dependents, living in the same household and not included in the benefit group, at the TANF payment standard;
- Deduct amounts paid to legal dependents not living in the household;
- Deduct payments of alimony or child support;
- Any remaining income is countable deemed income.

ODHS|OHA will exclude the resources of the parents of the minor parent.

Note: Requirements for verifying income and deductions for major parents apply when determining the deemed income for a minor parent living with a biological parent.

Minor parents living with their major parents and then turn 18

When a minor parent turns 18 years old and they are on their major parent's TANF case, the 18 year old must be determined to be eligible for TANF separate from their major parent's case. Minor parents are caretaker relatives and at age 18, they are no longer considered a dependent child. An application for TANF benefits must be filled out and their eligibility will need to be determined along with their JOBS status.

Teens with no children who turn 18 are allowed to remain on their parent's case as long as they continue to attend high school or equivalent at full-time hours per the school, until their 19th birthday. Once an individual is 19, they are no longer eligible as a dependent child regardless of their educational status.

Participation, cooperation and exemption for teen parents and minor parents

Teen parents who are 18 or 19 years old are still considered to be JOBS-eligible. Teen parents must participate in the basic education component if they have not obtained their high school diploma, GED, or equivalent. Teen parents are JOBS-exempt from the requirement to participate in the basic education component if they have good cause.

A minor parent under age 18 is exempt from the requirement to participate in the basic education component if the minor parent has been excused by the local school district from state compulsory school attendance and meets the following conditions:

- The employment goal of the minor parent is an occupation or occupational field that does not require a high school diploma or GED, there is a labor market demand for it, and the goal is appropriate for the participant and likely to lead to self-sufficiency, and
- The minor parent is participating in the jobs skills training component and an education component designed to result in a literacy level of at least grade 8.9.

Note: Teen parents can be assigned to employment training to prepare for occupations or occupational fields for which there is a labor market demand and either they have failed to achieve good or satisfactory progress in completing their educational activities, or educational activities are inappropriate for their education or employment goals.

ERDC When applying for ERDC, working minor parents living with their parent(s) can choose whether to apply with or without their parent(s). If the minor parent chooses to apply on their own, they would be considered the caretaker.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD A child (participant under age 19) who has a child of their own shall be considered a minor parent for the purposes of determining eligibility for the MAGI Parent or Other Caretaker Relative and Extended Medical Assistance.

Minor parents can also be considered for other HSD medical programs where they meet all the financial and non-financial criteria..

Oregon Administrative Rule(s)

461-135-0080 — TANF Eligibility for Minor Parents
461-110-0350 — Filing Group; ERDC
461-001-0000 — Definitions for Chapter 461
461-145-0860 — Deemed Assets, Parent of a Minor Parent; TANF
461-135-0080 — TANF Eligibility for Minor Parents
461-110-0630 — Need Group
461-110-0750 — Benefit Group
461-110-0330 — Filing Group; TANF
461-110-0630 — Financial Group
461-110-0210 — Household Group
410-200-0015 — General Definitions

ERDC Reservation List

This is specifically relevant to ERDC.

The ERDC Reservation List is not currently activated.

ERDC The Employment-Related Day Care program has limited funding. ODHS|OHA monitors the caseload to ensure enough funding is available to maintain all the cases through the end of the budget cycle. ODHS|OHA will use a child care reservation list to slow down the number of families being added to the caseload to make sure the program will stay within the allowed budget.

When the ERDC Reservation List is activated, ODHS|OHA must review all applicants to determine if they are required to be added to the reservation list or if they meet an exemption. If they do not meet an exemption, ODHS|OHA will place them on the reservation list for future selection. The participant will be sent a decision notice of ineligibility for the ERDC program.

Applicants may be exempt from the ERDC Reservation List if they meet one of the following:

- **TANF transition policy**
  If a member of the filing group has received a partial or full month of REF, SFPSS or TANF program cash benefits from Oregon in at least one of the preceding three months, the filing group is not required to be on the ERDC Reservation List. Pre-TANF does not count.
- **Head Start or Early Head Start Partnership**
  If a member of the filing group is eligible for a current slot opening with a Head Start or Early Head Start Partnership-contracted program, the filing group is not required to be on the ERDC Reservation List. For this situation, approval from the Child Care Policy Unit must be received prior to opening an ERDC case.
- **Child Welfare referral policy**
  If a child in the filing group has had involvement with Child Welfare and a Child Welfare worker has created an ongoing safety plan where child care will:
  - Help prevent removal of the child from their home, or
  - Allow the child to return home or to be placed in care with a relative, or
  - Be placed with an adult whom the child has an established relationship.

The Child Welfare worker will determine when a family will meet this exemption. The Child Welfare worker will complete the Employment Related Day Care (ERDC) Reservation List Child Welfare Exception Referral (DHS 0861) form and give a copy to the parent and scan and send a copy to Central Office. A parent who applies for ERDC and has a completed DHS 0861 should be reviewed for ERDC eligibility. All other ERDC eligibility criteria must still be met.

- **TA-DVS program benefits**
  If the filing group is currently eligible or has been determined eligible for TA-DVS in the current or at least one of the preceding three months from DHS, they must still meet all other ERDC eligibility requirements.
- **Reapplying for ERDC after a break of less than two months**
  Individuals reapplying for ERDC are only required to be on the Reservation List if they have had a break in ERDC benefits of two consecutive calendar months or more.

Applicants who do not meet one of the criteria above do not need to complete an application. An ERDC interview is also not required if the information received to determine the denial is not questionable. However, the denial must be narrated, a denial notice must be mailed and a reservation list referral emailed to Reservation.ERDC@dhsoha.state.or.us.

Reservation list selection process

Applicants must request benefits within the deadline on the selection letter or they will be dropped from the Reservation List until they reapply.

Applicants selected from the Reservation List who request benefits after the deadline on the selection letter will be returned to the Reservation List to await future selection.

- Although the application process should be completed as soon as possible, the applicant and worker have

45 days from the date of request to complete it. The 45 days can be extended if circumstances beyond the control of the applicant delay the eligibility decision past that limit.

- The date of request also establishes when benefits can begin. This is the first day of the month in which the request is made if eligibility requirements and application processing time frames are met.
- The date of request for applicants selected from the Reservation List is the first day of the month in which the request is made after being selected from the list, if eligibility requirements and application processing time frames are met.

SNAP This does not apply to the SNAP program.

TANF This does not apply to the TANF program.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Oregon Administrative Rule(s)

461-115-0016 — Application Process; Reservation List for ERDC

Non-citizen sponsors

Click here for Non-citizens.

Chapter 2: Eligibility

Section 4: Household information

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Household information

Introduction

This section covers unique situations that may exist for individuals. Some of these situations affect who must apply together, and others provide exceptions or additional provisions to rule. When determining eligibility, ODHS|OHA reviews these situations for accurate program benefit decisions.

Click here for Eligibility groups.

Pregnancy

When an individual is pregnant, an unborn child can connect the parents in some programs if they are residing in the same household.

Some programs do not require the parents to apply together until their child is born when the parents are in the same household.

Click here for Eligibility groups.

If the parents are residing in the same household and a child is born, when do they need to apply together?		
	During pregnancy	**When birth is reported**
SNAP		✓
TANF	✓	
ERDC	✓	
REF	See program-specific information	See program-specific information
MSP	See program-specific information	See program-specific information
OSIPM	See program-specific information	See program-specific information
HSD	See program-specific information	See program-specific information

If the individual knows their expected due date and pregnancy gestation (how many weeks pregnant), this should be documented. The expected due date of the individual is needed because, in some situations, it determines when an applicant can be eligible for benefits.

SNAP

When pregnancy is reported, ODHS|OHA will ask if the alleged father is living in the same dwelling and make note of the reply. If they are living together but do not purchase and prepare their food together, they can each form a filing group. They are not required to apply together until the child is born.

When ODHS|OHA receives a report that the child has been born and it has been reported that the parents are living together, information about the other parent must be gathered and the child may not be added to the SNAP case until the other parent is also added.

If the parents are not living together, the child is added to the case the first of the month following the

report of the birth.

ODHS|OHA does not ask if the child has been brought home. However, if it is volunteered that the infant is staying at the hospital or Child Welfare has taken custody of the child, the infant will not be added to the case until the first of the month following when it is reported the infant has gone home with the parent(s).

TANF When applying or receiving TANF and a pregnancy is reported, both parents are considered in the filing group and must apply together. If there are other dependent children in the home when a pregnancy is reported, the family must apply together even if the father of the unborn child is not the parent of the other dependent children. If the unborn child is the only child in the home, the family would not be eligible until the first day of the month before the month the due date falls.

ERDC When applying for ERDC, if an individual is pregnant, both parents in the household are considered to determine eligibility.

REF Pregnancy does not change eligibility or filing groups on a REF case until the filing group meets potential eligibility for TANF. TANF is always a prior resource to REF. Once the pregnancy reaches the first of the month before the month of the due date, the filing group can apply for TANF. If the case becomes eligible for TANF, the REF case would be closed.

MSP Pregnancy does not change eligibility or filing groups on an MSP case.

OSIPM Even though an individual on OSIPM is already receiving OHP+ benefits, updating the case with the pregnancy due date gives the individual additional benefits including enhanced dental and vision coverage. It also includes access to:

- Maternity Case Management, a program that provides prenatal and postpartum visits by a maternity case manager,
- Nurse Family Partnership, a free, voluntary program that partners first-time moms with nurse home visitors,
- Oregon MothersCare, a program that connects mothers to prenatal care and other resources, and
- The Prenatal and Newborn Resource Guide, a great resource during pregnancy and after the birth of the baby.

The effective date for individuals receiving OSIPM who qualify for a higher benefit level due to pregnancy is the date the pregnancy was reported.

For a pregnant individual receiving OSIPM, the effective date for closing benefits is no earlier than the last day of the 12th calendar month after the last day of pregnancy falls, except at the individual's request..

If the individual's pregnancy ends early for any reason (abortion, miscarriage, premature birth, etc.) or the pregnancy goes beyond the expected due date, the case will need to be updated to reflect the change. The due date controls the 12 months of protected eligibility for which the mother is eligible. If the pregnancy ends in a different month than the due date is coded, update the due date to whenever the pregnancy ended.

ODHS|OHA must accept self-attestation of pregnancy unless ODHS|OHA has information that is not

reasonably compatible with the individual's statement, in which case we can require verification from a doctor's office or clinic.

See the website below for additional benefit information: https://public.health.oregon.gov/HealthyPeopleFamilies/Women/Pregnancy/Pages/index.aspx

HSD

For HSD medical programs, a pregnant woman is a woman currently pregnant or within the postpartum period which begin the day after the pregnancy ends and extends to the end of the 12th calendar month following the month in which the pregnancy ends. Individuals who are eligible and receiving Medicaid/CHIP benefits at any time during their pregnancy, their eligibility is protected through the 12 months post-partum period. This means they remain eligible for their medical benefits regardless of most changes reported to their case and even if the case would otherwise close due to failure to respond to renewal or RFI.

Individuals who are eligible for CWM Plus Pregnant Parent or Other Caretaker Relative (EMPP) or CWM Plus Pregnant Woman (EMPR) are eligible for protected pregnancy benefits for 60 days following the month in which the pregnancy ends.

There are several types of assistance a pregnant woman is potentially eligible for an each has specific financial and non-financial eligibility criteria.

- OHP Plus Pregnant Parent or Other Caretaker Relative (PCPR):
  - The individual is a U.S. citizen or meets non-citizen requirements*,
  - The individual is pregnant or in the post-partum period,
  - The individual is a parent, primary caregiver, or spouse of a primary caregiver of a dependent child living in the household, and
  - Income is at or below the federal poverty level (FPL) for the program.

* If the pregnant woman does not meet the non-citizen requirement, but meets all other criteria of the PCPR program, she will be determined eligible for CWM Plus Pregnant Parent or Other Caretaker Relative (EMPP) if she is 19 or older and Cover All Kids Parent or Other Caretaker Relative (CKPC) if she is under 19.

- OHP Plus Pregnant Woman (PREG):
  - The individual is a U.S. citizen or meets non-citizen requirements*,
  - The individual is pregnant or in the post-partum period, and
  - The individual's income is at or below 185% of the FPL and they are not receiving SSI income.

* If the pregnant woman does not meet the non-citizen requirement, but meets all other criteria of the PREG program, she will be determined eligible for CWM Plus Pregnant Woman (EMPR) if she is 19 or older and Cover All Kids Pregnant Woman (CKPW) if she is under 19.

In 2017, the Reproductive Health Equity Act (House Bill 3391) was passed. Due to this Act passing, individuals who do not meet the non-citizen requirements are able to continue receiving the same level of benefits as the OHP Plus Pregnant Woman benefit package during their post-partum period. These benefits are referred to as Reproductive Health Equity Fund (RHEF) benefits in rule and in the system will

show as CWM Plus Pregnant Woman-postpartum (EMPW). These individuals who do not meet the non-citizen requirements will continue to receive their protected eligibility for 60 days following the end of their pregnancy.

For all HSD medical programs, protected eligibility for pregnant individuals continues through the end of their post-partum periods unless the individual:

- Is no longer an Oregon resident,
- Becomes incarcerated,
- Dies,
- Begins receiving SSI income, or
- Requests voluntary termination of eligibility, including a request made by an individual authorized to act on the beneficiary's behalf.

Oregon Administrative Rule(s)

410-200-0135 — Assumed, Continuous and Protected Eligibility for Children and Pregnant Individuals
410-200-0425 — Specific Requirements; MAGI Pregnant Woman
410-200-0420 — SSpecific Requirements; MAGI Parent or Caretaker Relative

Individuals with disabilities, including blindness, or who are unable to work

In some programs, eligibility and work requirements are affected when there is a condition that impacts an individual's ability to obtain or maintain employment. Sometimes the condition must be acknowledged by federal or state government or a physician. At other times it can be self-reported or observed by the agency. Because the rules vary greatly based on program and purpose, ODHSIOHA reviews how the condition has been determined and each program's requirements.

SNAP Persons with disabilities, including blindness

Most all payments related to disability are countable when determining SNAP benefit eligibility.

Click here for Treatment of specific assets.

When an individual in the financial group meets one of the following criteria, the group does not have to meet the countable income limit when SNAP benefit eligibility is being determined. A filing group, including someone meeting the below criteria, is not subject to the shelter deduction limit.

SNAP defines an individual with a disability as a person who meets any of the following criteria:

- Receives SSI benefits under Title XVI of the Social Security Act
- Receives blindness or disability benefits under titles I, II, X, XIV or XVI of the Social Security Act
- Receives OSIPM or other state or federal supplement under section 1616(a) of the Social Security Act based on disability or blindness criteria under Title XVI of the Social Security Act

- Receives state general assistance benefits based upon disability or blindness criteria under Title XVI of the Social Security Act
- Receives interim assistance pending receipt of SSI or receives disability-related medical assistance under Title XIX of the Social Security Act
- Receives a state or federally administered supplemental benefit under Section 212(a) of Public Law 93-66
- Receives an annuity payment under Section 2(a)(1)(iv) of the Railroad Retirement Act of 1974 and is determined to be eligible for Medicare by the Railroad Retirement Board
- Receives an annuity payment under Section 2(a)(1)(v) of the Railroad Retirement Act of 1974 and meets the disability criteria used under Title XVI of the Social Security Act
- Receives Veterans Affairs benefits for non-service or service-connected disability rated or paid as total under title 38 of the United States Code
- Receives disability retirement benefits from a governmental agency because of a disability considered permanent under Section 221(i) of the Social Security Act
- Has a disability considered permanent under 221(i) of the Social Security Act section and is the surviving spouse or surviving child of a veteran and considered by the VA to be entitled to compensation for a service-connected death or pension benefits for a non-service connected death under Title 38 of the United States Code
- Is a veteran or surviving spouse of a veteran considered by the VA to be in need of Aid and Attendance benefits or permanently housebound under Title 38 of the United States Code
- Is a surviving child of a veteran and considered permanently incapable of self-support under Title 38 of the United States Code.

Unable to work – work registrants and the ABAWD Program

An individual is exempt from work registration and is not subject to the able-bodied adults without dependents (ABAWD) SNAP time limits because they meet the federal criteria of being “unable to work” when ODHS|OHA:

- Receives a report that someone meets the above definitions of disability, or
- Is informed by an applicant that they are experiencing mental or physical health medical conditions that prevent them from obtaining or maintaining work (this includes diagnosed and undiagnosed as well as temporary and permanent conditions), or
- Observes behavior that indicates the person is experiencing mental or physical health medical conditions that prevent them from obtaining or maintaining work.

Click here for SNAP employment services.

TANF Participants with physical or mental disabilities are not JOBS-exempt from JOBS program requirements. Per the Americans with Disabilities Act (ADA), all participants must have access to JOBS activities and support services if accommodating them does not fundamentally alter the purpose or intent of the JOBS activity in which they would participate.

Adults in the State Family Pre-SSI (SFPSS) program, including both adults in a two-parent household, are not subject to JOBS participation requirements or TANF time limits. Families in the SFPSS program are no longer considered TANF families. However, they have access to JOBS activities and support services. They would be considered JOBS volunteers.

Supplemental Security Income (SSI) is the only Social Security program funded under Title IV-E of the Social Security Act. Receipt of other Social Security programs such as Social Security based on a disability (SSDI) or Social Security based on retirement, widow's benefits or a parent's or spouse's disability benefits (SSB) does not prevent an individual from receiving TANF.

Click here for Other parent available to provide care.

ERDC When the second parent in the home has a disability or is otherwise unable to care for the child, documentation must be provided to approve child care benefits for the first parent's work schedule.

Click here for Employment and training (E&T) services.

REF Participants with physical or mental disabilities are not Refugee Employment Programs(REP)-exempt from REP requirements. If they are unable to engage in REP activities due to disabilities, documentation is requested to excuse participants from engaging.

Adults receiving Supplemental Security Income (SSI) are not eligible for REF.

MSP This does not apply to MSP.

OSIPM Refer to Basis of need for information on disabilities or blindness.

HSD This does not apply to HSD medical programs.

Oregon Administrative Rule(s)

461-001-0000 — Definitions for Chapter 461
461-130-0305 — General Provisions; Employment Programs
461-130-0310 — Participation Classifications: Exempt, Mandatory, and Volunteer

Former Foster Care

This section is only relevant to medical programs.

The Former Foster Care Youth Medical (FFCYM) program helps ensure former foster care children are covered under Medicaid until they turn 26. While there is no income test for FFCYM, an individual must meet the following requirements:

- Have been in foster care under the responsibility of the Oregon Department of Human Services or tribe and enrolled in Child Welfare Title XIX Medicaid when they turned 18 or the age when Oregon Medicaid or Oregon tribal foster care assistance ended under Title IV-E of the act (this includes children who were in Oregon Youth Authority [OYA] foster care),
- Be under age 26,

- With the exception of the MAGI Adult program, not be eligible for other Medicaid programs, and
- Cannot be receiving Supplemental Security Income (SSI), adoption assistance or foster care maintenance payments.

SNAP This does not apply to the SNAP program.

TANF This does not apply to the TANF program.

ERDC This does not apply to the ERDC program.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Oregon Administrative Rule(s)

461-001-0000 — Definitions for Chapter 461
461-130-0305 — General Provisions; Employment Programs
461-130-0310 — Participation Classifications: Exempt, Mandatory, and Volunteer
410-200-0407 — Specific Requirements-Former Foster Care Youth Medical Program

Medicare

Receipt of Medicare is relevant to medical only. Medicare is a federal medical benefits program that is administered by CMS (Center for Medicare and Medicaid Services) which contracts with intermediaries such as Blue Cross or Aetna. It is not administered by the state like Medicaid.

To be eligible for Medicare, an individual must:

- Be over age 65,
- Receive SSDI for two years,
- Be a survivor of a deceased worker (spouse or child), or
- Have end-stage renal disease (ESRD) or Lou Gehrig's disease (ALS).

There are three types of Medicare:

- Medicare Part A covers hospitalization,
- Medicare Part B covers doctor bills and outpatient treatment,
- Medicare Part C are Medicare Advantage plans available in many areas. Individuals with Medicare Parts A and B can choose to receive all of their health care services through one of these provider organizations, and
- Medicare Part D which covers most prescription drugs.

Some recipients are required to pay a premium for Medicare Part A and there is always a premium for Medicare Part B.

It is important to note that an individual can be eligible for Medicare without receiving Social Security cash benefits (SSB or SSDI). An example of when a person could be receiving Medicare without receiving any cash benefit is if a person is working and earns income above the income limit for SSDI. The social security administration would end the income part of the benefit, but keep Medicare open as long as the individual pays for it.

Boarder/lodger

This applies specifically to the SNAP program.

SNAP Click here for Eligibility groups.

TANF This does not apply to the TANF program.

ERDC This does not apply to the ERDC program.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Shared custody

Custody can refer to legal custody granted by a court or parenting time (whether court ordered or not). ODHS|OHA takes into consideration what is occurring when it differs from the court order. Some applicants may apply for children who are in shared physical custody or "parenting time" situations. For some programs, ODHS|OHA must ask about the parenting time the applicant has with the child, but in others ODHS|OHA is not to ask about shared parenting time unless more than one individual is applying for benefits for a child. Because the rules are so different from program to program, it is important that ODHS|OHA carefully assess which rules apply to the applicant.

Unless there is a dispute or a reason to question the individual's statement about parenting time or meal arrangements with a child, ODHS|OHA accepts the statement of the applicant.

SNAP When determining eligibility for the SNAP program, ODHS|OHA does not ask if any of the children on the application are in a shared parenting time arrangement.

If the child is on another SNAP case, the agency asks the applicant if the child is in a shared parenting situation. If so, the agency asks questions to determine the number of the 21 meals the child receives from the applicant's home each week. The home the child leaves from to go to school receives credit for breakfast and lunch for that day.

If the child is receiving 11 or more of their weekly meals from the applicant's home on a regular basis, ODHS|OHA sends an appropriate notice to remove the child from the other case. If not, ODHS|OHA sends the applicant a denial of benefits for that child.

If there is a dispute about who may receive benefits for the child(ren), it must be determined from whose household they receive the majority of their 21 weekly meals. Determine the number of the 21 meals the

child receives in each home. The home the child leaves from to go to school receives credit for breakfast and lunch for that day.

When possible and the parenting time/meal provision is close to equal, ODHS|OHA may work between the persons wanting SNAP for the child(ren) to help the parties come to an agreement that allows both parties a turn to receive benefits (e.g., each person having the right to apply for one child each if there are two children, or a one year each rotation if there is only one child). The decision to follow an agreement is the applicants' decision and the agency honors the agreement.

Click here for additional information about shared custody found in Eligibility groups.

TANF Whether or not there is a legal agreement, for TANF, shared custody prompts us to ask questions:

- Where do the child(ren) sleep most of the time?
- Where do they eat their meals?
- Who is responsible for school and medical appointments?

In cases where they report and claim everything is equal, there may be no TANF eligibility because there is no primary caretaker.

Individuals living in multiple household groups in one month

Individuals who live in more than one household group during a calendar month are members of the household group in which they spend more than half of their time, except as follows:

- Parents who sleep 30 percent or more of their time during the calendar month in the household of the dependent child(ren)
- A dependent child is included in the household group with the caretaker relative who usually has the major responsibility for care, control and supervision of the dependent child, if the dependent child lives with two household groups in the same calendar month for at least one of the following reasons:
  - Education
  - The usual caretaker relative is gone from the household for part of the month because of illness or a family emergency.

An award by a court of joint (50/50) legal custody does not, by itself, mean a child does not meet the definition of household group member.

Click here for Eligibility groups.

ERDC A child who lives with different caretakers during the month may be considered a member of both households. In shared caretaker situations, both caretakers could have their own ERDC case if they are eligible. The child is listed on each case.

If a caretaker does not indicate there is shared custody on IE (ONE) and there is an existing ERDC case with the child for whom benefits are requested, the second ERDC case would be denied. It is important to communicate with applicants that they review this section in shared custody situations.

Even in shared custody situations, authorized child care hours are calculated based on each caretaker's highest verified work hours. It is the responsibility of the child care provider and parent to ensure care is being billed for the correct case.

Click here for Eligibility groups.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD For HSD medical programs, it is important to determine where a child spends the majority of their time in a shared custody situation in order to ensure the correct individuals are included in their EDG.

Tor children whose parents are divorced, separated or unmarried, the custodial parent is the parent with whom the child lives, with the following considerations:

- If the child lives part-time with both parents, the parent with whom the child spends most nights is the custodial parent.
- If it cannot be determined which parent the child spends the most nights because the child spends equal nights with both parents, a court order or binding custody agreement establishing physical custody is used to identify the custodial parent. Please note, this is the only time ODHS|OHA should use a court order to determine who the custodial parent is for the HSD medical programs.

Oregon Administrative Rule(s)

461-110-0210 — Household Group
410-200-0015 — General Definitions

Domestic violence

Click here for the Temporary Assistance for Domestic Violence Survivors (TA-DVS) Eligibility Manual.

Some programs allow for certain eligibility requirements to be waived for survivors of domestic violence.

An individual can be a survivor of domestic violence (DV) and qualify for the provisions that apply to DV survivors, whether they have applied for TA-DVS. The presence of domestic violence and being a recipient of the Temporary Assistance for Domestic Violence Survivors (TA-DVS) grant are two different things.

According to ODHS|OHA rule, domestic violence is defined as the occurrence of one or more acts listed below between family members, intimate partners or household members:

- Attempting to cause or intentionally, knowingly or recklessly causing physical injury or emotional, mental or verbal abuse
- Intentionally, knowingly or recklessly placing another in fear of imminent serious physical injury
- Committing sexual abuse in any degree as defined in ORS 163.415, 163.425 and 163.427
- Using coercive or controlling behavior

- As used in this section, "family members" and "household members" mean any of the following:
  - Spouse
  - Former spouse
  - Individuals related by blood, marriage (see section (42) of this rule) or adoption
  - Individuals who are cohabitating or have cohabited with each other
  - Individuals who have been involved in a sexually intimate or dating relationship, or
  - Unmarried parents of a child.

The TA-DVS program is a type of assistance that supports domestic violence survivors by providing short-term (emergency) financial assistance and safety planning to help flee domestic violence (DV) and/or help remain free from violence.

A survivor is never required to verify occurrences of domestic violence, have a restraining order or apply for a restraining order.

Click here for the Temporary Assistance for Domestic Violence Survivors (TA-DVS) Eligibility Manual.

SNAP No rules for the SNAP program may be waived when there is domestic violence.

However, when a survivor applying for SNAP has recently left the household where their abuser lives and is residing in a domestic violence shelter or a safe home, the applicant may be included in two filing groups in the same month.

TANF ODHS|OHA is authorized to waive or modify requirements of the TANF program that make it harder for survivors to escape domestic violence or put them at risk of further or future domestic violence.

When a survivor of domestic violence applies for TANF but not TA-DVS, there are requirements that can be reviewed to be waived.

For which type of cases do you waive TANF requirements due to domestic violence (DV)?

- TA-DVS standalone (E2), and
- TANF cases (2 or 82) where TANF requirements were waived due to DV.

ODHS|OHA will need to determine when to waive TANF requirements.

Determining when to waive a TANF requirement:

- How does the specific TANF requirement you are considering waiving put the survivor at further risk of domestic violence or prevent them from escaping domestic violence?
- How does the TANF requirement unfairly penalize the survivor?

When waiving requirements:

- Waiver or modification of TANF requirements is not intended to be automatically granted to every identified survivor of domestic violence.
- ODHS|OHA may decide, on a case-by-case basis, to waive or modify TANF eligibility requirements that put a survivor at risk of harm by domestic violence or which would make it more difficult for

the survivor to escape domestic violence.

- The waiver or modification of program requirements is intended to be temporary, to help survivors of domestic violence move forward with their self-sufficiency plan and meet program requirements when safe.
- The decision to waive or modify eligibility requirements should be re-evaluated at least every six months. If it is determined there is a continued safety risk, the waiver can continue for as long as a safety risk exists or if a new safety risk arises.
- When deciding to waive a requirement or continue a waiver, a worker should talk with the survivor about potential safety risk. The risk must be associated with domestic violence.

What eligibility requirements cannot be waived?

- The requirement to be a dependent child, caretaker relative or parent
- The requirement that a dependent child live with a caretaker relative
- The requirement for parents to apply together if they are living together, even if one parent is the alleged abuser
- The requirement to be an Oregon resident
- TANF countable income.

When a pregnant woman is at risk of or has a safety concern due to domestic violence, ODHS|OHA may waive the requirement for her to have reached the first of the calendar month prior to the month in which the due date falls.

Click here for TANF and TA-DVS program requirements in relation to domestic violence.

Click here for Temporary Assistance for Domestic Violence Survivors (TA-DVS) Eligibility Manual.

ERDC Domestic violence is considered when reviewing citizen requirements for ERDC. If non-citizens are at risk of domestic violence, the citizenship requirement is waived for the household.

Click here for Citizenship/Non-citizen status.

REF This does not apply to the REF program.

MSP No additional program-specific information.

OSIPM No additional program-specific information.

HSD There are no specific eligibility requirements that can be waived due to DV. If a survivor has left the home, it will be important to assess whether their tax filing status has changed if they are currently receiving medical benefits. If the survivor is a new applicant for medical, their tax filing status should be determined based on how they intend to file taxes.

Program compliance

There are different compliance requirements for each program. Failure to comply with these requirements may

affect program eligibility. These requirements are disqualifications, disqualifying transfer of assets, fleeing felon and parole violators, failure to cooperate with the Division of Child Support (DCS), intentional program violations (IPV), quality control (QC) reviews, requirement to pay copay or make other satisfactory arrangements, and work registration.

Other resources

TANF DV Waiver QRG: Describes the process for granting waivers to help survivors of domestic violence to meet TANF eligibility requirements while maintaining their safety.

Disqualifications

There are many types of possible disqualifications from program benefits.

SNAP

Applicants and participants of SNAP are ineligible if they make a disqualifying transfer of resources to qualify for benefits. Individuals must report transfers of resources at application, at redetermination and when the transfer occurs. ODHS|OHA must evaluate a transfer of resources to determine whether it was valid.

For ODHS|OHA to evaluate the transfer, the individual must provide documentation showing the terms of the sale or disposal of the resource. They also must provide evidence if they are claiming the transfer was valid. A non-valid transfer of a resource may be disqualifying if the transfer occurs during the three months preceding the filing date or during a certification period. A valid transfer will not result in a benefit disqualification.

Criteria for valid transfers

ODHS|OHA will consider a transfer valid if any of the following are true:

- The resource was excluded or owning the resource did not cause the group to exceed the resource limit, so transferring it does not change eligibility.
- The resource is transferred between people in the same financial group; it is still counted regardless of who owns it.
- The resource was sold or traded for compensation equal to or greater than its fair market value.
- The transfer settled a legally enforceable claim against the resource or individual.
- The transfer was court-ordered.
- The transfer happened because the individual was a victim of fraud, misrepresentation or coercion; legal steps have been taken to recover the resource.
- The resource is an annuitized annuity.
- The transfer is between members of the filing group and an ineligible student.
- The resource was transferred for reasons other than to qualify for benefits, e.g., a parent placing funds in an education trust fund.

When the transfer does not meet any of the above criteria, it may still be determined valid if the individual can establish their intent was not to transfer the resource to become eligible for SNAP. To prove this,

the individual would need evidence of making a good-faith effort to sell or exchange the resource for compensation or for goods or services equal to fair market value.

If ODHS|OHA determines the transfer of resources was not valid, a disqualification from SNAP benefits of up to one year is imposed. The length of the disqualification depends on the amount of uncompensated value involved.

The following formula is used to determine the uncompensated value. ODHS|OHA will do the following:

- Determine the fair market value of the resource.
- Subtract the compensation received for the transfer.
- Add this amount to the group's other countable resources.
- The amount this total exceeds the group's resource limit is the uncompensated value.

The following chart shows the disqualification periods:

Amount of uncompensated value	Period of disqualification
$0.00-249.99	1 month
$250.00-999.99	3 month
$1,000.00-2,999.99	6 month
$3,000.00-4,999.99	9 month
$5,000.00 or more	12 month

The agency will notify an individual of disqualification with a basic decision notice for applicants; and a timely continuing benefit decision notice for recipients, Notice of Decision and Action Taken (DHS 456) or Notice of Planned Action (APD 540). The notice must specify the amount of the uncompensated value used in the calculation and the length of the disqualification period. The disqualification starts the date ODHS|OHA imposes the disqualification period by closing or denying benefits.

The disqualification ends when the individual has served the entire disqualification period and not before. If someone would like SNAP benefits after completing their disqualification, they must initiate a request.

TANF

To qualify for benefits, a need group must not have made a disqualifying transfer of their assets within three years prior to the filing date with the intention of establishing or maintaining eligibility. The applicant must report any transfer at application, redetermination, and when the transfer occurs. The failure to report or making a disqualifying transfer of available resources will result in closure or denial of benefits.

When the individual is ineligible for benefits because of a disqualifying transfer of assets, the individual remains ineligible until the disqualification period ends or when the full equity rights in the asset are transferred back to the individual or the individual receives adequate compensation.

If an applicant is allowing the disqualifying transfer, their application for benefits will be denied. If benefits are currently open, they will be closed if a disqualifying transfer is determined. The number of months for a disqualification period is equal to the uncompensated fair market value portion of the resource, divided by the TANF payment standard for the financial group.

Assets not subject to disqualifying transfer

- Personal belongings such as household items and clothing
- Assets sold or traded for at least fair market value
- Assets transferred between members of the same financial group
- Transfers to settle a legal claim, or if the amount of the asset was equal to or less than an amount excluded at initial eligibility
- Transfers because of a court order or if the individual was a victim of fraud, misrepresentation or coercion.

Penalties in the TANF/JOBS Program

There are two types of penalties related to participation in the TANF/JOBS program.

1. JOBS Disqualification; and
2. Non-JOBS Disqualification.

JOBS disqualifications are applied to individuals who are JOBS eligible and determined not to have good cause for failure to engage in case plan activities. The coding used for these types of disqualifications include DQ1, DQ2, DQ3, DQ4 and DQR.

Non-JOBS disqualifications are applied to individuals who are JOBS volunteers or JOBS exempt but required to attend an alcohol and drug assessment or treatment, or mental health treatment in accordance with OAR 461-135-0085. The coding used for these types of disqualifications include MQ1, MQ2, MQ3, MQ4 and MQR.

DQs and MQs do not transfer to each other. If a participant is at an MQ1 and becomes JOBS-eligible, the MQ would end and ODHS|OHA would begin the re-engagement process for a JOBS-eligible participant.

Requirement to attend alcohol and drug (A&D) assessment or treatment, or mental health treatment

An individual who is JOBS eligible, JOBS volunteer, or JOBS exempt may be required to:

- Attend an assessment for A&D if:
  - The individual has self-disclosed the illegal use of a controlled substance, and
  - The assessment is available at no cost to the participant.
- Attend medically appropriate treatment for A&D or mental health if:
  - The individual reports a qualified and appropriate professional has diagnosed them with A&D or a mental health disorder within the previous 12-months and recommended treatment; or
  - An assessment or evaluation resulted in a mental health diagnosis requiring medically appropriate treatment for the individual to be successful in the workplace.

Penalties for non-engagement with alcohol and drug (A&D) assessment or treatment or mental health (MH) treatment

Penalties for not engaging with A&D assessment or treatment and mental health treatment program

requirements are progressive. The re-engagement process as outlined above is used to determine that the participant refused to engage in their agreed-upon activities without good cause. The penalties for failing to engage with treatment are as follows:

- The first level, the family grant is reduced by 25 percent.
- The second level, the family grant is reduced by 50 percent.
- The third level, the family grant is reduced by 75 percent.
- The fourth level, the family grant is reduced by 100 percent.
- During the fifth and sixth months, TANF is closed for the entire family (need group). The participant's need group is not eligible for TANF benefits for two consecutive months, after which they must reapply for TANF benefits. If the individual re-applies within three months of an active disqualification, they must complete a two-week cooperation period. (DQR is considered an active disqualification.)

Good cause for missed appointment

Good cause for a missed A&D assessment or treatment, or mental health treatment appointment must be granted if an aspect of a disability caused the participant to miss the appointment. For example, if the participant suffers from panic attacks and that was the reason for not attending the appointment it would be considered good cause. Keep in mind, workers are not required to grant good cause when a participant reports they missed an appointment because they were illegally using a controlled substance or intoxicated at the time. For more information on good cause, see OAR 461-130-0327.

When does the disqualification end?

The disqualification ends in the following instances:

- The disqualified person demonstrates two consecutive weeks of cooperation and a willingness to participate in treatment as required under OAR 461-135-0085.
- The disqualified person's classification changes from JOBS-exempt to JOBS-eligible.
- The disqualification was applied in error.
- It becomes known that the failure to cooperate was based on previously unknown domestic violence issues.
- It becomes known that the failure to cooperate was based on an aspect of a previously known or unknown disability.
- A required accommodation or modification that would allow the participant to engage was not provided.
- The disqualified person is no longer a member of the household group. The disqualification follows the person.

For more information about ending this type of disqualification see OAR 461-135-0089.

JOBS disqualifications

JOBS disqualifications are applied independently to any JOBS-eligible individuals who do not engage in

JOBS program requirements. In multi-parent households, more than one adult can be disqualified if the individual adults do not engage in JOBS program requirements. A participant that fails to engage with their case plan, without good cause, are subject to disqualification/grant sanction.

Grant reductions for non-engagement with the JOBS program requirements are progressive. They are as follows:

- In the first level, the family grant is reduced by 25 percent.
- In the second level, the family grant is reduced by 50 percent.
- In the third level, the family grant is reduced by 75 percent.
- In the fourth level, the family grant is reduced by 100 percent.
- During the fifth and sixth months, TANF is closed for the entire family (need group). The need group is not eligible for TANF benefits for two consecutive months, after which they must reapply for TANF benefits. If the individual reapplies within three months of an active disqualification, they must complete a two-week cooperation period. (DQR is considered an active disqualification).

When does a JOBS disqualification end?

The JOBS disqualification process ends in the following instances:

- The disqualified participant demonstrates two consecutive weeks of engagement.
- A JOBS-eligible adult in the need group demonstrates two consecutive weeks of engagement (this can be the non-disqualified adult in a multi-parent household).
- The disqualified participant becomes exempt from the JOBS program.
- The disqualification was applied in error.
- It becomes known that the failure to engage was based on previously unknown domestic violence issues.
- It becomes known that the failure to engage was based on an aspect of a previously known or unknown disability.
- A required accommodation or modification that would allow the participant to engage was not provided.
- The disqualified person is no longer a member of the household group. The disqualification follows the person.

ERDC This does not apply to the ERDC program.

REF Who can be disqualified from the REF employment program?

Individuals who must cooperate with the activities specified on their case plan and who fail to cooperate without good cause are subject to disqualification/grant sanction.

Disqualifications are applied independently to any mandatory individuals who do not cooperate in employment program requirements. In two adult households, more than one adult can be disqualified if the individual adults do not cooperate in the employment program requirements.

REF employment disqualification grant closure

There are two disqualification levels for noncooperation with the REF employment program requirements. They are as follows:

- In the first level, the disqualified individual is removed from the grant for three months. If this is the only individual on the case, the case is closed for three months.
- In the second level, the disqualified individual is removed from the grant for six months. If this is the only individual on the case, the case is closed for six months. Because the REF cash grant is only for eight months, a second disqualification makes the refugee permanently ineligible for REF cash benefits.

When does a REF employment disqualification end?

A REF employment disqualification cannot end early. It must be served in full, unless one or more of the following situations exists:

- The disqualified participant is now exempt from employment program participation and disqualification.
- An applicant who would be subject to an employment program disqualification under OAR 461-130-0330 withdraws the application before benefits are approved.
- The disqualification was applied in error. Do not count that disqualification.
- It becomes known that the failure to cooperate was based on previously unknown domestic violence issues.
- It becomes known that the failure to cooperate was based on an aspect of a previously known or unknown disability.
- A required accommodation or modification that would allow a disabled participant to participate was not provided.
- The disqualified person is no longer a member of the household group. The disqualification follows the person.

Effective date for ending a disqualification

The disqualification ends after the participant completes the full disqualification period. After serving the disqualification period, the refugee must reapply for program benefits.

MSP

Disqualifying transfer of assets

Transfers of assets must be evaluated on a case-by-case basis, and the decision about whether a disqualification takes place will depend on the unique facts surrounding each case. If a transfer is made for less than fair market value is not exempt from disqualification, there is a rebuttable presumption that the asset was transferred for the purpose of establishing or maintaining eligibility.

Individuals in standard living arrangements are not disqualified for transfers of assets. However, if a disqualifying transfer is within the look-back period when the individual later applies for services, the individual must be disqualified at that time even if the asset was transferred before there was a service

need.

The form *Information on the Transfer of Assets Penalty* (APD 0543) provides general information to individuals about disqualifying transfers. The form is optional. Consider using the form for Medicare Savings Program individuals (QMBP, SLMB, QSMF) in standard living arrangements who own or have already transferred property that could be subject to the rules on disqualifying transfers if the individual were in a nonstandard living arrangement.

The 7210 also provides individuals with information regarding the transfer of assets on page 40. The information should be reviewed with applicants during intake.

OSIPM Disqualifying transfer of assets

Transfers of assets must be evaluated on a case-by-case basis, and the decision about whether a disqualification takes place will depend on the unique facts surrounding each case. If a transfer is made for less than fair market value is not exempt from disqualification, there is a rebuttable presumption that the asset was transferred for the purpose of establishing or maintaining eligibility.

Individuals in standard living arrangements are not disqualified for transfers of assets. However, if a disqualifying transfer is within the look-back period when the individual later applies for services, the individual must be disqualified at that time even if the asset was transferred before there was a service need.

Also note that an individual receiving SSI or deemed to be eligible for SSI in a nonstandard living arrangement who would otherwise be ineligible for OSIPM due to a disqualifying transfer of assets is not eligible for long-term care services. The individual can continue to receive OSIPM but is disqualified from receiving long-term care services until the disqualification period has been served. This policy is not retroactive. It only applies to disqualifying transfers that occur on or after July 1, 2007.

The form *Information on the Transfer of Assets Penalty* (APD 0543) provides general information to individuals about disqualifying transfers. The form is optional. Consider using the form when:

- An individual assumed eligible for OSIPM in a standard or non-standard living arrangement owns assets that could result in disqualification from long-term care services if transferred, or
- An individual assumed eligible for OSIPM has already transferred property that would result in disqualification from long-term care services, but the individual is currently in a standard living arrangement.

The 7210 also provides individuals with information regarding the transfer of assets on page 40. The information should be reviewed with applicants during intake.

Refer to LTC for disqualification periods, determining values and hardships.

HSD This does not apply to HSD medical programs.

Fleeing felon and parole and probation violators

The participant is ineligible for SNAP, TANF and REF benefits when ODHS|OHA receives a report from a local, state

or federal corrections agency or the courts that the individual is in violation of conditions of parole, probation or post-prison supervision. Their ineligibility continues until the local, state or federal corrections agency or the courts report the individual is cooperating with the conditions of their parole, probation or post-prison supervision.

The individual who is in violation of parole, probation or post-prison supervision is ineligible and is removed from the need group. Other individuals in the benefit group may remain eligible for benefits. The parole, probation or post-prison supervision violator's income and resources are still considered when determining eligibility.

SNAP No additional program-specific information.

TANF No additional program-specific information.

ERDC This does not apply to the ERDC program.

REF No additional program-specific information.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Failure to cooperate with the Division of Child Support (DCS)

This applies specifically to the TANF and medical programs.

SNAP This does not apply to the SNAP program.

TANF To qualify for benefits, TANF applicants must assign their support rights and must agree to cooperate with child support unless good cause exists. Assignment allows DCS to pursue, collect and keep child support and spousal support for any members in the benefit group.

Participants must cooperate with DCS unless good cause exists. Cooperation with DCS includes assisting in establishing paternity and obtaining support cash payments.

A parent or caretaker relative can choose to not get TANF benefits for a child. While the parent or caretaker does not have to cooperate with child support for any child not in the benefit group, the child is still in the household, filing, financial and need groups. This means any child support for that child counts against the TANF grant, minus the disregard. Note: A parent or caretaker relative with only one child who chooses not to get TANF for that child because they do not want to pursue child support is ineligible for TANF. In this situation, explore whether the family has a safety concern with pursuit of child support and whether good cause would be appropriate..

Sanctions for failure to cooperate with child support

- For applicants: Applications and renewal for cash benefits are denied for the entire family who fail to agree to cooperate and there is not good cause.
- For open TANF cases: Before a worker can impose a child support sanction, good cause must be determined. The family coach will attempt to reach the participant by phone. If unable to reach the participant by phone the family coach will send a Child Support Cooperation 1-019 pend

the participant to determine if there is good cause for not cooperating with DCS. If there is no response or the worker finds there is not good cause, the family coach will add a new record in the cooperation with child support section to reflect noncooperation with the correct child and absent parent situation.

Then the family coach will need to apply a child support sanction CS1 to begin the sanction process. The ONE system will generate a timely reduction notice (CASH NOE).

- For participants: The net monthly cash benefit amount, after income deductions and reductions for JOBS noncooperation are applied (where applicable), shall be reduced by the following percentages:

Level	Benefit Reduction	Effective Date
CS1	25%	1st month following the month in which failure to cooperate is determined
CS2	50%	2nd month following the month in which failure to cooperate is determined
CS3	75%	3rd month following the month in which failure to cooperate is determined
CS4	100% ineligibility	4th month following the month in which failure to cooperate is determined, and all subsequent months in which failure to cooperate continues

Once the program has been updated for a CS1, ONE moves from one month to the next applying child support sanctions automatically, without intervention required, for sanctions CS1 to CS3. Timely notices are sent automatically. When a penalty rolls to CS3 and prior to imposing a CS4, ODHS uses the existing grant termination staffing process to assess the family's situation. When appropriate, community partners are involved in the family assessment. The CS3 penalty must be manually updated to CS4 by the Family Coach.

Ending DCS sanctions

End the support noncooperation sanctions when the participant cooperates by completing the necessary forms, providing requested information, scheduling an appointment with DCS, or taking whatever other actions are required by DCS to indicate cooperation or a determination for good cause has been made. A task will be generated by DCS through the ONE system notifying ODHS when a participant is now cooperating. Update the cooperation screen supplement the cash assistance back to the date the participant cooperated by taking whatever other actions were required to indicate cooperation.

Once a penalty has ended, any subsequent penalties for noncooperation with support will start at the first level (25 percent, per above).

Good cause for noncooperation with DCS for child support

- Cooperation is reasonably anticipated to result in emotional or physical harm to the dependent child or to the caretaker relative.

- Continuing efforts to obtain support would be detrimental to the dependent child because of the following:
  - The child was conceived because of incest or rape.
  - Legal proceedings for adoption are proceeding before a court.
- The parent is being helped by a public or licensed private social agency to resolve the issue of whether to release the child for adoption.
- If good cause is found, DCS will take no action to establish paternity or a child support order, nor will DCS enforce child support on a new or ongoing child support case.
- The need for continued good cause coding should be reviewed at each renewal or application for TANF.

Click here for Child support programs.

ERDC This does not apply to the ERDC program.

REF This does not apply to the REF program.

MSP Refer to pursuit of assets.

OSIPM Refer to pursuit of assets.

HSD In households where a child has at least one absent parent, the parent or caretaker relative who is in the household must agree to cooperate with the Division of Child Support unless there is good cause. When the primary applicant signs either the OHP 7210 form or ONE application, they are agreeing to cooperate.

Good cause for noncooperation with DCS for child support

- Cooperation is reasonably anticipated to result in emotional or physical harm to the dependent child or to the caretaker relative.
- Continuing efforts to obtain support would be detrimental to the dependent child because of the following:
  - The child was conceived because of incest or rape,
  - Legal proceedings for adoption are proceeding before a court, or
  - The parent is being helped by a public or licensed private social agency to resolve the issue of whether to release the child for adoption. If good cause is found, DCS will take no action to establish paternity or a child support order or to enforce child support on a new or ongoing child support case.
- The need for continued good cause coding should be reviewed at each renewal and application for TANF. If it is known that a child was conceived because of incest or rape do not ask the participant to re-explain their reason for good cause at every intake. Do ask the participant if they wish to retain good cause for noncooperation with child support for this child.

Click here for Child support programs.

Intentional program violations (IPVs)

An intentional program violation is when an individual intentionally makes false or misleading statements or misrepresents, conceals or withholds information related to their request to be eligible for an ODHS|OHA program. An IPV is also defined as the use, presentation, transfer acquisition, receipt, possession or trafficking of public assistance benefits.

An IPV is established through a final order affirming an IPV has occurred following an IPV hearing, or by ODHS|OHA receiving a signed Agreement to Intentional Program Violation, Temporary Assistance to Needy Families (TANF – cash for families), Supplemental Nutrition Assistance Program (SNAP – food benefits) Waiver of Right to Hearing (MSC 649C) form.

Click here for Overpayments.

An individual is disqualified for a 10-year period from receiving benefits in the program in which the individual committed fraud if the individual is convicted in state or federal court, is found guilty in an IPV hearing, or admits in a written waiver of the right to an IPV hearing, of having made a fraudulent statement or representation with respect to the identity or place of residence of the individual in order to receive multiple benefits simultaneously from one or more states under programs funded under the Food Stamp Act of 1977 and Nutrition Act of 2008.

IPVs do not apply to families in the ERDC program but do apply to child care providers.

SNAP When a SNAP IPV is established against an individual, that person is disqualified from receiving SNAP benefits for a specific period of time.

Intentional program violation person disqualification (DQ) periods:

- First IPV = 12 months
- Second IPV = 24 months
- Third IPV = Permanent

When someone in the SNAP filing group is serving an IPV DQ, the group is not categorically eligible. After someone has completed their IPV DQ period, they must request or apply for SNAP if they want to receive benefits.

SNAP IPVs established in another state or established in the Food Distribution Program on Indian Reservation Lands continue in effect in Oregon.

Additionally, effective October 1996, when an IPV is established against any individual found guilty of:

- Trading SNAP benefits for firearms, ammunition or explosives, the individual will be disqualified from SNAP benefits permanently starting with the first DQ;
- Trading SNAP benefits for controlled substances, the individual will be disqualified from SNAP benefits for 24 months with the first DQ and permanently for the second DQ;
- Trafficking (buyer or seller) in SNAP benefits of $500 or more, the individual will be permanently disqualified from SNAP benefits.

TANF The individual of the TANF household will receive an IPV if the individual:

- Is convicted in state or federal court of having made a fraudulent statement or representation with

respect to the place of residence of the individual to receive assistance simultaneously from two or more states under programs funded under title IV or XIX of the Social Security Act, or

- Is found guilty in an IPV hearing or admits, in a written waiver of the right to an IPV hearing, to having made a fraudulent statement or representation with respect to the identity or place of residence of the individual to receive benefits simultaneously from two or more states.

If the Investigator has documentary evidence of an IPV and has decided not to refer the case for prosecution, the Investigator will refer the case to the IPV Team for IPV processing.

When the final hearing order is received by the IPV Team and the claimant is found to have committed an IPV, the case is referred to the Overpayment Writing Unit (OWU) for initiation of disqualification penalties and collection of the overpayment.

IPV (intentional program violation) person disqualification periods:

- First IPV = 12 months
- Second IPV = 24 months
- Third IPV = permanent

The following is a nonexclusive list of reasons that support a determination of permanent ineligibility:

- Safety concerns or
- The likelihood of future violations or
- The degree of egregiousness of any of the established IPVs or
- The degree of primary involvement in the violation by the provider.

Click here for Program integrity.

ERDC This does not apply to the ERDC program.

REF The individual in the REF household will receive an IPV if the individual:

- Is convicted in state or federal court of having made a fraudulent statement or representation with respect to the place of residence of the individual to receive assistance simultaneously from two or more states under programs funded under title IV or XIX of the Social Security Act, or
- Is found guilty in an IPV hearing or admits, in a written waiver of the right to an IPV hearing, to having made a fraudulent statement or representation with respect to the identity or place of residence of the individual to receive benefits simultaneously from two or more states.

If the Investigator has documented evidence of an IPV and has decided not to refer the case for prosecution, the Investigator will refer the case to the IPV Team for IPV processing.

When the final hearing order is received by the IPV Team, and the claimant is found to have committed an IPV, the case is referred to the Overpayment Writing Unit (OWU) for initiation of disqualification penalties and collection of the overpayment.

IPV (intentional program violation) person disqualification periods:

- First IPV = 12 months
- Second IPV = 24 months
- Third IPV = permanent

The following is a nonexclusive list of reasons that support a determination of permanent ineligibility:

- Safety concerns, or
- The likelihood of future violations, or
- The degree of egregiousness of any of the established IPVs, or
- The degree of primary involvement in the violation by the provider.

Click here for Program integrity.

MSP If the investigator has documented evidence of an IPV and has decided not to refer the case for prosecution, the investigator will refer the case to the IPV team for IPV processing.

When the final hearing order is received by the IPV team and the claimant is found to have committed an IPV, the case is referred to the Overpayment Writing Unit (OWU) for initiation of disqualification penalties and collection of the overpayment.

IPV (intentional program violation) person disqualification periods:

- First IPV: 12 months
- Second IPV: 24 months
- Third IPV: permanent

OSIPM If the investigator has documented evidence of an IPV and has decided not to refer the case for prosecution, the investigator will refer the case to the IPV team for IPV processing.

When the final hearing order is received by the IPV team, and the claimant is found to have committed an IPV, the case is referred to the Overpayment Writing Unit (OWU) for initiation of disqualification penalties and collection of the overpayment.

IPV (intentional program violation) person disqualification periods:

- First IPV: 12 months
- Second IPV: 24 months
- Third IPV: permanent

HSD This does not apply to HSD medical programs.

Requirement to pay copay or make other satisfactory arrangements

This applies specifically to the ERDC program.

Families receiving ERDC are responsible to pay a portion of their child care costs. This portion is called a copay. If the family does not make arrangements to pay their copay, their ERDC case will be closed.

Click here for Child care copays.

SNAP This does not apply to the SNAP program.

TANF This does not apply to the TANF program.

ERDC Caretakers are required to pay their copay. When copays are not paid or another satisfactory arrangement is not made, a family will lose their eligibility for the ERDC program and their case will be closed.

Satisfactory arrangements may include bartering or income in-kind. For example, a parent may provide child care for a provider's children instead of paying the copay. Parents and providers should be encouraged to put any agreement in writing. The parent should receive a receipt when the provider is paid, whether the payment is bartered or in cash.

If the parent has more than one provider, the copay should be paid to the one who provides the most care. This provider is called the primary provider; the other(s) are called the secondary provider(s).

If the copay exceeds the billed amount or the maximum allowed by ODHS|OHA, the copay amount owed by the parent may be less than the copay. DPU will determine the total amount owed. DPU may change the primary provider designation or split the copay on future billing forms among all the providers who bill for care.

If a provider indicates on the Child Care Billing (CCB) form that a parent did not pay the required copay or make satisfactory arrangements to pay it, the Direct Pay Unit (DPU) will end benefits and send a closing notice as soon as timely notice requirements allow. DPU also codes a copay not met (CNM) case descriptor on the family's case (on UCMS) and an "N" is coded in the copay met field on the DPCS screen. If the parent later requests ERDC, they cannot qualify until past copays are paid or satisfactory arrangements are made with the provider.

The period of ineligibility ends in either of the following circumstances:

- On the first day of the month in which the customer makes the copayment or makes satisfactory arrangements with the provider, or
- On the first day of the month after three years have lapsed from the date the customer failed to make payment.

The provider has up to 60 days after the CCB is processed to notify ODHS|OHA that the copay or satisfactory arrangements have not been made. If not reported within 60 days, ODHS|OHA will consider the copay requirement met.

Determining when payment arrangements are satisfactory

If an ERDC case has been closed because of an unpaid copay, it can be reopened under any of the following circumstances:

- The provider agrees the copay has been met or satisfactory arrangements have been made.
- The parent submits evidence that payment has been made, such as a receipt or canceled check.
- The parent verifies the debt was discharged by a bankruptcy filing.

- The parent has attempted to pay the provider, but the provider refuses payment. This can occur when the copay is part of a larger bill that includes charges above the maximum rates. The case can be reopened if the parent presents evidence of an attempt to pay the entire copay.
- The parent attempts to pay the provider, but the provider cannot be located.

The effective date for reopening the case is the first of the month in which the copay requirement was met.

Reopening an ERDC case closed because of an unmet copay

When a family whose case was closed because of an unmet copay reapplies, the worker must determine if the copay has now been paid or satisfactory arrangements made with the provider. There are a number of ways to do this. The more common include a statement or the Copayment Agreement (CM00893) notice from the provider, a phone call to the provider or a receipt or canceled check.

If the worker determines the family has attempted to pay the copay but cannot because the provider cannot be located or refuses payment, the ERDC case should be reopened.

Evidence of an attempt to locate the provider could include returned mail, an attempted phone call by the worker or a call to the local Child Care Resource and Referral Agency (CCR&R). In some cases, a provider may refuse to accept the copay because the caretaker also owes for charges above ODHS|OHA limit. Evidence of this could include a letter from the provider with a returned check or a phone call from the worker to the provider.

After the worker determines and verifies the copay requirement has been met, the ERDC case is reopened. A case note needs to be added and an email sent to DPU requesting the copay flag be changed back to a “Y” and billing forms issued.

The ERDC case is reopened effective the beginning of the month the copay arrangement is satisfied. A period of ineligibility exists when a lapse of unsatisfied copay arrangement occurs for one month or more after the effective date of closure.

Removing an unmet copay on a case that remains closed

To prevent payment problems and to clear up history payment records, an unmet copay flag is removed on a closed case when:

- Three years have lapsed from the month the copay was not met. (The computer will automatically remove the copay not met flag from DPCS after three years), or
- Satisfactory arrangements for copay are met and verified.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Work registration

Click here for SNAP employment services.

SNAP No additional program-specific information.

TANF This does not apply to the TANF program.

ERDC This does not apply to the ERDC program.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Oregon Administrative Rule(s)

461-135-0415 — Requirement to Make Copay or Satisfactory Arrangements; ERDC
461-135-0400 — Specific Requirements; ERDC
461-165-0180 — Eligibility of Child Care Providers
461-130-0330 — Disqualifications; Pre-TANF, REF, SNAP, TANF
461-135-0200 — Multiple Disqualifications; TANF
461-135-0085 — Requirement to Attend an Assessment or Evaluation, or Seek Medically Appropriate Treatment for Substance Abuse and Mental Health; Disqualification and Penalties; Pre-TANF, TANF
461-195-0601 — Intentional Program Violations; Defined
461-195-0611 — Intentional Program Violations; Establishment and Appeal
461-195-0621 — Intentional Program Violations; Penalties and Liability for Overpayments
461-120-0340 — Client Required to Help Department Obtain Support from Noncustodial Parent; TANF
461-140-0210 — Asset Transfer; General Information and Timelines
461-140-0242 — Disqualifying Transfer of Assets Including Home; OSIPM
461-105-0410 — Client Requirement to Cooperate in Quality Control Review; ERDC, SNAP, REF, REFM, and TANF

Chapter 2: Eligibility

Section 5: Financial eligibility

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Financial eligibility

Introduction

There are many financial eligibility requirements for ODHS|OHA programs. These can include income and resources, both considered assets. This chapter of the Oregon Programs Eligibility Notebook will cover various aspects of financial eligibility.

Categorical eligibility

This applies specifically to the SNAP program. "Categorical eligibility" is a term used within the SNAP program. Categorical eligibility does not mean that a household is automatically eligible for SNAP benefits.

What categorical eligibility means is that certain eligibility factors do not apply to the SNAP case when all individuals in the filing group are categorically eligible for SNAP. This applies specifically to the SNAP program.

SNAP Categorical eligibility for SNAP benefits means that a household is considered to have automatically passed a SNAP gross income test, net income test and/or asset test because of having already passed the income and asset tests of another means-tested program:

In Oregon, there are three main categories of Categorical Eligibility.

1. **Categorically Eligible (CE):**

   The individuals who receive or are authorized to receive the following benefits meet the criteria of CE:

   - Temporary Assistance to Needy Families (TANF) cash assistance:
   - General Assistance (GA); or
   - Supplemental Security income (SSI) – receiving payments

2. **Expanded Categorical Eligibility (ECE):**

   The individuals who receive or are authorized to receive the following benefits meet the criteria of ECE:

   - SSI under Section 1619(a) or 1619(b) of the Social Security Act (42 U.S.C. 1382h(a) or (b)) http://www.dhs.state.or.us/spd/tools/program/osip/wg09/wg09.htm. Considered eligible for SSI although may not actually be receiving payments.
   - Employment Related Day Care (ERDC)
   - Pre-TANF
   - Temporary Assistance to Domestic Violence Survivors (TA-DVS)
   - TANF JOBS Plus,
   - Housing Stabilization Program through Housing and Community Services
   - TANF related Employment Payments (EP)

3. **Broad Based Categorically Eligible (BBCE):**

   The filing group must meet all of the following criteria listed below and not have an individual who is CE or ECE:

   - The filing group's countable income is below 200 percent of the federal poverty level (FPL).
   - Have resources that came from lottery or gambling winnings of less than the resource limit for household containing at least one elderly disabled individual.
   - Have been given, or will be given upon approval, the TANF funded pamphlet "*Information and Referrals for Low Income Households*" (MSC 3400, ONE-095).

The ONE System Categorical Eligibility Determination

The categorical eligibility determination is fully automated in ONE. The ONE System will make a preliminary determination of categorical eligibility based on the EDGE household composition results and the answers to the Income and Expenses. If the SNAP case appears to be categorically eligible, ONE will then automatically by-pass the Asset test.

Categorically Eligible Households

An approved categorically eligible household's benefit amount depends on household size, countable and adjusted income and allowable expenses.

- A household with 1 or 2 people will receive at least the minimum SNAP benefit amount.
- If a household with 3 or more people will receive the calculated benefit even if it $0. This allows the household to inform ODHS of changes that may increase their eligibility without requiring a new application.

Note: Being eligible for SNAP at any benefit level allows Oregonians to be eligible for other programs, including, but not limited to: Energy Assistance, Free or Reduced Price Meals, Free or Reduced Cost Phone Services, and other programs/services/activities.

Who is not categorically eligible for SNAP benefits?

The following filing groups cannot be considered categorically eligible:

- They are disqualified due to a SNAP Intentional Program Violation.
- The head of household is disqualified for failure to comply with work registration requirements.

Note: Being categorically eligible does not end a SNAP disqualification. Households containing an ABAWD individual who is disqualified due to exceeding the SNAP time limits remain categorically eligible for SNAP.

- Non-SSI elder/disabled filing groups with gross income in excess of the Categorical Eligibility Income Standard.
- A filing group that loses SNAP benefit eligibility due to lottery or gambling winnings is not eligible for SNAP benefits until meeting SNAP financial eligibility resource and income requirements.

Note: For this rule to apply the filing group must be the same members as the filing group which lost eligibility due to lottery/gambling winnings.

The next time such a household reapplies and is certified for SNAP after losing eligibility under this rule, the household would not be considered categorically eligible. If eligible, the household would need to be certified under regular SNAP rules.

After the filing group has been determined eligible and approved for SNAP as a non-categorically eligible filing group, subsequent determinations can use categorical eligibility.For these filing groups , you must request asset information and appropriate verifications to determine eligibility.

Households containing an ABAWD individual who is disqualified due to exceeding the SNAP time limits remain categorically eligible for SNAP.

How long is a household categorically eligible?

A SNAP household can lose categorical eligibility at any time during the certification period.

Households determined categorically eligible due to household income less than 185 percent of FPL and the receipt of the pamphlet on TANF information and referral services are categorically eligible for the entire certification period unless an IPV disqualification is applied, the head of household is disqualified for failing to comply with work requirements or a change in circumstances is reported indicating the income exceeds 185 percent of FPL.

If categorical eligibility is based on eligibility for specific programs and the eligibility for that program ends, categorical eligibility does not continue. Review and determine if categorical eligibility exists another way, such as household under 185 percent of FPL.

Eligibility factors

In creating categorical eligibility for SNAP, Congress assumed certain eligibility factors were met in the program that made the individual categorically eligible. Therefore, if factors are verified for another program, they are also verified for SNAP. The eligibility factors that are assumed met and not used in determining SNAP eligibility for categorically eligible individuals are:

- Social Security number (SSN)
- Resources, and
- Sponsored non-citizens' information.

ODHS|OHA is required to look at SSN and sponsored non-citizens' information if they have not been verified through categorical eligibility in another program. However, ODHS|OHA is not required to review resources beyond verifying income the household is receiving from those resources.

In addition to not reviewing these eligibility factors, a categorically eligible SNAP household with income above the countable and adjusted income limits can still be eligible for SNAP because there is no comparison of income to the countable or adjusted income limits. Categorically eligible individuals are not assumed eligible for SNAP; they must meet all other program requirements.

All eligibility factors still need to be verified for other programs. Members of the benefit group must be considered Oregon residents to be categorically eligible. All individuals applying for SNAP must provide their SSN; however, it is not required at application as W204 match will verify this number.

ODHS|OHA will determine SNAP eligibility and benefit amounts for al categorically eligible households. This means all of the financial and non-financial eligibility factors will be considered, other than SSN, Oregon residency, and resources. These factors include:

- Household composition (who must be considered in the SNAP filing group)
- Student status (if a student is eligible for SNAP benefits)
- Citizen/non-citizen status (if a non-citizen meets eligibility criteria for SNAP)
- SNAP time limits and work requirements
- Financial eligibility (ongoing income)
- Eligibility for deductions (child support, shelter costs, etc.).

For categorically eligible SNAP benefit groups, a benefit calculation is completed solely to determine the amount of benefits.

Click here for Benefit calculation.

An ineligible non-citizen may be categorically eligible when the other members of the household are receiving ERDC or some TANF-related benefits, and the ineligible non-citizen is a member of the filing group for that program. This does not mean the ineligible non-citizen becomes eligible for SNAP benefits. This means the ineligible non-citizen's resources are not considered, and the household income is not compared to the countable and adjusted income limits.

Households with non-categorically eligible members

When a household group contains some individuals who meet categorical eligibility and some who do not, those who meet categorical eligibility will have their resources excluded. This applies even if the resources are jointly owned by those who meet categorical eligibility and those who do not. Eligibility is determined based on the resources of those who are not categorically eligible. When one member of the group is not categorically eligible, the case is coded with "NA" with an "N" code in the CAT EL field. Therefore, the household must have resources and income within the resource and income limits to qualify for SNAP.

Click here for examples: Categorical eligibility.

Oregon Administrative Rule(s)

461-135-0505 — Categorical Eligibility for SNAP

Special eligibility for Medicaid individuals

Assumed eligibility

Assumed eligible individuals are individuals who meet the eligibility requirements of a program based on other benefits they receive or are deemed to receive.

MSP

People who receive Part A of Medicare and SSI are assumed to meet the financial and citizen/non-citizen requirements for QMB; there is no assumed eligibility for SMB or SMF. This means that the person will receive QMB for as long as they meet all the non-financial requirements. They still have to meet residency and pursuit of health care coverage and cash medical support requirements as described in "Pursuit of assets."

OSIPM and HSD

The following groups of individuals are assumed to meet the financial and citizen/non-citizen requirements for Medicaid. This means that the person will receive OSIPM for as long as they meet all the non-financial requirements. Those who are receiving SSI or have 1619(a) or (b) status are also assumed to meet citizenship/non-citizen requirements; additional verification is not necessary. Resources do not have to be considered. These groups include:

- Lawful recipients of SSI benefits; i.e., the individual is eligible for and receiving SSI benefits.
- People deemed eligible for SSI under Sections 1619(a) or (b) of the Social Security Act that covers individuals whose impairment has not changed, but who have become gainfully employed and have continuing need for OSIPM
- Individuals (described in the two above bullets) who are in a nonstandard living arrangement and are, thus, not assumed eligible for home and community-based services
- Individuals who would otherwise be ineligible due to a disqualifying transfer of assets (only applies to transfers that occur on or after July 1, 2007)
- Individuals whose countable resources exceed the limit after an eligibility worker performs the calculation under 461-160-0580 (i.e. completing a resource assessment). This only applies to married individuals at initial application or when they marry after they begin receiving services.

Note: If an existing SSI service recipient receives or obtains resources that place them over the resource limit, complete a 538A and send to SSA, but do not close OSIPM or services until or unless SSA terminates SSI.

Note: If an assumed eligible individual in a standard living arrangement reports a transfer, provide them with a copy of the SDS 0543.

A pregnant individual's eligibility is protected through the twelve calendar months following the month in which the pregnancy ends. A pregnant individual eligible for and receiving HSD medical or OSIPM who becomes ineligible while pregnant is assumed eligible for HSD medical or OSIPM through the twelve calendar months following the month in which the pregnancy ends. This assumed eligibility does not extend to Medicare Savings Programs.

A child born to a mother eligible for and receiving any Medicaid benefit is assumed eligible for the MAGI Child program under this section until the end of the month the child turns 1 year of age.

Note: The SDS 538A should be completed and sent to the Social Security Administration in the following instances:

- When assets are identified or reported that would result in ineligibility for OSIPM if the individual were not assumed eligible, or
- When an SSI recipient enters a nursing facility.

Continuous eligibility

A child found eligible for OSIPM is assumed eligible until the end of the 12th month after eligibility is determined. When an assumed eligible child loses eligibility with time remaining in the 12-month continuous eligibility period, the child's OSIPM can continue for the remainder of the 12-month eligibility period if they are not eligible for any other Medicaid program.

To be eligible for the continuous eligibility, an individual must meet all of the following requirements:

- Be under age 19
- Be a U.S citizen or qualified non-citizen
- Be receiving OHP Plus Medicaid benefits, and
- Not have received Medicaid for 12 full months from initial application or most recent redetermination.

Continuous eligibility ends

- When the child moves out of state
- When the child voluntarily ends OSIPM
- The end of the continuous eligibility period
- When the child turns age 19, or
- When the child dies.

Note: It will also end when the child is found eligible for MAGI or CHIP.

The continuous eligibility period is based on the most recent OSIPM program approval date. A child losing eligibility less than 12 months after having been approved for benefits qualifies for continuous program benefits for the balance of the 12-month period following that approval.

Click here for information on verifying assumed and protected eligibility.

An individual found eligible for the Healthier Oregon medical program who no longer meets the age requirements:

- Shall maintain continuous eligibility so long as they continue to meet all other financial and non-financial eligibility criteria; or
- May regain eligibility if:
  - They respond within the 90-day reconsideration period (see OAR 410-200-0110) after closure due to failure to respond at renewal; and
  - They meet all financial and non-financial eligibility criteria.

Protected eligibility

Disabled Adult Children (DAC)

Individuals are evaluated for OSIPM as a disabled adult child if they meet all of the following requirements:

- The individual is age 18 or older.
- The Social Security Administration has determined that the individual became blind or a person with a disability before reaching the age of 22.
- The individual lost SSI benefits on or after July 1, 1987, because either the individual became eligible for Social Security DAC benefits when a parent died, retired or became disabled and began receiving Social Security Benefits (SSB); or the individual was already receiving SSB and SSI at the same time but lost SSI because the SSB increased. (An individual who receives railroad retirement benefits (RRB) does not meet this requirement--it must be SSB).
- The individual would continue to be eligible for SSI in the absence of the Social Security DAC benefits or increases to that benefit.

Note: A DAC is exempt from a service liability if receiving waivered services; however, DAC individuals must pay a service liability if receiving nursing facility services.

Pickle Amendment individuals

An individual is eligible for OSIPM under the Pickle Amendment if they meet all other eligibility requirements, but is over income because of Social Security Title II Benefits (SSB/SSDI) cost-of-living increases after April 1977, and:

- Is receiving SSB or SSDI Title II benefits for the aged, survivors or persons with disabilities, (An individual who receives railroad retirement benefits (RRB) does not meet this requirement--it must be SSB/SSDI).
- Was eligible for and receiving SSI or state supplements but became ineligible for those payments after April 1977 (individual does not have to lose SSI due to COLA), and
- Would be eligible for SSI or state supplement if the SSB/SSDI COLA increases paid under section 215(i) of the Social Security Act were deducted from current SSB/SSDI benefits; this applies after the last month the individual was both eligible for and received SSI or a supplement and was entitled to SSB/SSDI.

The SSB/SSDI amount received by the individual when they became ineligible for SSI or OSIPM is used as the individual's countable Social Security income, for the purposes of the Pickle Amendment. If the amount cannot be determined, it is calculated based on sections (3) and (4) of 461-135-0780.

Note: An individual eligible under the Pickle Amendment is exempt from a service liability if receiving waivered services.

If there is no multiplier amount for a particular year, it is because there was no SSA COLA in that year.

Widows/widowers

A widow or widower receiving Title II benefits from the Social Security Administration claim of a deceased spouse or deceased former spouse is eligible for OSIPM if the individual meets all of the following:

- Is not entitled to premium-free Medicare Part A, and

- Became ineligible for SSI because of a mandatory application for and receipt of widow's or widower's Social Security disability benefits.

Note: The individual must be receiving Title II Social Security Benefits. Receiving railroad retirement benefits (RRB) is not countable as widow/widower income—it must be Social Security Benefits.

Eligibility under this rule did not exist before July 1, 1988.

Note: A person eligible as a widow or widower is exempt from a service liability if receiving waivered services.

Click here for information on verifying assumed and protected eligibility.

Eligibility for individuals with blindness or disability eligible for SSI in December 1973

Individuals are eligible for OSIPM if:

- They were eligible for SSI due to blindness or disability in December 1973 and
- They have continuously met the SSI eligibility criteria used in December 1973, including the criteria for blindness or disability; or
- They are the essential spouse and living in the same household of a person eligible for SSI due to blindness or disability in December 1973, and
- The essential spouse provides a service that otherwise would have to be provided by some other means.

Individuals in an institution since 1973

For OSIPM, individuals in an institution are eligible for benefits even if their income is over 300 percent of the full SSI standard for a person living alone if:

- The person has continuously met the SSI eligibility criteria used in December 1973 for people in an institution, and
- The person needs institutional care as determined by preadmission screening nurses.

1972 COLA individuals

People are eligible for OSIPM if they meet all eligibility requirements except that they are over income because of an SSB cost-of-living increase in July 1972, and:

- They were entitled to receive SSB in August 1972, and
- They received benefits under OSIPM or a state program for the aged, blind or disabled, or were eligible for such a program; or
- They would have been eligible if they had not been in a medical facility.

Individuals in state psychiatric institutions and training centers

People residing in state psychiatric institutions (Eastern Psychiatric Center or Oregon State Hospital) are eligible for benefits if they are:

- 65 years of age or older
- Under 21 years of age, or

- 21 years of age or older, if the basis of need is disability or blindness; eligibility was determined before the individual reached 21 years of age; and the individual entered the institution before reaching 21 years of age.

Click here for the Residents of State Hospitals and Training Centers Worker Guide.

Oregon Administrative Rule(s)

461-135-0010 — Assumed Eligibility for Medical Programs
461-135-0830 — Eligibility for Disabled Adult Children; OSIPM
461-135-0771 — Individuals with blindness or disability eligible for SSI in December 1973; OSIPM
461-135-0780 — Pickle Amendment Clients; OSIPM
461-135-0790 — Eligibility for People in an Institution since 1973; OSIPM
461-135-0800 — Eligibility for 1972 COLA Clients; OSIPM
461-135-0820 — Eligibility for Widows and Widowers; OSIPM
461-135-0950 — Eligibility for Inmates and Residents of Public Institutions

Other resources

OSIPM Protected Eligibility: Covers OSIPM Protected Eligibility and provides guidance to staff on how to enter these cases into ONE. It also provides guidance on 1619(b) cases and the SSI Discontinuance screen.

Income limits

Income is money or other benefits an individual receives from working, social security benefits, investments, etc. ODHS|OHA gathers all information regarding income in the financial group, which is used to determine program eligibility.

Each program has countable and/or adjusted income limits. Applicants must fall at or below these limits to qualify for benefits. Some programs have an initial income limit as well as an ongoing or exit limit to maintain benefits throughout the benefit period.

"Countable" means an available asset (either income or a resource) is not excluded and may be considered by programs to determine eligibility. "Adjusted income" means the amount determined by subtracting income deductions from countable income.

The limits for all programs can be found on the DHS Combined Standards form (DHS 5530).

SNAP The SNAP countable income limit is one of the tests used to determine whether applicants are eligible for SNAP. All need groups must pass this income test each month, unless they are categorically eligible, or they include a member who meets the SNAP elderly or individual with disabilities criteria.

Click here for Categorical eligibility.
Click here for Eligibility groups.

TANF To meet eligibility, the financial group must be under the TANF income and payment standards.

Exit limit increase (ELI)

The exit limit increase is designed to lessen the benefit cliff impact on families. The policy allows families to gradually phase off the TANF program when parents become employed, instead of experiencing an abrupt loss of benefits from their monthly cash assistance as they hit the income limit.

A TANF benefit group that has countable earned income is eligible for an exit limit increase in the following situations:

- An open TANF case with earned income to determine if the case is over the exit limit increase countable income limit, or
- Restoring a TANF case within 30 days of closure when the case closed with earned income received by a member of the benefit group prior to closure.

ELI serves as both the countable and adjusted income limits for the above two case types.

ELI is only for individuals in the benefit group. If the TANF benefit group reports someone has moved into the home with income, the calculation to determine eligibility is based on the countable income limit (not the exit limit increase).

Coding exit limit increase (ELI) and no adult standard exit limit increase (NAS)

The new exit limit increase (ELI) and the no adult standard (NAS) codes will have to be coded on all cases with an EML or self-employment (SLF) coding.

At initial eligibility:

Workers will need to calculate earned income (EML) or self-employment (SLF) income for TANF.

Manual calculation:

Countable – 100% of EML or SLF and 100% of unearned income

Adjusted – 50% of EML or SLF and 100% of unearned income

Then workers will need to compare the total to the appropriate standard chart for coding on UCMS.

Click here for Earned income.
Click here for Self-employment income.
Click here for Unearned income.

For ongoing eligibility:

Workers will be able to code ELI or NAS on cases with EML or SLF and the computer will do the calculation.

Non-needy caretaker relative grants

In the TANF program, a caretaker relative other than a parent who chooses not to be included in the need group is subject to the non-needy caretaker relative countable income limit standard. The non-needy caretaker relative countable income limit standard for the filing group is set at 185 percent of the federal poverty level (FPL).

Once the caretaker relative decides they need TANF benefits, the household is subject to the same TANF and JOBS requirements as parents. This includes adult income limit standards.

The following caretaker relatives can be a non-needy caretaker relative:

- Grandfather or grandmother
- Brother, sister, half-brother or half-sister
- Uncle, aunt, first cousin, nephew or niece
- Stepfather, stepmother, stepbrother or stepsister
- The spouse of anyone listed above, or
- Any blood relative.

A stepparent or stepsibling may be considered a caretaker relative even if the marriage to the biological or adoptive parent ended in death or divorce. When a caretaker relative of one child applies for another child in the same household, the groups must be combined. A dependent child can only be in one filing group at a time.

ERDC

The ERDC income limit is different at the initial certification versus during the certification and at recertification.

Initial certification

The income limit is 200 percent of the federal poverty level (FPL) when a family is applying for ERDC as a new applicant. A new applicant includes those who are reapplying after a break in benefits of more than one calendar month.

During the certification and at recertification

The income limit is higher during the certification (referred to as the ongoing income limit) and at recertification (referred to as the exit limit). This allows families to maintain child care assistance while experiencing moderate financial gains — helping to reduce the cliff effect — for those receiving ERDC and those reapplying without a break in benefits of more than one calendar month.

Self-employment income

Income from self-employment for ERDC is compared against the ERDC income limits before deductions, based on filing group size. If the family is below the income limit, they meet the income eligibility; costs for their business can be explored.

Click here for Self-employment income.

REF

To meet eligibility and continue REF benefits, the financial group must meet and maintain the REF income and payment standards.

To meet REFM eligibility, the financial group must meet the adjusted income standard during the month of application only — after a 50 percent deduction on all earned income, and deduction of all medical costs incurred during the month of application. Once a refugee has been determined eligible for REFM (and not

eligible for Medicaid), that refugee will maintain financial eligibility for the remainder of their eight months in the United States.

MSP

Individuals must meet income eligibility at initial application and throughout the benefit period to continue receiving benefits.

For QMB, the financial group must have adjusted income at or below the QMB income limits.

For SMB and SMF, the financial group must have adjusted income below the SMB and SMF income limits.

Protected eligibility from SSA COLAs — Each year, from Jan. 1 until the new program income standards are put into effect (usually in March), all ongoing MSP recipients have protected eligibility from the annual SSA Cost-of-Living Adjustment (COLA). This includes those requiring a renewal.

OSIPM

Individuals in a standard living situation and their financial group must have adjusted income below the OSIPM income limits to meet eligibility at initial application and maintain eligibility throughout the benefit period.

Those who do not qualify for OSIPM as a standard living situation and are being evaluated under the ACS or LTC services rules must have countable income below 300% of the SSI standard.

Individuals who receive SSI or are deemed eligible for SSI under Section 1619(a) or (b) of the Social Security Act are assumed eligible and automatically meet all financial eligibility factors, including income.

Click here for ACS.
Click here for EPD.
Click here for LTC Services.

Other resources

Oregon Supplemental Income Program – Medical (OSIPM) and Medicare Savings Programs (MSP): Contains overview of OSIPM and MSP programs, including Income and Resource Standards, Eligibility Criteria, and Medicare Part A/B/C/D breakdown and description.

HSD

Most HSD medical programs follow IRS rules for counting income and use Modified Adjusted Gross Income (MAGI) to determine program eligibility and benefit level of applicants. With some exceptions, MAGI income includes federally taxable income already received and reasonably expected to be received. Each person for whom benefits are requesting for will have the countable income from their EDG compared to the income standards chart.

HSD medical programs that use MAGI have both a monthly and annual income test. The monthly income uses MAGI-based methodology and prospective budgeting. The annual income test uses MAGI methodology and is performed when someone requesting benefits is not eligible using monthly income. The difference between the monthly and annual income test is outlined in the paragraph below where the eligibility rules for the 100% annual income test are stated.

For the annual income test, income received for the calendar year is compared to the 100 percent FPL standard. If the annual income is below the 100 percent FPL, it is converted to a monthly amount and

applied to the budget month by ONE. The following eligibility rules apply to the 100% annual income test:

- The annual income test can only be used for tax filers or tax dependents.
- The annual income test cannot be applied for individuals who are married filing separately.
- The annual income test counts taxable income excluded for MAGI-based determinations (what is used for the monthly income test). These include foreign earned interest, tax-exempt interest, Tribal, scholarship income and, under some conditions, Social Security Disability Insurance (SSDI) and Social Security benefits (SSB) income.
- Unborn children do not count toward the family size group for annual income.

Income of the following individuals is excluded when they are not expected to be required to file a tax return for the tax year in which eligibility is being determined. This is true whether the child or tax dependent actually files a tax return:

- Children, regardless of age, who are included in the household of a parent, and
- Tax dependents.

IRS code § 6012(a) (1) is used to determine who is required to file a tax return and considers the following: marital and filing status, disability, blindness and type of income being received. ONE relies on the non-financial information collected and income information entered on the annual income screen to determine whether a person is required to file.

Certain deductions allowable under IRS can be deducted from countable MAGI-based and MAGI income. These deductions are excluded from countable MAGI-based and MAGI income, before comparing the income to the applicable MAGI Income Standard to determine financial eligibility.

Some allowable tax deductions are not available to select from in ONE. When a deduction is reported and not available as a drop-down to select from, select “Other Allowable Tax Deduction/Expense.”

The HSD medical programs listed below do not use MAGI income methodology and do not have an income test:

- Breast and Cervical Cancer Treatment Program (BCCTP)
- Extended Medical Assistance (EXT)
- Former Foster Care Youth Medical (FFCYM)
- Substitute Care (SAC)

Click here for examples: Income limits.

Oregon Administrative Rule(s)

461-155-0030 — Income and Payment Standards; REF, TANF
461-155-0180 — Income Standards; Not OSIP, OSIPM, QMB
461-155-0225 — Income Standard; REFM
461-160-0160 — Earned Income Deduction; REF, REFM, and TANF
461-155-0190 — Income and Payment Standards; SNAP and DSNAP
461-160-0400 — Use of Income to Determine Eligibility and Benefits; SNAP
461-110-0750 — Benefit Group
461-155-0020 — Prorated Standards; Adjusted Number in Household; TANF
461-155-0030 — Income and Payment Standards; REF, TANF
461-160-0100 — How Income Affects Eligibility and Benefits; REF, REFM, TANF
461-135-0400 — Specific Requirements; ERDC
461-155-0150 — Child Care Eligibility Standard, Payment Rates, and Copayments
461-160-0300 — Use of Income to Determine Eligibility and Benefits for ERDC
461-155-0250 — Income and Payment Standards; OSIPM
461-155-0290 — Income Standard; QMB-BAS
461-155-0295 — Income Standard; QMB-SMB, QMB-SMF
410-200-0315 — Standards and Determining Income

Resource limits

A resource is something of value. Some resources are countable and some are excluded. Some resources are considered available and others are not. A resource is something an individual has legal interest in, the ability to sell or convert to cash (liquid resources, vehicles, life insurance, burial reserves, real property, annuities, trusts, etc.), and/or use for support and maintenance. Resources are considered when determining eligibility for most programs.

An asset cannot be considered income and a resource in the same month; income received in one month is considered a resource the next month.

Individual programs have different resource limits.

Each program that considers resources when determining eligibility has specific limits to the amount of countable resources an individual can have access to, both at application and for ongoing eligibility.

For more information about how to count the value of resources, click here for Treatment of specific assets.

SNAP Resources can affect whether an individual or filing group is categorically eligible.

Only non-categorically eligible need groups are required to meet the resource limit. Categorically eligible need groups are assumed to meet resource limit requirements. In groups where some members meet categorical eligibility and others do not, the categorically eligible members' resources are not considered in determining eligibility. This applies even if the resource is shared with a member who is not categorically eligible.

Click here for Benefit calculation.

The resource limit for SNAP is $3,750 for any of the following reasons:

- At least one member is age 60 or older.
- At least one member meets the SNAP definition of individuals with disabilities.
- The money comes from lottery or gambling winnings.

The resource limit for SNAP is $2,500 for all others.

TANF The resource limit for TANF is $2,500 for any of the following:

- A new TANF applicant
- A TANF need group that does not have at least one caretaker relative or parent who is receiving TANF (such as a no-adult household)
- A TANF need group that has at least one JOBS participant who is currently serving a disqualification.

The resource limit for TANF is $10,000 for all others.

ERDC The resource limit for ERDC is $1 million for all individuals at both initial eligibility and for ongoing eligibility.

Resources are not verified for ERDC, and instead are self-reported only.

REF The resource limit for REF is $2,500 for any of the following:

- A new REF applicant
- A REF need group with at least one member required to participate in an employment program who is:
  - Not progressing in their case plan, or
  - Currently serving a disqualification.

The resource limit for REF is $10,000 for all others.

MSP All resources are excluded for MSP.

OSIPM The resource limit for OSIPM is $2,000 for an individual and $3,000 for a need group of two at both initial eligibility and for ongoing eligibility.

The resource limit for OSIPM-EPD is $5,000.

Individuals who receive SSI or are deemed eligible for SSI under Section 1619(a) or (b) of the Social Security Act are assumed eligible and automatically meet all financial eligibility factors, including resources.

Deemed resources

When a child in a standard living arrangement who is not assumed eligible is applying for OSIPM, the parental resources are deemed available to the child. The amount deemed available to the child is the

amount the parental resources exceed the resource limit of:

- A one person need group if one parent lives in the child's household, or
- A two person need group if two parents (or one parent and the spouse of that parent) live in the child's household.

Parental resources mean the countable resources of:

- Each ineligible parent (a natural or adoptive parent not receiving SSI or TANF) in the child's financial group, and
- Each spouse of that same ineligible parent.

If more than one child is applying, the value of the deemed resources is divided evenly between the applying children. If an applying child is determined to be ineligible for OSIPM for any reason, including excess resources resulting from deeming, no resources are deemed to that child. Any resources deemed to an applying child determined to be ineligible for OSIPM are deemed equally to other applying children.

The parental resources are not deemed available to a non-applying child.

The value of the parental resources is subject to deeming whether or not those resources are available to the child.

Click here for information on Long-Term Care (LTC) services resource calculations and exclusion.
Click here for information on resources excluded specifically for Employed Persons with Disabilities (EPD).

HSD HSD medical programs do not consider resources in the eligibility determination.

Click here for examples: Resource limits.

Oregon Administrative Rule(s)

461-001-0000 — Definitions for Chapter 461
461-135-0400 — Specific Requirements; ERDC
461-135-0505 — Categorical Eligibility for SNAP
461-160-0010 — Use of Resources in Determining Financial Eligibility

Other resources

Oregon Supplemental Income Program – Medical (OSIPM) and Medicare Savings Programs (MSP): Contains overview of OSIPM and MSP programs, including Income and Resource Standards, Eligibility Criteria, and Medicare Part A/B/C/D breakdown and description.

Medical Asset Check via AVS *includes screenshots: Describes what benefit programs are eligible for the Medical Asset Check and the different types of assets that are checked by the AVS interface. Provides instruction for initiating the check and responding to discrepant and undisclosed resources.

Tracking Submitted Requests in the Asset Verification System (AVS) *includes screenshots: Gives step-by-step process of how to check status of pending AVS requests via the Case Queue.

Call Center Software – Playing the Asset Verification System (AVS) recording & Capturing Verbal Signature *includes screenshots: Walks through the process of having the Oregonian listen to the AVS recording, Capturing the verbal signature, downloading the recording, and saving the file in ONE at the individual level.

Non-MAGI Resources *includes screenshots: Describes how to use and locate Non-MAGI resources

Resources *includes screenshots: Reviews the resource categories and their respective screens. Describes how historical data appears on the Resource Questions screen.

Availability of assets

Individuals' income and resources are their assets; these assets may or may not be available to them. Only those assets considered available are used in determining program eligibility. If an asset is determined to be unavailable to the applicant, it is important this is clearly narrated. If an asset does meet the requirements to be considered unavailable, it is considered available.

Income

Income may be available or unavailable to the applicant. This can affect program eligibility.

The amount of income considered available is the gross amount before deductions. For example, garnishments, taxes and other payroll deductions including flexible spending accounts are included in the gross amount.

Income is considered available the date it is received or the date a member of the financial group has a legal right to the payment and the legal ability to make it available, whichever is earlier, except as follows:

- Income usually paid monthly or on some other regular payment schedule is considered available on the regular payment date if the date of payment is changed because of a holiday or weekend.
- Income withheld or diverted at the request of an individual is considered available on the date the income would have been paid without the withholding or diversion.
- An advance or draw of earned income is considered available on the date it is received.
- Income that is averaged, annualized, converted and prorated is considered available throughout the period for which the calculation applies.
- Deemed income is considered available, even if not received.

The following income is not considered available:

- Wages withheld by an employer in violation of the law
- Income received by another person who does not pay the participant their share
- Income received by an individual for the financial group after they have left the household
- For a participant who is not self-employed, income required to be expended on an ongoing, monthly basis on an expense necessary to produce the income, such as supplies or rental of work space
- Income controlled by the individual's abuser if the participant is a survivor of domestic violence, the individual's abuser controls the income and will not make the money available to the filing group, and the abuser is not in the individual's filing group. Click here for the Temporary Assistance for Domestic Violence (TA-DVS) Program.

Income received by the financial group but intended and used for the care of someone not in the financial group is available as follows:

- If the income is intended both for someone in the financial group and someone not in the financial group, the portion of the income intended for the care of the individual not in the financial group is considered unavailable.
- If the portion intended for the care of the individual not in the financial group cannot readily be identified, the income is prorated evenly among the individuals for whom the income is intended. The prorated share intended for the care of the individual not in the financial group is then considered available.

For an SSA rep payee who receives money for someone outside the financial group, the income is not considered available to the rep payee.

SNAP The portion of a payment from the TANF program counted as disqualifying income is considered available income.

Benefits from the General Assistance program are available unearned income, including ongoing monthly payments, housing allowances paid to the landlord, utility allowances, accommodation allowances, and the personal incidentals payment.

Lump-sum income is treated as a resource unless rule requires a different treatment. The following income is not considered available:

- Monies withheld from or returned to the source of income to repay an overpayment from that same source with one exception: TANF grants reduced to recoup a participant-caused overpayment.

TANF Income from assistance programs (e.g., public assistance, unemployment compensation or Social Security) withheld to repay an overpayment is considered available.

The following income is not considered available:

- Monies withheld from or returned to the source of income to repay an overpayment from that same source is unavailable with one exception: the portion of a payment from an assistance program (e.g., public assistance, unemployment compensation or Social Security) withheld to repay an overpayment is available.

ERDC Income from assistance programs (e.g., public assistance, unemployment compensation or Social Security) withheld to repay an overpayment is considered available.

Lump-sum income is considered a resource and is excluded.

The following income is not considered available:

- Monies withheld from or returned to the source of income to repay an overpayment from that same source is unavailable with one exception: the portion of a payment from an assistance program (e.g., public assistance, unemployment compensation or Social Security) withheld to repay an overpayment is available.

REF Income from assistance programs (e.g., public assistance, unemployment compensation or Social Security) withheld to repay an overpayment is considered available.

The following income is not considered available:

- Monies withheld from or returned to the source of income to repay an overpayment from that same source is unavailable with one exception: the portion of a payment from an assistance program (e.g., public assistance, unemployment compensation or Social Security) withheld to repay an overpayment is available.
- Reception and placement (R&P) grants from the resettlement agency with which the refugee is involved. The resettlement agency receives R&P grants to reimburse the resettlement agency and any possible sponsor for the cost of helping the refugee get established in Oregon. The resettlement agency will sometimes issue a check for part of the R&P grant to the sponsor and the refugee, or just to the refugee. The R&P grant is excluded as income or resources for REF and REFM for both determining eligibility as well as calculating financial assistance levels.

MSP The following income is considered available, even if not received:

- Deemed income
- The portion of a payment from an assistance program (e.g., public assistance, unemployment compensation or Social Security) withheld to repay an overpayment of the same source unless the individual was receiving OSIPM or MSP when they were overpaid and ODHS|OHA was counting the overpaid amount.

  Note: SSDI and SSI are paid from different sources. SSDI reduced to recoup an SSI overpayment is considered available.

The following income is not considered available:

- Monies withheld from or returned to the source of income to repay an overpayment from that same source is unavailable with the exception of bullet two above. If the individual was receiving OSIPM or MSP when they were overpaid and ODHS|OHA was counting the overpaid benefit, the amount withheld is considered unavailable until we “ignore” the same amount of overpaid benefits ODHS|OHA counted previously.

OSIPM The following income is considered available, even if not received:

- Deemed income
- The portion of a payment from an assistance program (e.g., public assistance, unemployment compensation or Social Security) withheld to repay an overpayment of the same source unless the individual was receiving OSIPM or MSP when they were overpaid and ODHS|OHA was counting the overpaid amount.

  Note: SSDI and SSI are paid from different sources. SSDI reduced to recoup an SSI overpayment is considered available.

The following income is not considered available:

- Monies withheld from or returned to the source of income to repay an overpayment from that same source is unavailable with the exception of bullet two above. If the individual was receiving OSIPM or MSP when they were overpaid and ODHS|OHA was counting the overpaid benefit, the amount withheld is considered unavailable until we "ignore" the same amount of overpaid benefits ODHS|OHA counted previously.

HSD For HSD medical programs, income is considered available on the date it is received or the date the individual has a legal right to it. If the income is withheld or diverted at the request of an individual, it is considered available on the date the income would have been paid.

Income would only be considered unavailable for one of the following reasons listed below. Otherwise, the income is considered available and will be considered in the countable income:

- Assistance program OVP withheld to repay same source not from previously counted income
- Assistance program OVP withheld to repay same source from previously counted income
- Non-assistance program OVP withheld to repay same source
- Money not received because payment was reduced to cover expenses to secure the payment.

Resources

Resources are considered unavailable to the individual in any of the following situations:

- The applicant has a legal interest in the resource, but it is not in their possession and they are not able to gain possession of it.
- The resource is jointly owned with others not in the financial group who are unwilling to sell their interest in the sale, and the applicant's interest is not reasonably able to be sold.
- The applicant is verifiably incompetent to gain access to or use the resource, and there is no legal representative to use the resource on the applicant's behalf.
- The resource is an irrevocable or restricted trust and cannot be used to meet the basic monthly needs of the filing group.
- The applicant is a survivor of domestic violence. Attempting to use the resource would potentially subject the individual to further risk of domestic violence, or the applicant is using the resource to avoid returning to an abusive situation. Click here for Temporary Assistance for Domestic Violence Survivors (TA-DVS) Program.
- A resource is considered unavailable to the individual during the time the individual does not know they own

the resource.

- If a resource is subject to an early withdrawal penalty, the amount of the penalty is considered unavailable to the individual.

SNAP Unless a resource is made unavailable by the above reasons, a resource owned jointly by a participant and another individual is available in its entirety to the participant.

TANF Unless a resource is made unavailable by the above reasons, jointly owned resources are available to members of a financial group only to the extent they own the resource.

ERDC Unless a resource is made unavailable by the above reasons, jointly owned resources are available to members of a financial group only to the extent they own the resource.

REF A resource is considered unavailable to the individual if the resource is located in the individual's country of origin.

Reception and placement (R&P) grants from the resettlement agency the refugee is involved with are excluded as a resource. The resettlement agency receives R&P grants to reimburse the resettlement agency and any possible sponsor for the cost of helping the refugee get established in Oregon. The resettlement agency will sometimes issue a check for part of the R&P grant to the sponsor and the refugee, or just to the refugee. The R&P grant is excluded as income or resources for REF and REFM for both determining eligibility and calculating financial assistance levels.

MSP All resources are excluded for MSP.

OSIPM Unless a resource is made unavailable by the above reasons, jointly owned resources are available to members of a financial group only to the extent they own the resource.

Deemed resources (not EPD)

When a child is applying who is not assumed eligible, the parental resources are deemed available to the child. The amount deemed available to the child is the amount the parental resources exceed the resource limit of:

- A one person need group, if one parent lives in the child's household, or
- A two person need group, if two parents (or one parent and the spouse of that parent) live in the child's household.

Parental resources mean the countable resources of:

- Each ineligible parent (a natural or adoptive parent not receiving SSI or TANF) in the child's financial group, and
- Each spouse of that same ineligible parent.

If more than one child is applying, the value of the deemed resources is divided evenly between the applying children. If an applying child is determined to be ineligible for OSIPM for any reason, including excess resources resulting from deeming, no resources are deemed to that child. Any resources deemed to an applying child determined to be ineligible for OSIPM are deemed equally to other applying children.

The parental resources are not deemed available to a non-applying child.

The value of the parental resources is subject to deeming whether or not those resources are available to the child.

Click here for more information on resources for LTC services.

HSD HSD medical programs do not consider resources in eligibility determination.

Click here for examples: Availability of assets.

Oregon Administrative Rule(s)

461-140-0020 — Availability of Resources
461-140-0040 — Determining Availability of Income
461-140-0120 — Availability and Treatment of Lump-Sum Income
461-145-0455 — Resettlement and Placement (R&P) Grants

Prospective eligibility and budgeting

Prospective budgeting is used for determination of financial eligibility. Prospective budgeting means to look forward, to reasonably anticipate what future income will be using representative income verification provided. In prospective eligibility and budgeting, income is budgeted so the anticipated amount is the same for each month (except, for some programs, in the initial month).

When prospective budgeting is used correctly (true and complete information is provided), there is no applicant-caused overpayment. Similarly, no supplement of benefits is needed to be issued when lower benefits were received. Prospective budgeting allows families to have the same benefit level each month unless there is a change in their financial or household situation.

Prospective budgeting works best when using the following best practices:

- ODHS|OHA and the applicant jointly determine the anticipated income to be counted.
- Representative income is used, so eligibility is based on estimated valid figures.
- The applicant is aware of what changes must be reported, and
- Applicants are advised they may be asked to repay any overpayments regardless of whether they are caused by the applicant or ODHS|OHA.

SNAP For SNAP eligibility on a new application, applicant's circumstances are always looked at prospectively. That is, ODHS|OHA considers what is already known has happened in the initial month (the month containing the filing date), and what is expected to happen for the remainder of the month. When the whole month is considered, eligibility and benefits are issued based on the same information. If the applicant is not eligible, the application is denied. This is prospective eligibility and budgeting for SNAP.

Prospective eligibility is used for new applications regardless of which reporting system is used for ongoing months. There is one exception to using actual income already received plus income expected for the remainder of the month: when cases are certified in SRS when ongoing income that is expected to

continue is converted.

Note: An application is considered new only when it is received after a break in benefits. It is a new application if a household returns an application for redetermination after the prior certification month ends.

If the amount of income to be received or when it will be received is uncertain, the portion of the applicant's income that is uncertain should not be counted by ODHS|OHA.

TANF In the initial month, actual income is only used if the income comes from a new or terminated source, or if the previous ongoing income is significantly different from ongoing income.

A job or income source is considered new if the participant will receive their first payment in the initial month. If the individual has already received their first payment prior to the initial month, the income source is considered ongoing. Actual income is not used for self-employment or periodic income.

Prospective eligibility and budgeting is used for stable income, income that can be prorated and annualized income. It can also be used for participants who leave the filing group due to domestic violence and for benefit groups when a new individual is added in the payment month after ODHS|OHA is notified the individual is a household member.

The participant and ODHS|OHA jointly determine the anticipated income to be counted. ODHS|OHA will count only income reasonably certain to be available. However, some income is considered available even when it is not received in the budget month (e.g., converted, averaged and annualized income).

ERDC For ERDC, income is budgeted so the anticipated amount is the same for each month, including the initial month.

This policy is intended to help ODHS|OHA and participant predict the family's income with a reasonable degree of accuracy using prospective eligibility and budgeting. Important considerations include:

- The copay for future months should be known in advance so both the family and the child care provider will know how much ODHS|OHA will pay, and how much the family will be expected to pay.
- Some differences between estimated income and actual income are to be expected. However, unanticipated changes during the certification may occur and should follow reporting requirements.

When the initial month's income is different (higher or lower), the initial month is still used to calculate an average for ERDC budgeting. Situations when the initial month can be different are:

- An applicant gets a new job
- An applicant changes jobs
- Other situations that may cause an income to increase or decrease.

Income is calculated in ONE as follows:

(First month's income) + (ongoing income x 11 months) = total income for the certification period / 12 months = monthly income.

REF In the initial month, actual income is only used if the income comes from a new or terminated source, or if the previous ongoing income is significantly different from ongoing income.

A job or income source is considered new if the participant will receive their first payment in the initial month. If the individual has already received their first payment prior to the initial month, the income source is considered ongoing. Actual income is not used for self-employment or periodic income.

Prospective eligibility and budgeting is used for stable income, income that can be prorated and annualized income. It can also be used for participants who leave the filing group due to domesticviolence, or for benefit groups when a new individual is added in the payment month after ODHS|OHA is notified the individual is a household member.

The participant and ODHS|OHA jointly determine the anticipated income to be counted. ODHS|OHA will count only income reasonably certain to be available. However, some income is considered available even when it is not received in the budget month (e.g., converted, averaged and annualized income).

MSP

Initial and ongoing months

ODHS|OHA converts and averages prospective income except in any month in which a new source of income begins, an existing source ends, or the amount changes. In such months, only income actually received or expected to be received is counted for all income except periodic and self-employment income. ODHS|OHA converts and averages prospective income except in any month in which a new source of income begins, an existing source ends, or the amount changes. In such months, only income actually received or expected to be received is counted for all income except periodic and self-employment income.

Retroactive months

In a retroactive month for which the individual is requesting benefits:

- Income is averaged and converted to a stable monthly amount as needed.
- For any retroactive month in which a new source of income begins, an existing source ends or the amount changes: If averaging and converting the income results in ineligibility, only income actually received or expected to be received in that month is counted.
- Any ongoing periodic income received in a retroactive month is averaged over the period it covers.
- A new source of periodic income received in a retroactive month is averaged from the month of receipt forward.

OSIPM

Initial and ongoing months

ODHS|OHA converts and averages prospective income except in any month in which a new source of income begins, an existing source ends or the amount changes. In such months, only income actually received or expected to be received is counted for all income except periodic and self-employment income.

Retroactive months

In a retroactive month for which the individual is requesting benefits:

- Income is averaged and converted to a stable monthly amount as needed.
- For any retroactive month in which a new source of income begins, an existing source ends or the amount changes: If averaging and converting the income results in ineligibility, only income actually received or expected to be received in that month is counted.
- Any ongoing periodic income received in a retroactive month is averaged over the period it covers.
- A new source of periodic income received in a retroactive month is averaged from the month of receipt forward.

HSD Initial and ongoing months

For ongoing income, use prospective budgeting to convert the income, even in the initial month. If the ongoing income is changing in the initial month, e.g., if they have reduced hours, we treat that as "new" income. When a source of income is new or terminated in a month being considered for eligibility, actual income is used.

Click here for examples: Prospective eligibility and budgeting.

Oregon Administrative Rule(s)

461-150-0020 — Prospective Eligibility and Budgeting
461-150-0060 — Prospective or Retrospective Eligibility and Budgeting; ERDC, REF, REFM, SNAP, TANF

Other resources

Income *includes screenshots: Describes all categories of income: Earned, Self-Employment, Unearned, Unpaid, and Specific. Includes general guidance on how to enter income verification and how to verify no income. Provides instruction on updating and terminating income, and when to update, delete, or add a record. Explains the 100% Annual Income screen and the pay frequency calculation factor. Includes FAQ on income.

Frequency of income

The frequency of income is determined when the individual is paid weekly, biweekly, monthly, quarterly, semiannually or yearly.

Stable income is income consistently received each month. Stable income can be received weekly, biweekly, twice per month or monthly.

Variable income means earned or unearned income that is not always received in the same amount each month.

Periodic income is income received on a regular basis, but less frequently than monthly, such as quarterly, semiannually, annually or as a contract employee. Periodic income is averaged over the applicable period. Depending on the source, it can be counted as earned or unearned income.

Lump-sum income is income received too infrequently or irregularly to be reasonably anticipated or received as a one-time payment; this includes income received less frequently than annually, such as every 24 months. When an

individual has access to a lump-sum payment they choose to receive in monthly installments, it is still considered a lump sum. F**or SNAP, TANF, ERDC and REF/REFM**, lumpsum income is counted as a resource.

Calculation methods

Calculations are determined by the frequency of pay, the income type and how much of the income is counted monthly.

If the applicant has stable income representative of future earnings, the prospective budgeting calculation is used.

Prospective budgeting calculation

ODHS|OHA will calculate income using provided income verification for at least one month's recent earnings and converted as follows:

- Monthly pay is the same amount with no conversion.
- Once a week pay is converted to a monthly amount by multiplying by 4.3.
- Twice a month pay (e.g., paid 15th and 30th of each month) is converted to a monthly amount by multiplying by 2.
  and
- Biweekly pay (e.g., paid every other Friday) is converted to a monthly amount by multiplying by 2.15.

If the applicant's earnings vary, the variable calculation is used.

Variable budgeting calculation

ODHS|OHA will process earnings in the following method when using the variable budgeting calculation:

- Total at least a month's worth of gross wage pay stubs or pay verification.
- Divide the total by the number of pay periods represented.
  and
- Convert the income as follows:
  - Monthly pay is the same amount with no conversion.
  - Once a week pay is converted to a monthly amount by multiplying by 4.3.
  - Twice a month pay (e.g., paid 15th and 30th of each month) is converted to a monthly amount by multiplying by 2.
    and
  - Biweekly pay (e.g., paid every other Friday) is converted to a monthly amount by multiplying by 2.15.

Periodic income calculation

Periodic income is averaged over the applicable period. For example, income received quarterly is averaged over three months; income received once per year is averaged over 12 months; and income received twice per year is averaged over six months.

The following information applies specifically to OSIPM and MSP:

Periodic income is averaged both for determining financial eligibility for OSIPM and MSP when calculating countable income, and for calculating patient liability for services. However, there are some differences in how it is treated for eligibility vs. liability calculation purposes.

Calculating periodic income for determining eligibility

- Exclude $10 each month, per individual, from the combined amount of earned periodic income and lump-sum income.
- Exclude $20 each month, per individual, from the combined amount of unearned periodic income and lump-sum income.

  Note: This doesn't mean the individual has to have both types of income to receive the exclusion. It means, if they do have both in any given month, the amounts are combined before the exclusion is applied.
- Average periodic income that is ongoing when the individual applies over the applicable period. This is true even if, e.g., the income is paid annually and was received 10 months prior to the DOR and applies to retroactive months as well.
- Do not count or average new periodic income received for the first time in any month after the DOR month until the month it is received.
- Count and average new periodic income received for the first time in the DOR month beginning in the DOR month.
- Average and count new periodic income that is received for the first time in a retroactive month from the first month of receipt forward.

Calculating periodic income for determining service liability

- The $10 and $20 exclusions do not apply.
- Periodic income is not averaged or counted when calculating service liability until it is received in a month after the date of request for services. For example:
  - If the service DOR is September but services don't begin until October, any periodic income received in October will be averaged and counted in the liability calculation beginning in October.
  - An annual $12,000 payment received in January 2019 by someone who requests services in February 2019 will not be averaged and counted when calculating service liability until January 2020.

It is very important to notify individuals who receive periodic income that they should budget accordingly. Caution them against spending the income when they receive it or they may not have the funds to pay their liability in the months the income covers.

Click here for more information on service liability.

Lump-sum income calculation

For SNAP, TANF, ERDC and REF/REFM, lump-sum income is counted as a resource.

The following information applies specifically to OSIPM and MSP:

Lump-sum income is treated as follows if it is received by a member of a financial group.

- $10 is excluded from combined lump-sum and periodic income of each individual.
- $20 is excluded from combined unearned lump-sum and periodic income of each individual.

  Note: This doesn't mean the individual has to have both types of income to receive the exclusion. It means, if they do happen to have both, the amounts are combined before the exclusion is applied.
- At the individual's option, also exclude any amount they turn over to ODHS|OHA for reimbursement of previous assistance.

Count any remaining lump-sum income as earned or unearned income in the month of receipt. For OSIPM, any amount remaining in future months is counted as a resource except retroactive SSB and SSI payments.

Annualized income calculation

The following information applies specifically to SNAP, TANF, ERDC, and REF/REFM programs:

Annualized means the income for a year is divided by 12 to arrive at a monthly amount. If past income is not representative of the income expected for the current year, ODHS|OHA should anticipate the current yearly amount and divide it by 12. Income is usually only annualized in very specific circumstances: self-employment income and contracted income.

Contracted income is only annualized if it meets all of the following criteria:

- The income is not paid on an hourly or piecework basis (the exception to this would be if the contract is specifically for a set number of hours to be paid over a certain time period).
- The income is received in less than a 12-month period.
- The income earned is meant to cover the entire year.

Keys to an accurate calculation

ODHS|OHA will consider the following when calculating an applicant's income:

- Who is included in the financial group for each program, and which income is included or excluded?
- What is the reporting system, if applicable?
- Is it an initial application or redetermination? If the initial month, will anticipated income be different in future months?
- What is the type of income?
- How often is the income received?
  and
- Can the income be converted, averaged or annualized?

ODHS|OHA should always address overtime, tips, vacation pay, holiday pay or commissions, if applicable. It is important to confirm with the applicant that their income verification is representative of the future; non-representative verification should not be used.

Use of rounding in calculating countable income

This section applies to OSIPM and MSP only

All gross income received for a certain time period should be rounded to the nearest dollar. If any calculations are required to convert the income to a stable monthly amount, the result of each calculation is also rounded to the nearest dollar.

IMPORTANT: Rounding is not used when calculating adjusted income or an individual's liability. In other words, you still use rounding to determine countable income, but any calculations after that to determine adjusted income and liability are not rounded. This includes medical costs and any other applicable deductions, which are not rounded at any stage of the calculation.

Click here for examples: Frequency of income.

Oregon Administrative Rule(s)

461-140-0110 — Treatment of Periodic Income
461-140-0120 — Availability and Treatment of Lump-Sum Income
461-145-0490 — Social Security Benefits
461-145-0510 — SSI
461-150-0020 — Prospective Eligibility and Budgeting
461-150-0060 — Prospective or Retrospective Eligibility and Budgeting; ERDC, REF, REFM, SNAP, TANF
461-150-0070 — Prospective Budgeting of Stable Income
461-150-0080 — Prospective Budgeting of Variable Income
461-150-0090 — Prospective Budgeting: Annualizing and Prorating Contracted or Self-employment Income; Not OSIP, OSIPM, or QMB

Other resources

Annual Income Calculator *includes screenshots: Interactive Excel spreadsheet used for calculating annual income utilizing a variety of factors, including payment amount, payment frequency, and hourly wage

Earned income

Earned income is income from the following: compensation for services performed, including wages, salaries, per diem, commissions, tips, representative payee fees, sick leave, vacation pay, draws, income received in exchange for an individual's physical or mental labor. This also includes Health Engagement Model (HEM) payments, or other similar payments. Additional forms of earned income include, but are not limited to:

- Educational income
- Cafeteria plan benefits
- Wages and
- Profit sharing.
- Compensation in a form other than money such as food, clothing, cars, furniture and payments made to a third party (in-kind).

For more information regarding treatment of individual income types, click here for Treatment of specific assets.

Oregon Administrative Rule(s)

461-145-0130 — Earned Income; Treatment

Unearned income

Unearned income is income received by the applicant and/or persons in the financial group other than earned income. Some examples of unearned income include adoption assistance, child support, spousal support, Social Security benefits, unemployment compensation and educational income.

Each unearned income type is treated differently by various programs. Click here for Treatment of specific assets.

Educational income

Educational income is income designated specifically for educational expenses. To be considered educational income, the income must be received by one of the following:

- A student at a recognized institution of post-secondary education

  Note: Post-secondary education is education offered primarily to individuals age 18 and older. Admission may (but does not necessarily) require a high school diploma or equivalent.
- A student at a school for individuals with disabilities
- A student in a vocational education program
- A student in a program that provides for completion of requirements for a high school diploma or the equivalent.

To determine the amount of educational income to exclude, educational expenses listed in the financial aid letter are used unless one of the following is true:

- The student provides verification of amounts different than those listed in the award letter, in which case the verified amounts from the student are used.
- The student receives child care benefits – ERDC benefits or other child care subsidies. The amount the student actually pays for child care (including the ERDC copay) is excluded as educational income instead of the amount shown in the award letter.
- The student states that actual transportation costs exceed the amount allowed for the expense in the award letter. In that situation, the number of miles to and from school is multiplied by 20 cents. The product or the amount shown in the award letter, whichever is greater, is excluded.

The following items are excluded:

- Educational income authorized by the Carl D. Perkins Vocational and Applied Technology Education Act or Title IV of the Higher Education Act or made available by the Bureau of Indian Affairs
- All income from educational loans.

The cost of the following items from the remaining educational funds (including non-Title IV work study, externship, graduate assistantship, graduate fellowship wages and internship) is excluded:

- Tuition, mandatory fees, books and supplies, transportation, required rental or purchase of equipment or

materials charged to students enrolled in a specific curriculum, all miscellaneous personal expenses (except room and board), and loan originator fees and insurance premiums required to obtain an educational loan

- In all programs except ERDC, dependent care.

After allowing exclusions, the remaining income is treated as follows:

- Income received through work study (including work study provided through a VA program or other educational program), fellowships and teaching-assistant positions (not previously indicated to be excluded) is considered earned income.
- Educational income not indicated in the above bullet is prorated over the period it is intended to cover. If the applicant has already received the income, the prorated amount is counted monthly beginning the first month of the period. If the applicant has not received the income at the time the eligibility determination is made, the prorated income is counted starting the month the applicant expects to receive it.

Educational awards paid under the National and Community Service Trust Act of 1993 (including AmeriCorps) are excluded.

Oregon Administrative Rule(s)

461-145-0365 — National and Community Service Trust Act (NCSTA), including AmeriCorps (other than AmeriCorps VISTA)
461-145-0150 — Educational Income
461-145-0550 — Unemployment Compensation Benefits
461-145-0580 — Veterans' Benefits
461-145-0410 — Program Benefits
461-145-0490 — Social Security Benefits
461-145-0001 — Adoption Assistance
461-145-0090 — Disability Benefit

Self-employment income

Self-employment income is received directly from an applicant's own business, trade or profession, rather than earning a salary or wages from an employer. Self-employment is usually a form of earned income; in rare circumstances, it can also be unearned income. Individuals are considered self-employed if they are considered an independent contractor by the business that employs them (e.g., driving companies), or, if they meet four of the five following criteria:

- Are engaged in an enterprise for the purpose of producing income
- Are responsible for obtaining or providing a service or product by retaining control over the work or services offered
- Have principal responsibility for the success or failure of the business operation by assuming the necessary business expenses and profit or loss risks connected with the operation of the business
- Are not required to complete an IRS W-4 form for an employer, and do not have federal income tax or FICA payments withheld from a paycheck, and
- Are not covered under an employer's liability insurance or workers' compensation.

However, there are some individuals who have special requirements and rules regarding whether they are or are not considered self-employed, regardless of whether they meet the criteria listed above. They are as follows:

- Homecare workers paid by APD are not self-employed.
- Child care providers paid by DPU.
- Individuals who sell plasma, redeem beverage containers, pick mushrooms for sale or similar enterprises are considered to be self-employed for all programs except OSIPM-EPD.
- If a member of the financial group actively manages a property 20 hours or more per week, the income is treated in the same manner as self-employment income. If a member of the financial group does not actively manage a property 20 hours or more per week, the income is counted as unearned income with exclusions allowed, only in accordance with Oregon administrative rule.

A self-employed individual may have expenses associated with their business. It is important that ODHS|OHA has this discussion with the participant and makes thorough case notes to explore potential deductions when determining eligibility because each program has different treatment regarding self-employment income and financial eligibility.

Verification of self-employment income can include tax records, business ledgers or other business records that clearly show the business income. In most situations, the past year's records can be used to budget for the current year, unless the applicant states this income is not representative; in this case, new verification is needed and can be anticipated based on the past month or more.

Click here for the Self-Employment Worker Guide.

SNAP Self-employed persons should have their income annualized when the self-employed person has been in business for a year or more and the income is representative. This income should not be changed at the Interim Change Report, and ODHS|OHA would not make the applicant provide verification of their income again.

If the self-employed person has not been in business for more than one year, but their past income is representative, ODHS|OHA can accept what they have as verification.

If the self-employed person has been in business for a year or more but the past income is not representative, the current situation is used. This may be the last month, or the last six months. A conversation is needed with the applicant to determine what is most representative.

Some income types are rarely seen in the branch. Other types are treated differently depending on the individual case situation. For example, an in-home caregiver may be an employee receiving a wage or may be self-employed. The determination must be made carefully for each applicant. The self-employment determination is not made based on who pays the income taxes, FICA or worker's compensation for the applicant.

A person has self-employment income if they are working in their own business, trade or profession where they are responsible for obtaining or providing the service or product. Individuals who are self-employed independently determine the manner, method and process of business operations, and they have full responsibility for the success or failure of the business operation. If the person does not meet

those criteria, they are not considered self-employed.

For SNAP, self-employment income is generally annualized if the business has been in operation for more than 12 months; the income may be earned part of the year but intended to live on for the full year, and the applicant anticipates the income from the past is representative of the future. However, ODHS|OHA should not annualize the income if the past income does not reflect the household's actual income circumstances because the business is experiencing a substantial increase or decrease in business.

In this situation, the self-employment income should be calculated based on anticipated earnings. In addition, income is not annualized if it is earned in part of the year, it is not intended to cover the full year, and the applicant has different employment for the other part of the year.

TANF In the TANF program, Gross income from a self-employed participant is used for eligibility. TANF does not use any deductions to the self-employed income in the calculation for income limits. The gross earnings are used for the initial and exit TANF income limits with no deductions used in the determination. This may be the annualized 12-month income or the representative income from the self-employment business.

ERDC The gross earnings of a self-employed individual are used before deductions when reviewing for ERDC eligibility. This means the total earnings are compared to the initial, exit and ongoing ERDC income limits to determine whether the family is eligible for ERDC prior to exploring costs or deductions of the business. If the family is below the ERDC income limits using the gross earnings of their self-employment income, they meet ERDC income eligibility. Costs can be determined at this point.

Determining costs

There are various ways to treat self-employment income within ERDC:

- **No costs**
  - If the applicant states they have no cost associated with running their business, the full gross amount is used.
- **50% cost**
  - If the applicant states they have at least $1 in costs, they receive the 50 percent deduction. This does not need to be verified. Most businesses have at least $1 in costs.
- **Total allowable costs**
  - If the applicant says they have more than 50 percent in costs, the full allowable cost can be used. The amount of the deduction does not need to be verified but is limited to costs that fit the definition of an allowable cost as described in Treatment of specific assets.

In the ERDC program, individuals may choose if they would like to deduct costs or not. Because countable income is directly tied to their copay amount, it is up to the family to make the best choice financially, whether they need more child care hours or a lower copay (a higher income will result in higher child care hours and a higher copay, while a lower income will result in lower child care hours and a lower copay).

After subtracting the deduction, if any, from the gross self-employment income, what remains is used to determine the copay.

In ONE, workers need to select which option the family has chosen (zero, .5, or actual cost) in the ERDC Self Employment Deduction screen after running eligibility. After doing so, the system will calculate and display child care hours and copay.

For information regarding child care hours for self-employed individuals, click here for Child care hours.

REF No additional program-specific information.

MSP No additional program-specific information.

OSIPM In all other programs, self-employment is determined strictly for financial purposes. Some types of income that do not meet the typical definition of self-employment are categorized as such anyway. When determining eligibility for OSIPM-EPD, employment or self-employment is also a condition of eligibility; as a result, the definition of self-employment is more restrictive for that program.

See Employed Persons with Disabilities for more information.

HSD For HSD medical programs, income is considered self-employment if it is listed on individuals' taxes as self-employment. For individuals who do not file taxes, use the tool provided on the income screens within ONE to determine if they are self-employed. The combined total amount of all business-related expenses should be coded on the MAGI Deductions screen using the Deduction Type "Self-Employment Expenses." These expenses are used as a deduction against all income sources. For example, an individual with $500 earned income, $700 self-employment and $1,000 self-employment expenses will have MAGI countable income of $200 [($500+$700)-$1000)].

Click here for examples: Self-employment income.

Oregon Administrative Rule(s)

461-145-0910 — Self Employment; General; Not OSIP, OSIPM, or QMB
461-145-0915 — Self-Employment; General; OSIP, OSIPM, QMB
461-145-0130 — Earned Income; Treatment
461-145-0120 — Earned Income; Defined

Other resources

Self-Employment Income: How to identify self-employment and use the Self-Employment Screening Tool and the types of verification used for self-employment, reading tax forms, and review of Self-employment screens in ONE.

Terminated income

Terminated income is income an individual reports they are no longer expecting to continue. This is often due to lost employment, or a reduction in other types of benefits, such as Social Security. Terminated income is treated differently in each program but is not considered to be ongoing income.

Click here for Job separation and voluntary reduction of hours.

SNAP People on strike

Strikers include the following:

- Employees on strike
- Employees involved in a concerted work stoppage effort, and
- Employees whose work stopped due to the expiration of a collective bargaining agreement.

Individuals are not considered to be participating in a strike when the following occur:

- The work place is closed by the employer to resist the employees' demands (lock-out).
- They are unable to work because of striking employees (e.g., a lumber mill strike may make truckers who deliver lumber unable to work).
- They end employment with the company involved in the strike and accept another full-time job. To qualify as a full-time job, the job must be for 30 hours or more per week and pay at least the federal minimum wage times 30 hours.
- The striker loses their job because the employer hired a permanent replacement.
- They are exempt from the work registration requirements under OFSET the day prior to the strike due to a reason other than being employed 30 hours a week.

Individuals cannot receive increased SNAP benefits because of an income decrease due to participation in a strike. The individual on strike is choosing not to access earned income available to them. Therefore, the pre-strike income is considered available in the eligibility determination.

To determine eligibility and benefits for applicants, ODHS|OHA will count each striking member's full month's income prior to the strike. ODHS|OHA will also consider all other SNAP eligibility factors.

Strikers are required to register for SNAP employment and training programs. Applicants who must participate in a work program should be made aware of jobs that are vacant due to a strike. However, they are not required to accept said jobs.

TANF No additional program-specific information.

ERDC For ERDC, income is budgeted so the anticipated amount is the same for each month, including the initial month.

Income is calculated in ONE as follows:

(First month's income) + (ongoing income x 11 months) = total income for the certification period / 12 months = monthly income.

For ERDC, income from employment is still required when determining initial eligibility.

REF No additional program-specific information.

MSP No additional program-specific information.

OSIPM No additional program-specific information.

HSD No additional program-specific information.

Oregon Administrative Rule(s)

461-150-0050 — Prospective Eligibility and Budgeting; OSIP, OSIPM, and QMB
461-150-0060 — Prospective or Retrospective Eligibility and Budgeting; ERDC, REF, REFM, SNAP, TANF
461-130-0328 — Effect of Strikes

Unpaid work

Individuals may sometimes work without receiving payment. This is called unpaid work. Examples of unpaid work might include doing odd jobs, volunteering, bartering, internships, work study or job training.

Unpaid work will usually result in no income. However, there are certain situations where it is exchanged for in-kind income, such as free housing or other benefits. For more information regarding this type of exchange, click here for Earned income.

SNAP No additional program-specific information.

Click here for SNAP employment services.

TANF No additional program-specific information.

Click here for Working with families.

ERDC No additional program-specific information.

REF No additional program-specific information.

MSP No additional program-specific information.

OSIPM No additional program-specific information.

HSD No additional program-specific information.

Expenses and deductions

At the time they apply for benefits, applicants may be paying for items or services. These are called expenses. Common expenses include housing expenses such as rent or mortgage payments, utility payments such as electricity or cell phone payments, child care payments, child support payments, Medicare premiums and medical bills. Some programs allow a deduction for certain expenses; some also allow standard deductions that are not expense-related. These deductions may affect program eligibility or benefit level.

There are various expenses individuals may pay on a monthly or yearly basis that may be considered when determining program eligibility.

Types of expenses

Child support (and arrearage)

Individuals may be paying court-ordered child support on a sporadic or monthly basis for a child residing out of their home. They may also be paying back-payments, called arrearage.

Spousal support and alimony

Spousal support means income paid (voluntarily, per court order or per administrative order) by a separated or divorced spouse to the other spouse.

Domestic violence related expenses

This applies specifically to the TA-DVS program.

Some individuals applying for TA-DVS may have expenses related to their safety situation. There is a form available to help workers determine survivors' financial eligibility: Temporary Assistance for Domestic Violence Survivors Eligibility and Benefit Calculation Worksheet (ODHS 1542). Domestic violence related expenses are removed from the applicant's available income as it has been set aside for a purpose related to their safety. Click here for the Temporary Assistance for Domestic Violence Survivors (TA-DVS) Eligibility and Benefit Calculation Worksheet.

Educational expenses

Students may be paying for educational expenses, such as tuition, books, meal plans or child care associated with their schooling.

Medical expenses

Medical expenses include any payments made by the applicant for medical expenses for themselves or another member of the filing group.

Shelter expenses

Shelter expenses include payments for housing such as rent, mortgage, mortgage insurance, property taxes, homeowner's association fees, etc.

Utility expenses

Utility expenses include payment for utilities such as electric, gas, garbage, internet, telephone and other utility payments.

Impairment-related work expenses

Impairment-related work expenses (IRWEs) are payments for a service or an item that is excluded for SSI eligibility/payment purposes when the severity of the impairment is such that the individual must purchase or rent items and services in order to work.

To be allowed as an IRWE, the expense must be directly related to work and it must be necessary, due to the individual's disability.

Employment and independence expenses

Employment and independence expenses (EIEs) are specific to the Employed Persons with Disabilities program. They are expenses that contribute to the person's ability to work and enhance independence.

Any expense that can reasonably be expected to enhance the individual's independence and facilitate employment will be allowed as an EIE deduction. EIEs may include costs for vehicle modifications, assistive technologies and payments to approved accounts.

Blind work expenses

Blind work expenses (BWEs) are expenses incurred by blind individuals. These expenses facilitate employment and independence. They are very similar to IRWEs and EIES, except that the person must be blind in order for the costs to count as deductions. BWEs include costs that workers without disabilities must pay, such as taxes, union dues and payroll mandatory contributions (such as pensions and disability insurance).

Deductions of expenses

Many expenses may be used as a deduction within the SNAP program that may affect a household's monthly SNAP allotment.

SNAP The following expenses may be considered when determining the deductions within the SNAP program:

Medical expenses

To be eligible for a deduction for medical expenses, individuals must either meet the SNAP definition of "elderly" or "individual with disabilities."

Filing groups with more than $35 in allowable monthly medical expenses and less than $205.01 in medical expenses will receive a standard medical deduction (SMD) of $170 from their countable income.

Filing groups with more than $205 in allowable monthly medical expenses will receive a deduction of the actual verified amount of their medical expenses.

Medical deduction chart

Filing groups with more than $35 in allowable medical expenses and less than $205.01	Filing groups with more than $205 in allowable medical expenses
Standard medical deduction ($170) from their countable income	Deduction of the actual verified amount of medical expenses minus $35

Allowable medical expenses

A medical deduction is allowed for the expenses of services provided by, prescribed by or used under the direction of a licensed medical practitioner. Examples of allowable medical expenses include, but are not limited to:

- Health insurance premiums, deductibles and coinsurance (includes Medicare premiums not covered by Medicaid and EPD participant fees)
  - Long-term-care insurance premiums are deductible if the insurance pays for services while an

individual is receiving waivered or nursing facility services or is in an intermediate care facility for those experiencing cognitive disabilities.

- Medical and dental care, including psychotherapy, rehabilitation services, hospitalization and outpatient treatment
- Prescription drugs and medications prescribed by a licensed medical practitioner, as well as medical supplies and equipment, dentures, hearing aids, prostheses and prescribed eyeglasses (Postage expenses for order-by-mail prescriptions are also allowable.)
- Over-the-counter medications approved by a licensed practitioner or other qualified health professional (no formal written prescription is required)
  - Medical supplies include prescribed adult-sized diapers, such as Depends.
  - Medical supplies do not include special diets or special foods prescribed by a doctor. A person on a low- or high-sodium diet may purchase prescribed high-sodium foods with their SNAP benefits. Some dietary drinks high in nutrients may be purchased on a medical card.
- Nursing care, nursing home care and hospitalization, including payments on bills for people who were members of the household immediately prior to entering a state-certified hospital or nursing home
- Maintaining an attendant, a home health aide, a housekeeper or dependent care services due to age or illness, including an amount equal to a one-person SNAP payment standard when the individual furnishes the majority of the attendant's meals
- Individual offset payments when residing in a group living facility
  - Service expenses are allowable, which is the amount over room and board.
- Prescribed assistance animals (such as seeing-eye dog, a hearing dog or housekeeper monkey) that have received special training to provide a service to a participant (This deduction includes the cost of acquiring these animals, their training, food, and veterinarian bills.)
  - Special training means the animal has been trained to do something for their owner that the animal would not normally know to do. The training needs to be related to providing a service the individual needs due to their disability. Obedience training does not constitute special training.
  - Questions to consider:
    - » What disability created the need for the service animal?
    - » What is the service the animal is providing?
    - » What is the training the animal received?
- The reasonable cost of transportation and/or lodging needed to obtain medical treatment or services.
  - The same rate as approved by DMAP for medical transportation should be used. This can be found in the NEMT Brokerage Operations Manual on page 59.

Unallowable medical expenses

Some medical expenses are not allowed when ODHS|OHA is reviewing an individual's medical deductions. Examples of unallowable medical expenses include, but are not limited to:

- Expenses for items that can be purchased with SNAP benefits (e.g., special diets, nutritional drinks or organic food) (This is true even if the medical practitioner is prescribing the special food items for the individual.)
- Expenses related to medical marijuana or growing medical marijuana
- Expenses for gym memberships for general health purposes
- Expenses that are past due, defaulted or carried over from a previous billing period
- Medical expenses paid by credit card (Medical expenses paid by credit card are considered to be paid in full at the time the payment is made. The subsequent ongoing credit card payments are not allowable as a medical deduction.)
- Any medical expenses of other filing group members who do not meet the SNAP definition of elderly or individual with disabilities.

Verifying medical deductions for elderly/individuals with disabilities

Medical expenses must be verified. Verification of medical deductions can come in many forms. Verification could include a call to a provider's office to validate such things as payment plans and payment status, bill amounts or frequency of visits to help determine anticipated ongoing copays. Other types of verification may include, but are not limited to, receipts for over-the-counter medications, receipts for supplies showing the purchase and purchase amount, print-outs from pharmacies showing monthly medications, and the number of months for which the prescription was supplied.

Verification of medical expenses should include the specific cost, the frequency of use and proof the services are under direction of a licensed medication practitioner. Verification could include a prescription, note or collateral contact.

Monthly expenses of $35 or less will result in no medical deduction, so the applicant's statement is an acceptable form of verification.

Monthly expenses of at least $35.01 but not over $205 will result in the standard medical deduction, so at least $35.01 per month in expenses must still be verified.

Monthly expenses over $205 must be fully verified to allow the actual expenses.

- If the applicant reports expenses over $205 but submits verification of at least $35.01 but not over $205, the amount verified that will result in the standard medical deduction will be used instead of actual expenses.

At application and recertification

At initial application, ODHS|OHA verifies medical expenses of at least $35.01 if the individual is to receive the SMD. If an individual has verified medical expenses of at least $35.01 and less than $205.01, ODHS|OHA codes the reported amount of the monthly medical expenses. If an individual reports monthly medical expenses greater than $205, all medical expenses must be verified.

At recertification, medical expenses do not need to be verified and the individual's statement is acceptable, unless the individual reports a change in their medical expenses that causes them to increase over $35 (if they were previously paying under this amount) or if medical expenses increase over $205.

At both initial application and recertification, a reasonable estimate of the individual's expenses should be used for the certification period. When current and anticipated medical expenses have been determined, ODHS|OHA averages the total over the certification period by combining current and expected medical expenses as follows:

- All current medical expenses are verified. Expenses can include installment payments on a bill, as long as the bill a) has not been allowed previously, b) the installment plan arrangements were made with the creditor before the bill became past due, and c) the individual has not defaulted on the plan.
- • Any current medical insurance expenses and coverage are verified to determine the portion of each medical cost the individual is responsible to pay.
- • Any future medical expenses are reasonably anticipated to occur during the certification period based on the individual's medical history. The Medical Expense Worksheet for Supplemental Nutrition Assistance Program (SNAP) (DHS 0221MED) form may be used to calculate the allowable ongoing medical expenses.

Medical expenses reported during the certification period

If an individual reports unanticipated medical expenses they have incurred during the certification period, a deduction is allowed for the new or increased cost only if it is not past due or carried forward from a previous billing period. For medical expenses reported in the certification period, individuals may choose for ODHS|OHA to do one of the following:

- Allow the cost the month after it is reported, or
- Average the cost as follows:
  - Whether paid or not paid and not past due, ODHS|OHA averages it from the first of the month after which it was reported to the end of the certification period.
  - If the individual gets a medical bill they have not paid and it is not yet past due but due after their certification period ends, the deduction is allowed in the next certification period.

  or
- Allow the amount of an installment payment if the individual and creditor made an installment plan before the bill became past due and the individual has not defaulted on the loan.

After using one of these methods to determine how much of an unanticipated medical bill changes the deduction amount for each month, ODHS|OHA staff will adjust benefits for the future. No restoration of lost benefits is needed because there has not been an administrative error in this case.

Medical deductions are determined prospectively, and when there is a change, the new deduction amount only prospectively affects the future. Therefore, when an individual reports a paid medical cost in the last month of their redetermination period, there is no adjustment needed. Benefits for the current month

have already been issued, and prospectively, since the bill has been paid, there is no medical expense expected for the next certification period.

Other resources

Medical Expenses: Medical expenses are allowable deductions for SNAP and Medical Programs. QRG covers the policy for medical expenses, screen steps, and verification requirements.

Dependent care expenses

This deduction is allowed when the SNAP group has a cost for caring for a dependent in the filing group who requires care. The care must be necessary for the caretaker to accept or maintain employment, comply with work registration requirements, attend training/education preparing them for a job, or look for work.

Dependent care expenses are not an allowable deduction when:

- The expense is being paid by JOBS or SNAP E&T programs (unless there is an additional out of pocket cost to the parent, called an overage)
- There is no unmet need (negative dollar amount) for a higher education student
- An unemployed parent is in the home and able to provide the care.

Common dependent care deductions include ERDC copay amounts, private payment made to a child care provider by the caretaker, or ERDC overage amounts (the amount unpaid by ODHS|OHA but still incurred to the parent). Other allowable dependent care deductions include the federal mileage reimbursement rate for transportation of the dependent child to and from care, and other fees associated with the dependent child's care and ability to participate in activities such as sports, preschool or afterschool programs.

Dependent care deductions are not allowed when the person providing care for the child is part of the filing group, or if the provider is the dependent's biological, adoptive or stepparent.

Court-ordered child support payments

Individuals may pay child support payments. This area differs from other SNAP deductions because it depends on what the individual pays, rather than what they are billed. Individuals paying legally obligated child support for children outside the household receive this deduction. This means the child for whom the support is paid cannot be a member of the household group. Child support deductions include the amounts the individual is paying for both current child support and arrearages (back payments), unless the payment is collected by Set-Off of Individual Liability (SOIL) recovery.

The child support deduction is limited to the amount a member of the filing group is paying for child support. The amount a noncustodial parent pays toward the child's medical bills or health insurance coverage is also allowed as part of this deduction.

To allow the deduction for payment of child support, both of the following must be true:

- The child support must be court-ordered.
  and

- The child(ren) the support is for cannot be in the same household group as the person ordered to pay the child support.

If each of the above is true, the following must be verified before the deduction can be allowed:

- That the support is court-ordered
- Which child(ren) the support is for, and
- The amount of child support the applicant is paying/has paid.

Utility Costs/Deductions

Allowable shelter and utility expenses help determine if a shelter deduction (the excess shelter deduction or the homeless shelter deduction) may be used in the calculation of the household's monthly SNAP allotment. The first step is to determine if there are allowable costs for shelter (housing) and for utilities.

Allowable Utility Expenses

When applicants have utility expenses, they are allowed a deduction based on the utilities they incur. The filing group must be billed for or paying these payments, which could include heating and cooling, cooking fuel, electricity, water, sewer, well installation and maintenance, septic tank system installation and maintenance, garbage collection fees, and the basic service fee and taxes for one telephone including a cell phone. Heating and cooling or cooking can be with electricity, natural gas, oil, propane, wood or other fuels.

If a household claims their vehicle as their home, gasoline is allowed as a utility cost when it is used for heat.

The receipt of energy assistance does not affect the utility deduction as long as the group will incur and be billed for heating and cooling expenses in excess of the energy assistance.

Each filing group must have an identified utility bill. Utility expenses included in rent are not generally a separately identified bill. To be separate, the rent receipt or identified billing statement must break out each identified cost (i.e., $350 rent, $50 electricity, $20 water and sewer, etc.).

When a filing group has allowable utility expenses, they receive one of four standard utility allowances in the calculation of their deduction. The standard amount is set by the state and derived from the average utility expenses for households in Oregon. Applicants with allowable expenses receive one of these four allowances. There is no additional allowance for actual utility expenses in excess of the utility allowances. There is also no proration when two or more filing groups share a residence and each pay utility expenses. There is no proration of the utility allowance for filing groups with ineligible members.

Utility Allowances

The utility allowances are based on allowable utility expenses as follows:

- **Full utility allowance (FUA):** To be eligible for FUA, the filing group must be incur the cost on a regular basis for its heating and cooling expenses.
  - Cooling expenses do not include portable home fans. All fuels (including geothermal, solar

panels, wood, oil, propane, gas and electricity) are considered heating expenses if they are the primary source actually used for heating.

- Wood heat is an allowed cost if the filing group purchases wood. This does not include the cost of a cutting permit, gas for a truck to haul the wood, chain saw expenses, etc.
- FUA is not allowed for the use of cooking stoves or electric blankets as a heat source. Space heaters and stoves (wood, pellet, coal, etc. used for heating purposes only) are utility expenses but do not qualify the household for FUA if it is a supplement to the main source of heat. If it is the only source of heat, the household does qualify for FUA.
- FUA is allowed based on the applicant's statement that they have these expenses unless it is questionable.
- The filing group must incur an out-of-pocket expense for the heating/cooling expenses. If the applicant is billed for their individual usage or a flat rate for heating/cooling expenses separate from the rent, FUA is allowed. Verification is not necessary unless questionable.
- FUA is not allowed for filing groups charged a flat amount for rent and utilities that do not separately identify heating and cooling expenses.
- Some applicants have low-income housing and receive a HUD payment for utility expenses. The HUD utility reimbursement (paid directly to the individual or to the utility company) may cover all or most of the heating bill. If the individual is responsible for the balance of the bill, they are also eligible for FUA.
- If a filing group is sharing a dwelling with another group and they share utility expenses, FUA may be given to each group paying a share of the heating expenses. There is no proration.

- **Limited utility allowance (LUA):** The limited utility allowance is given when the filing group is paying for at least two allowable non-heating utility expenses, such as telephone and water bills.
  - One cost may be for a telephone. More than one phone does not count as more than one utility expense.
  - Cable and internet are not allowable utility expenses.
  - The cost for phone cards are not allowable utility expenses.
- **Telephone utility allowance (TUA):** The telephone utility allowance is given when the filing group is paying for a telephone or prepaid cell phone and has no additional utility expenses.
  - The telephone may be a landline, a cell phone or an internet phone service.
  - A filing group that pays only for a cell phone qualifies for TUA even if another filing group in the household has a landline available.
  - The cost for phone cards are not allowable utility expenses.
- **Individual utility allowance (IUA):** The individual utility allowance is given when the filing group is billed on a regular basis for one allowable non-heating cost, such as a water bill.
  - This cost cannot be for a telephone.
  - Cable and internet are not allowable utility expenses.

Utility Deduction

There is no utility deduction. The appropriate allowance will be used in the calculation to determine is a shelter deduction is used in the SNAP budget.

Shelter Costs/Deductions

Allowable Shelter Expenses

Shelter or housing expenses include billed amounts for continuing charges for rent, mortgage (including a second mortgage) or other continuing payments leading to home ownership, including interest on such payments. These expenses must occur where the filing group is currently residing. See below for costs incurred for an unoccupied home.

The applicant's monthly mortgage bill is allowed as a housing expense even when it is not being paid because it is in foreclosure or is a reverse mortgage, if the applicant is still incurring the cost/debt.

Payments on a home equity loan or line of credit are also allowed if the home is listed as collateral on the loan, and the financial institution is listed as a lien holder on the home.

Other allowable housing expenses include:

- Property taxes (even when they are deferred)
- State and local assessments
- Mortgage insurance premium (MIP)
- Insurance on the structure of the home
- Condominium and association fees charged to owners and renters to cover common area expenses
- Itemized housing expenses paid at the time of closing, such as insurance and property taxes
- Expenses that are not reimbursed by private or public sources for repairing a home damaged or destroyed by a disaster (such as fire or flood)
- For homeless groups living in their vehicle, payments on the vehicle and the portion of insurance payments that cover vehicle damage (comprehensive and collision only).

Unoccupied home. In addition to shelter costs incurred where the SNAP group resides, allow a deduction for a home the group is not occupying, if all of the following are met:

- The home is unoccupied because of illness, employment or training away from home, natural disaster or casualty loss;
- The SNAP group intends to return to the home;
- Any current occupants are not claiming shelter costs for SNAP; and
- The home is not leased or rented.

For an unoccupied home, allow only the actual verified utility costs as a deduction. Do this by adding the actual utility costs to the housing cost. Do not give the FUA or LUA for utilities on an unoccupied home.

Unallowable housing expenses include:

- Expenses to insure furniture or personal belongings

- Renters' insurance, even if it is required by the landlord in order to live in the dwelling
- Payments on delinquent property taxes and their interest
- Closing expenses.

Additional considerations:

- The individual can choose whether to allow the housing expense in the month it is billed or becomes due, or to average the cost over the period it is intended to cover. Therefore, a tax or insurance bill could be allowed as an expense in one month or averaged.
  - For example, to average a tax bill for $1,800 over a 12-month period, the deduction would be $1,800 divided by 12 months = $150 per month. This tax amount would be added to any payment amount plus averaged insurance amount to calculate the total monthly housing deduction. The worker does not do this calculation, ONE does it. The worker will code $1800 billed annually.
  - It is often to the best interest of the applicant to average the cost over a period of time and receive increased benefits for the total certification period, rather than allowing the cost in one month and increasing benefits for one month only.
- For housing expenses billed on a weekly or biweekly basis, these payments are converted to a monthly amount by multiplying weekly amounts by 4.3 and biweekly amounts by 2.15. ONE will do this calculation when the worker coded the amount and the frequency correctly.
  - For example, an applicant charged $80 per week for housing expenses would have a housing cost of $80 x 4.3 = $344 per month.
- When a filing group shares housing expenses with persons in the dwelling who are outside the group, the deduction is allowed only for the amount actually incurred by the filing group.
  - For example, if two groups each pay half of the $450 rent, a $225 deduction is allowed. In addition, if the filing group collects the rent from the other group and then forwards the full amount to the landlord, the $225 is not counted from the other group as income or as a housing cost. This is because it is considered unavailable and does not affect the SNAP calculation.
- In some instances, a SNAP filing group does not have an allowable shelter expense because they are not responsible for the shelter expenses.
  - A SNAP group may not be responsible for the shelter expenses if they are working at an apartment complex in exchange for rent. In this situation, the value of the rent is not counted as income because it is income-in-kind.
  - In addition, the SNAP group does not have an allowable shelter expense for the value of the rent because the group is not responsible for making the rent payment.
  - Similarly, if a SNAP group receives Section 8, HUD, or other community agency housing assistance that pays part or all of their monthly rent expenses, the SNAP group does not have an allowable shelter expense for the portion paid by housing assistance.
- If an individual has a reverse mortgage (also sometimes known as a home equity conversion mortgage) on their primary residence, the following shelter expenses are allowed in addition to any

property tax and homeowner's insurance:

- Periodic monthly accrued interest charge
- Recurring finance charges
- Mortgage insurance premiums/payments (MIP)
- Recurring fees
- Required scheduled payments
- Continuing charges for other mortgages on the primary residence.

- Payments or proceeds from a reverse mortgage are not allowed as a shelter deduction. These payments are considered loan income.

Shelter Deductions

If the filing group has allowable shelter (housing) costs and/or an allowable utility allowance that information is used to determine if they receive a shelter deduction. The allowable expenses are not a deduction from the income . The shelter deduction is deducted from the income. There are two shelter deductions – the Excess Shelter Deduction (ESD) and the Homeless Shelter Deduction (HSD). Each filing group is eligible for only one shelter deduction if they have allowable costs. They are to receive the higher amount between the ESD and the HSD.

Excess Shelter Deduction

The ESD is determined by first totaling the gross income, less the earned income deduction, the standard deduction, dependent care deduction, medical expense deduction, and court ordered child support deduction. This gives the adjusted income amount. Next, determine the total shelter costs by adding the allowable shelter costs and the appropriate utility allowance the household is eligible for. Subtract half of the adjusted income from the total shelter. The remaining amount is the excess shelter cost.

- If less than the maximum ESD limit ($597 as of 10/1/21, the lesser amount calculated is the ESD.
- If more than the maximum ESD limit, then the maximum ESD is allowed unless there is an elderly or person with disabilities filing group member.
- If there is an elderly or person with disabilities filing group member the actual amount calculated is the ESD.
- Next check to see if the household is eligible for the Homeless Shelter Deduction.
- If not entitled to the HSD use the ESD in the calculation of adjusted income and benefits.

Homeless Shelter Deduction

The HSD is an alternative to the ESD for homeless households that do not receive free shelter throughout the month (i.e., homeless households with some shelter expenses). A homeless household with qualifying shelter expenses is eligible for the HSD ($159.73 as of 4/1/2022) in lieu of the ESD if the HSD is higher than the calculated ESD. The HSD will be subtracted from the countable income, after all other appropriate deductions, to determine the eligibility and allotments for the household.

"Homeless" means lacking a fixed regular and adequate nighttime residence and includes living in an

emergency shelter; shared housing with others due to loss of housing or economic hardship; or staying in motels, cars, parks, public places, tents, trailers, or other similar settings.

For homeless applicants, the household group consists of the individuals who consider themselves living together.

ONE will identify individuals who are homeless via a series of questions on the living arrangement screen.

TANF This does not apply to the TANF program.

ERDC This does not apply to the ERDC program.

REF This does not apply to the REF program.

MSP Calculate adjusted income by subtracting allowable deductions from countable income. Allow income deductions from the financial group's income in the following order:

- All child support paid by a non-applying spouse to any individual who does not live in the household
- One standard deduction of $20 (see note below)
- One standard earned income deduction of $65
- An income deduction for documented impairment-related work expenses
- One-half of the remaining earned income
- An income deduction for documented blind work expenses
- Any earned income used to fulfill a plan for self-support approved by the Social Security Administration.

Note: Subtract the $20 standard deduction from unearned income. If the financial group has no unearned income or less than $20 in unearned income, subtract the remainder from any earned income.

OSIPM Calculate adjusted income by subtracting allowable deductions from countable income.

Determine adjusted income as follows:

Individuals who live in the community with no children in the household (not EPD)

For the purposes of this section:

- Ineligible spouse means a spouse who is not eligible to receive either SSI or TANF benefits.
- Child means an individual who meets all of the following:
  - Is unmarried
  - Is not considered a decision-maker in the household
  - Is age 0–17, and
  - Has at least one natural or adoptive parent in the same household.
- Ineligible child means an individual who meets all of the following requirements:

- Is unmarried
- Is living with a natural or adoptive parent
- Is not considered a decision-maker in the household
- Is not eligible to receive SSI or TANF benefits, and
- Is either age 1–17, or 18–22 and attending full-time secondary, post-secondary or vocational-technical training designed to prepare the individual for employment.

The following deductions are used for applicants who:

- Live in the community or in 24-hour MH residential care settings
- Are not assumed eligible
- Do not receive nursing facility or home and community-based care, and
- Have neither ineligible children nor children in the HH group.

Single individual

If the individual has no spouse in the household group, deductions from the individual's countable income are made in the following order:

- One standard deduction of $20. This is deducted from unearned income first, and if unearned income is < $20, the remaining deduction is applied to earned income (if any).
- The following earned income deductions:
  - $65
  - An additional deduction for documented impairment-related work expenses
  - One-half of the remaining earned income
  - Any income deduction for documented blind work expenses
  - Any earned income used to fulfill a plan for self-support by the Social Security Administration.

If the individual's adjusted income is below the applicable OSIPM income limit for a need group of one, the individual meets the OSIPM income requirements.

Individual married to a spouse who is eligible to receive SSI or TANF

If the applicant is married to a spouse who is eligible to receive SSI or TANF, they are in the same financial group. Deductions from the couple's countable income are made in the following order:

- One standard deduction of $20. This is deducted from unearned income first, and if unearned income is <$20, the remaining deduction is applied to earned income (if any).
- The following earned income deductions:
  - $65
  - An additional deduction for documented impairment-related work expenses
  - One-half of the remaining earned income
  - Any income deduction for documented blind work expenses

- Any earned income used to fulfill a plan for self-support by the Social Security Administration.

If the couple's adjusted income is below the two-person OSIPM income standard, the individual meets the OSIPM income requirements.

Individual married to an ineligible spouse

If the applicant is married to an ineligible spouse who is in the household group, the applicant must first be financially eligible as an individual. Compare the adjusted income of the applicant (using the deductions for single individuals above) to the one-person OSIPM income standard. If the applicant is over the one-person standard, the applicant is financially ineligible, and you don't need to go further. If the adjusted income of the applicant is less than the one-person standard, proceed as follows:

- First, we deduct any child support the ineligible spouse pays for any individual outside the household group from the ineligible spouse's countable income. It is deducted from unearned income first, and any remainder is deducted from earned income.
- If the remaining countable income of the ineligible spouse is:
  - Greater than $420: Combine the countable income of the applicant and the ineligible spouse/ Take the deductions as described above and compare the resulting adjusted income to the two-person OSIPM income standard. If the resulting adjusted income is equal to or greater than the two-person OSIPM income standard, the applicant is not financially eligible.
  - Equal to or less than $420: Consider only the income of the applicant. As previously calculated in this section, the adjusted income of the applicant is less than the one-person OSIPM income standard. The applicant thus meets the OSIPM income requirements.

Individuals who live in the community with children in the HH (not EPD)

"Allocation" is an amount deducted from an ineligible spouse's income for each child not applying for OSIPM who lives in the household. The amount of the allocation is the difference between the couple SSI standard and the individual SSI standard (currently $420 in 2022).

"Parental living allowance" is the SSI/OSIPM standard for two if both parents are in the household or for one if one parent is in the household.

The following procedures come from the SSA POMS Manual SI01320.400 and SI01320.500.

Adult applying

1. If the applicant has an ineligible spouse, the applicant must first be income eligible as an individual. Compare the applicant's adjusted income (after deductions, see 461-160-0551(7) (b)through (g)) to the one-person OSIPM income standard. If the adjusted income of the applicant is less than the one-person standard, the applicant is eligible as an individual and you can proceed to the next step. If the adjusted income of the applicant is at or above the one-person standard, STOP. The individual is not eligible for OSIPM.

2. If the applicant is income eligible as an individual, deduct any child support the ineligible spouse pays for any individual outside the household group from the ineligible spouse's countable income. Like

the $20 standard deduction, it is deducted from unearned income first, and then any remainder is deducted from earned income.

3. From the ineligible spouse's remaining countable income, allocate a maximum of $420 to each ineligible child of the couple. The ineligible child's income is subtracted from the maximum $420 allocation to determine the actual amount.
4. Allocate from unearned income first and then, if necessary, from earned income.
5. If the remaining countable income of the ineligible spouse is more than $420, add the individual's remaining income to the applicant's income; subtract the normal income deductions (see 461-160-0551(7) (b) through (g)); and compare to the two-person non-SSI OSIPM income standard. The adjusted income must be less than the OSIPM income standard.
6. If the remaining countable income of the ineligible spouse is equal to or less than $420, consider the income of the applicant only. As previously calculated in step 1, the adjusted income of the applicant is less than the one-person OSIPM income standard, so the applicant meets the OSIPM income requirements.

Child applying

1. Income from ineligible parents is considered and an allocation to each ineligible child is done first. The ineligible child's other income is subtracted from the maximum $420 possible to determine the actual amount.
2. From the remaining countable income, allocate from unearned income first and then, if necessary, from earned income.
3. Take the normal income deductions from the remaining parental income (see 461-160-0551(7)(b) through (g)).
4. Deduct the SSI/OSIPM income standard for one or two (Parental Living Allowance), depending on the number of parents in the household.
5. The income left is deemed proportionately to each applying child.
6. If deeming to multiple children, the deemed income is split evenly among the applying children.
7. The deemed income is then added to each applying child's other countable income. Deductions are then taken and compared to the OSIPM non-SSI income standard for one person.

See here for EPD

Long-Term Care (LTC) services use standard deductions, medical costs and other expenses when calculating the adjusted income to determine the patient liability.

See here for more information on LTC deductions.

HSD Certain deductions allowable under IRS can be deducted from countable MAGI-based and MAGI income. These deductions are excluded from countable MAGI-based and MAGI income before comparing the

income to the applicable MAGI Income Standard to determine financial eligibility.

Not all allowable tax deductions are available to select from in ONE. When a deduction is reported and not available as a drop-down to select from, select "Other Allowable Tax Deduction/Expense."

Click here for examples: Expenses and deductions.

Oregon Administrative Rule(s)

461-160-0420 — Shelter Cost; SNAP
461-160-0040 — Dependent Care Costs; Deduction and Coverage
461-001-0000 — Definitions for Chapter 461
461-001-0015 — Definitions; SNAP
461-160-0055 — Medical Expenses That Are Deductible; OSIP, OSIPM, and SNAP
461-160-0780 — Determining Adjusted Income; OSIP-EPD and OSIPM-EPD
461-160-0550 — Income Deductions; Non-SSI OSIP (except OSIP-EPD) and OSIPM (except OSIPM-EPD) in the Community When There Are No Children in the Household Group
461-160-0552 — Income Deductions; Qualified Medicare Beneficiaries Programs
461-160-0540 — Determining Income Eligibility; QMB and OSIPM (except OSIPM-EPD) Living in the Community or Residing in a 24-Hour Mental Health Residential Care Setting
461-160-0415 — Medical Deductions; SNAP
461-160-0430 — Income Deductions; SNAP
461-160-0200 — Restoring Benefits
461-180-0020 — Effective Dates; Changes in Income or Income Deductions That Cause Increases
461-180-0030 — Effective Dates; Changes in Income or Income Deductions That Cause Reductions
461-135-1200 — Specific Requirements; TA-DVS

Other resources

Income Types: Comprehensive breakdown of earned, self-employment, unearned, and specific income. Includes income categories and income types selected when entering records in ONE.

Medical Expenses: Medical expenses are allowable deductions for SNAP and Medical Programs. QRG covers the policy for medical expenses, screen steps, and verification requirements.

Quick reference charts

Income type/frequency chart

Income type/frequency	Treatment
Stable monthly income: $200/month child support	$200/month
Stable income: $80 received weekly	$80 x 4.3 = $344/month
Stable income: $247 received every other week	$247 x 2.15 = $531.05/month
Stable income: $325 received twice a month	$325 x 2 = $650/month

Stable income: Hourly wage and weekly hours known. Applicant works 28 hours a week @ $9.50/hour	$9.50 x 28 x 4.3 = $1143.80 monthly
Variable income: Weekly hours or hourly wage vary or receives overtime, differential pay, etc. Past is representative. Arrive at an averaged pay per pay period using income received in the most recent 30 to 90 days. Convert to monthly income using 4.3, 2.15, 2 or 1.	$295 + $235 + $325 + $175 + $250 = $1280 ÷ 5 pay periods = $256 per pay period x 4.3 (paid weekly) = $1,100.80/month.
Variable income: past work hours are representative, but rate of pay changed. Can use past work hours x rate of pay and convert.	15 + 24 + 18 + 22 + 16 + 28 hours per pay period = 123 ÷ 6 pay periods = 20.5 hours. $9.00 x 20.5 x 4.3 = $793.35.
Variable income: past is not representative.	$525 and $550 last 2 months, was laid off and expects $200 this month. Count $200 only this month and 0 thereafter.
Variable income: changing monthly. Applicant just hired for Christmas season, expects $300 this month, will work full time @ $900 for 2 months, then half time.	Over 6 months count: $300, $900, $900, $450, $450, $450. (Change the income amount monthly using a tickler.)
Annualize: Contracted or self-employment is a full year's income received in less than 12 months; e.g., a farmer getting $10,700 over 3 months, a teacher getting $32,500 in 10 months. See the following ERDC note.	$10,700 ÷ 12 = $891.67/month; or $32,500 ÷ 12 = $2,708.33/month
Annualize: A self-employed individual is expected to make approximately $24,000 a year and has costs. Last tax year income is representative. For ERDC, allow the applicant to choose a deduction of the total gross amount: 50%, actual cost or no cost to have a lower copay/higher child care hours or vise versa.	Divide $24,000 by 12 = $2,000/month. For SNAP, code as SEC to get the 50% deduction for costs. If there are no costs, code as SEN. For ERDC, use the ERDC Self Employment Deduction screen in ONE after running eligibility to enter which cost option the applicant is choosing for their income and copay.

Benefit calculation

Benefits are calculated differently for each program and benefit type. Benefits for SNAP and TANF are loaded onto an EBT card for the individual based on their eligibility, whereas benefits for child care assistance through ERDC and TANF are paid to the individual's child care provider on behalf of the family. This section will cover how benefits are calculated based on the individual's eligibility for each program.

SNAP Benefit levels

The U.S. Department of Agriculture (USDA) conducts studies to determine SNAP benefit levels. They look at the average cost of food for a household.

Below are the current benefit levels or Thrifty Food Plan (TFP):

Maximum SNAP Allotments	
Number in the benefit group	**Amount**
1	$250
2	$459
3	$658
4	$835
5	$992
6	$1,190
7	$1,316
8	$1,504
Each additional individual	$188

For applicants who have passed the countable income limit (130 percent) and resource limit, the ONE systemperforms the SNAP benefit calculation. If the applicant is categorically eligible the resources limits will not apply. Elderly and individuals with disabilities need only to meet the adjusted income limit.

The 200 percent categorical eligibility income test is not part of this calculation.

It is very helpful to understand the SNAP calculation to be able to explain changes or potential changes in benefit amounts to applicants.

The system will round all amounts automatically. Amounts are rounded down for 1–49 cents and rounded up for 50–99 cents in each step of the calculation, except in step 9. The answer is rounded up for 1–99 cents in step 9. (ONE automatically does the rounding.)

This means:

- For income, add all pay from the same income source before rounding. Round income amounts before converting and again after converting.
- Round the cost of dependent care for each individual before comparing it to the limits.
- Add medical costs for all individuals before rounding and calculating the deduction.
- Do not round shelter costs until the excess shelter deduction has been computed.

The SNAP Benefits Computation (DHS 0221) worksheet is a great tool for workers to use and understand. It takes the worker through the calculation step by step.

Here is a high-level explanation of the calculation completed by the system to calculate the benefit allotment.

Income calculation

- **Step 1:** Enter the Income:
  - Add all types of income (the system will round the income for you).
  - If income includes self-employment with allowable costs of doing business, the system will allow 50 percent exclusion for the costs as long as Self Employment with Costs is selected. For

self employmentwith no costs, select Self Employment Without Costs. ONE will not allow the 50 percent exclusion for the costs.

- The subtotal is the applicant's SNAP countable income.
- This amount is compared to the SNAP countable income limit – 130 percent FPL.
- Filing groups that are categorically eligible or contain an elderly person or an individual with disabilities do not need to meet the SNAP countable income limit.

If the household is not categorically eligible or does not contain an elderly person or an individual with disabilities, and income is equal to or exceeds the countable income limit, the household is not eligible for SNAP and the computation ends with this step.

Deductions

- **Step 2:** Subtract 20 percent of the earned income.
- **Step 3:** Subtract the standard deduction amount for the household size. (See chart below.)
- **Step 4:** Subtract the dependent care deductions. (The system will round this amount for the worker.)
- **Step 5:** Total all the allowable medical costs. (The system will subtract $35 from the allowed medical costs.)
- **Step 6:** Subtract the court-ordered child support deduction. (The system will round this amount for the worker.)

Standard Deductions	
Others living in the dwelling	**Monthly countable income**
1–3 people	$177
4 people	$184
5 people	$215
4	$246

Shelter

- **Step 7:** Subtract the excess shelter costs. (The system will calculate the excess shelter costs.)
  - This requires a comparison of the subtotal through step 6 above to the applicant's shelter costs. According to the SNAP calculation, half of this subtotal should be available for the applicant to pay their shelter costs.
  - If half of this subtotal is less than the applicant's shelter costs, they have excess shelter and are entitled to another deduction.
  - If half of the subtotal is equal to or more than the shelter costs, the applicant has adequate funding for their shelter costs and does not have an excess to count as a deduction.
  - For most SNAP groups, the excess shelter deduction is the actual amount up to the allowable maximum shelter deduction. However, for groups containing a member who is elderly or is an individual with disabilities, the excess shelter deduction is the actual amount without a limit.
  - For groups that are homeless, compare the allowable Excess Shelter Deduction against the

Homeless Shelter Deduction effective for that federal fiscal year (this will be updated each year and reflected in the 5530). Whichever is greater will be subtracted from the countable income, after all other appropriate deductions, to determine eligibility and allotments for the household.

- **Step 8:** The resulting subtotal is the applicant's SNAP adjusted income – 100% FPL. It must be compared to the SNAP adjusted income limit below:

100% FPL	
Number in the benefit group	**SNAP adjusted income limit**
1	$1,074
2	$1,452
3	$1,830
4	$2,209
5	$2,587
6	$2,965
7	$3,344
8	$3,722
+1	$379

If the SNAP adjusted income is equal to or exceeds this limit, the group is not eligible unless they are categorically eligible. If the SNAP group's adjusted income is below the limit or they are categorically eligible, we continue the calculation to determine the benefit amount.

- **Step 9:** Multiply the subtotal in step 7 by 30 percent (the system will round this amount). This 30 percent of the SNAP adjusted income is the amount considered available to the group to spend on their food needs.
- **Step 10:** Subtract the subtotal in step 9 (the group's income available for food) from the TFP amount for the benefit group size. The difference is the SNAP benefit amount (unless the situation meets an exception).

To manually compute benefits, use the SNAP Benefits Computation (DHS 0221) form.

Special groups can be over the 200 percent FPL and still be eligible for benefits (e.g., NC1, SEC, elderly or disabled with high deductions).

Exception to the SNAP benefit calculation

When SNAP benefit calculation results in benefits of less than $20, special amounts are issued, as follows:

- In the initial month, no benefits are issued if the prorated amount is less than $10.
- For an ongoing month with one or two individuals in the benefit group, $20 is issued.
- For an ongoing month with three or more in the benefit group, $0 is approved.

Prorating benefits

Initial month

When the benefit group or an applicant is eligible for less than a full month's benefits, they will receive benefits intended to cover only the days for which they are eligible. This happens when benefits are approved on a new case, for example. This partial month's benefit is called prorated.

The exception is for filing groups containing a migrant or seasonal farm worker. Their benefits are not prorated if they received SNAP in the prior month from any state.

To calculate prorated benefits, first determine the benefit amount for a full month. Next, divide the full benefit amount by the number of days in the payment month. This will result in the benefit amount per day. Finally, multiply the daily benefit amount by the number of days the group or individual is eligible. The result is the prorated benefit amount.

At recertification

Applicants who establish their filing date within the last month of their current redetermination period and provide verification within the 30-day processing time frame do not have prorated benefits.

- Filing groups that establish their filing date after the end of their current redetermination period and provide verification within the 30-day processing time frame have prorated benefits from the filing date. The exception is for filing groups containing a migrant or seasonal farm worker. Their benefits are not prorated if they received SNAP benefits in the prior month from any state.

For groups that are not given extra time but submit verification after 30 days but within 60 days of the filing date, prorate the benefits from the date the verification was provided if they are eligible on that date.

TANF Benefit levels

The payment standards in this section are used to calculate benefit amounts for individuals receiving TANF benefits.

Benefit group containing an adult:

Number in need group	Amount
1	$339
2	$432
3	$506
4	$621
5	$721
6	$833
7	$923
8	$1,030
9	$1,093
10	$1,204
Each additional individual	$110

Benefit group containing no adult:

Number in household group	2	3	4	5	6	7	8	9	+10	Number in benefit group
	$228	$180	$167	$156	$150	$143	$140	$133	$132	1
		348	322	300	288	274	268	254	242	2
			477	444	426	405	396	375	372	3
				588	564	536	524	496	492	4
					702	667	652	617	612	5
						798	780	738	732	6
							908	859	852	7
								980	972	8
									1,092	9+

ERDC Copay calculation

The copay is calculated by ONE automatically. Copays are based on EDG size and countable income compared to the Federal Poverty Level (FPL). Workers and parents can find copay tables by EDG size and income on the ERDC website.

REF Benefit levels

The payment standards in this section are used to calculate benefit amounts for individuals receiving REF benefits.

Benefit group containing an adult:

Number in need group	Amount
1	$339
2	$432
3	$506
4	$621
5	$721
6	$833
7	$923
8	$1,030
9	$1,093
10	$1,204
Each additional individual	$110

Benefit group containing no adult (NO on case):

Number in household group	2	3	4	5	6	7	8	9	+10	Number in benefit group
	$228	$180	$167	$156	$150	$143	$140	$133	$132	1
		348	322	300	288	274	268	254	242	2
			477	444	426	405	396	375	372	3

Number in household group	2	3	4	5	6	7	8	9	+10	Number in benefit group
				588	564	536	524	496	492	4
					702	667	652	617	612	5
						798	780	738	732	6
							908	859	852	7
								980	972	8
									1,092	9+

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Oregon Administrative Rule(s)

461-155-0150 — Child Care Eligibility Standard, Payment Rates, and Copayments
461-145-0930 — Self-Employment; Determination of Countable Income
461-150-0090 — Prospective Budgeting: Annualizing and Prorating Contracted or Self-Employment Income; Not OSIP, OSIPM, or QMB
461-150-0080 — Prospective Budgeting of Variable Income
461-150-0020 — Prospective Eligibility and Budgeting
461-150-0060 — Prospective and Retrospective Eligibility Budgeting; ERDC, REF, REFM, SNAP and TANF
461-150-0070 — Prospective Budgeting of Stable Income
461-140-0110 — Treatment of Periodic Income
461-135-0400 — Specific Requirements; ERDC
461-160-0010 — Use of Resources in Determining Financial Eligibility
461-160-0015 — Resource Limits
461-160-0300 — Use of Income to Determine Eligibility and Benefits for ERDC

Treatment of specific assets

Different assets may be treated differently by program.

In ONE, assets that are treated as income (as opposed to a resource) are broken down into four main types: earned, self-employment, unearned and specific. They are coded within those screens with particular income categories and income types. Even if an income will be excluded, still code it within ONE; it will be excluded, as applicable.

Please click below to review treatment of and more information about each asset, including how to code in ONE:

Achieving a Better Life Experience (ABLE) Act of 2014	Educational income	Pension and retirement plans
Adoption assistance	Energy assistance	Personal belongings

Agent Orange disability benefits	Family Abuse Prevention Act (FAPA) payments	Personal injury settlements
Alaska Permanent Fund Dividend	Floating homes and houseboats	Plans for self-support
Animals	Food programs; other than SNAP	Program benefits
Annuities	Foster care/guardianship assistance payments	Radiation Exposure Compensation Act
	Gifts and winnings	Resource Assistance for Rural Environments (RARE) program
Approved accounts; OSIP-EPD and OSIPM-EPD	Groundfish disaster benefits	Real property
Bank accounts	Homes	Real property excluded under an interim assistance agreement
Black lung benefits	Housing and Urban Development (HUD) payments	Recreational vehicles
Burial arrangements and burial funds	Income-producing property	Refunds
Burial space and merchandise	Income-producing sales contracts	Reimbursements
Capital assets	Independent living subsidies/Chafee Housing Program	Representative payee payments
Cash	Indian (Native American) benefits	Reception and placement grants
Child support and cash medical support	Individual development account (IDA)	Sale of a resource
Contributions	Individual education account (IEA)	Shelter-in-kind income
Corporations and business entities	Inheritance	Social Security benefits (SSB)
Disability benefits	In-kind income	Vocational Rehabilitation payments
Disaster relief	Job Corps payments	Workforce Investment Act (WIA)
Disqualifying income; SNAP	Trusts	Workers' compensation
Dividends, interest, royalties	Unemployment compensation benefits	Work-related capital assets, equipment and inventory
Domestic Volunteer Services Act (VISTA, RSVP) and Small Business Act (SCORE, ACE)	Uniform Relocation Assistance Act and Real Property Acquisition Policies Act	Self-employment and microenterprise income
Earned income; defined	USDA meal reimbursement	
Social Security death benefit	Veterans' benefits	
Social Security income (SSI)	Victims' assistance	
Spousal support	Life estate	
Stipends	Loans and repayment of loans	
Stocks, bonds, and other securities	Lodger income	
Strikers' benefits	Manufactured and mobile homes	
Tax refund	Military income	
Ticket to Work program	Motor vehicles	

Earned income; treatment	National and Community Service Trust Act (NCSTA/AmeriCorps)	
Earned Income Tax Credit	Older Americans Act	
	Pension and Retirement Plans	

Other resources

Income *includes screenshots: Describes all categories of income: Earned, Self-Employment, Unearned, Unpaid, and Specific. Includes general guidance on how to enter income verification and how to verify no income. Provides instruction on updating and terminating income, and when to update, delete, or add a record. Explains the 100% Annual Income screen and the pay frequency calculation factor. Includes FAQ on income.

Resources *includes screenshots: Reviews the resource categories and their respective screens. Describes how historical data appears on the Resource Questions screen.

Lottery Winnings Task *includes screenshots: Describes the Lottery Winning Task, its frequency and the business process to close the task. Overviews the Lottery Winning screen and proper data entry for the screen.

Achieving a Better Life Experience (ABLE) Act of 2014

The Achieving a Better Life Experience (ABLE) Act of 2014 allows individuals with disabilities who qualify to open special accounts under Section 529 of the Internal Revenue Code. The purpose of these accounts is to allow qualifying people with disabilities to save money for items that enhance their quality of life without losing needed entitlements and public benefits.

Individuals can qualify to open an ABLE Act account (or have one opened for them) if:

- The individual is blind or has a disability that does or would qualify them to receive SSI or Social Security based on blindness or disability, and
- The onset of the blindness or the disability occurred before age 26.

In ONE, funds withdrawn from the ABLE Act are coded on the Unearned Income screen:

- Unearned Income Category – Able Act
- Unearned Income Type – there are three types to choose from, select the one which is applicable to the type being reported:
  - ABLE Act Withdrawn Funds: Not Qualified Non-Taxable Disability Expenses,
  - ABLE Act Withdrawn Funds: Not Qualified Taxable Disability Expenses, or
  - ABLE Act Withdrawn Funds: Qualified Disability Expenses

For all programs, balances in ABLE Act accounts are excluded as a resource.

- Monies withdrawn from ABLE Act accounts are excluded as income if they are used for Qualified Disability Expenses.
- Funds withdrawn from ABLE Act accounts for purposes other than Qualified Disability Expenses are counted as unearned income.

In ONE, to exclude the balance in an ABLE Act account as a resource:

- Exclusion Type: Other – Medical (except REFM)
- Use the balance of the account and then add ABLE Account to the description fields

For MSP and OSIPM, withdrawals or distributions from ABLE Act accounts are excluded as income.

Staff are not expected to monitor these accounts with regularity, given that all monies held in the accounts (as well as withdrawals or distributions) are excluded.

Oregon Administrative Rule(s)

461-145-0000 — Achieving a Better Life Experience (ABLE) Act
410-200-0015 (54) and (55) — General Definitions

Adoption assistance

Adoption assistance is financial assistance provided to families adopting children with special needs. Adoption assistance may be state or federally funded. Federal adoption assistance is authorized by the Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272). State adoption assistance is authorized by ORS 440.335.

In ONE, Adoption Assistance is coded on the Unearned Income screen:

- Unearned Income category – Other Income
- Unearned Income Type – Adoption Assistance

For all programs except HSD medical, ERDC, SNAP and TANF, treat adoption assistance as follows:

- Exclude the entire amount of adoption assistance from Oregon.
- Exclude the portion of adoption assistance for the special needs of the child when the adoption assistance is from other states. This includes needs such as special diet, special clothing, counseling and medical costs not covered under title XIX. Count the rest of the adoption assistance as unearned income.

Note: Children receiving adoption assistance are excluded from the TANF filing group. This means that the adoption assistance income is excluded when determining eligibility for TANF and when calculating the TANF benefit levell.

For ERDC and TANF, exclude adoption assistance.

For SNAP, adoption assistance is counted as unearned income.

For HSD medical programs, exclude adoption assistance.

Oregon Administrative Rule(s)

410-200-0015 (51) and (52) — General Definitions
461-145-0001 — Adoption Assistance
410-200-0015 (54) and (55) — General Definitions

Agent Orange disability benefits

In ONE, payments and benefits from Agent Orange are coded on the Unearned Income screen:

- Unearned Income Category – Other Income
- Unearned Income Type – there are two types to choose from, select the one which is applicable to the type being reported:
  - Agent Orange by Aetna
  - Agent Orange not by Aetna

For all programs except MSP, OSIPM and HSD medical:

- Exclude benefits from the Agent Orange Settlement Fund made by Aetna Life and Casualty Insurance Company for settling Agent Orange disability claims.
- Count payments made under the Agent Orange Act of 1991 and issued by the U.S. Treasury through the Department of Veterans Affairs, as unearned income.

For MSP, OSIPM and HSD medical programs, exclude all payments made under the Agent Oregon Act of 1991 or from the Agent Orange Settlement Fund or any other fund related to the settlement in the Agent Orange product liability litigation.

Oregon Administrative Rule(s)

461-145-0005 — Agent Orange Disability Benefits
410-200-0015 (54) and (55) — General Definitions

Alaska Permanent Fund Dividend

The Alaska Permanent Fund Dividend is issued annually to eligible Alaskan residents who apply for the payment. Out-of-state residents, except military personnel and students who claim Alaska as their residence, are not eligible unless they resided in Alaska and filed for the payment before leaving the state.

In ONE, Alaska Permanent Fund Dividend is coded on the Unearned Income screen:

- Unearned Income Category – Other Income
- Unearned Income Type – Alaska Permanent Fund

For all programs except HSD medical, count Alaska Permanent Fund Dividend payments as lump-sum income.

For HSD medical programs, exclude Alaska Permanent Fund Dividend.

Oregon Administrative Rule(s)

461-145-0008 — Alaska Permanent Fund Dividend
410-200-0015 (54) and (55) — General Definitions

Animals

For all programs, exclude an animal that is considered a pet or raised specifically as food for the filing group. For example, lamb or cattle or chickens that will be slaughtered and eaten by the individual would fall under this

category; chickens that lay eggs eaten by the individual or a dairy cow that provides them with milk are also included. Any animal can be considered a pet as long as it doesn't generate income, including cows, horses, sheep and chickens. Furthermore, animals can be both pets and a source of food for the family.

There is a distinction between animals sold for income (as above) and animals that produce income. For example, if a family has a cow and sells the milk or has chickens and sells the eggs, the animals are considered income-producing property and treated in accordance with the income-producing property rule. On the other hand, if selling the milk or eggs constitutes self-employment, the cow or chicken could be treated as a work-related capital asset and excluded.

In ONE, income from animals considered income producing is coded on the Self-Employment Income screen:

- Self-Employment Income Category – Income from Income Producing Animals
- Self-Employment Income Type – Income from Income Producing Animals

For OSIPM, the fair market value of animals raised or kept for eventual sale is countable as a resource. This could include pigs, sheep or cows raised and auctioned off at fair time or sold to a third party. This could also include puppies bred specifically for sale as pets or show dogs, or horses that are bred or purchased, trained and re-sold as roping or barrel-racing horses. These animals are countable resources regardless of whether or not they are also considered pets.

Animals that are used, kept or raised for the purposes of self-employment are excluded as a resource.

For MSP and OSIPM, if an animal is a source of both food and income for the filing group, the proceeds of any sale of the animal or its products are counted as unearned income. The fair market value of these animals is excluded.

Note: If some of the eggs and milk are consumed by the family and the excess is sold, the chickens and cows are still excluded; however, the income from selling the eggs and milk is counted as unearned income.

For HSD medical programs and MSP, resources are not considered in eligibility determination.

Oregon Administrative Rule(s)

461-145-0010 — Animals
410-200-0015 (54) and (55) — General Definitions

Annuities

For the purposes of this policy:

- "Actuarially sound" means commercial annuities [see subsection (d) of this section] that pay principal and interest out in equal monthly installments over the actuarial life expectancy of the annuitant, with no deferral and no balloon payments. This definition establishes actuarial life expectancy by the Periodic Life Table of the Office of the Chief Actuary of the Social Security Administration. For transactions (including the purchase of an annuity) occurring on or after July 1, 2008, the payout period must be within twelve months of the actuarial life expectancy, measured at the time of purchase.
- An annuity does not include benefits that are set up and accrued in a regularly funded retirement account while an individual is working, whether maintained in the original account or used to purchase an annuity if

the Internal Revenue Service recognizes the account as dedicated to retirement or pension purposes.

- "Child" means a biological or adoptive child who is:
  - Under age 21; or
  - Any age and meets the Social Security Administration criteria for blindness or disability.
- "Commercial annuities" means contracts or agreements (not related to employment) by which an individual receives annuitized payments on an investment for a lifetime or specified number of years.

In ONE, payments and benefits from annuities are coded on the Unearned Income screen:

- Unearned Income Category – Annuities
- Unearned Income Type – there are two types to choose from, select the one which is applicable to the type being reported:
  - Annuity - Non-Taxable
  - Annuity - Taxable

For all programs except MSP and HSD medical programs, an annuity is counted as a resource if the annuity does not make regular payments for a lifetime or specified number of years.; or

For OSIPM:

- When an individual applies for medical assistance, both initially and at renewal, the individual must report any annuity the individual or the individual's spouse owns.
- By signing the application for assistance, an individual and the spouse of an individual agree that ODHS|OHA, by virtue of providing medical assistance, becomes a remainder beneficiary as described in sections (6) and (7) below, under any commercial annuity purchased on or after Feb. 8, 2006. This applies unless the annuity is included in the community spouse's resource allowance under OAR 461-160-0580(2)(c).
- If ODHS|OHA is notified about a commercial annuity, it will notify the annuity's issuer of ODHS|OHA's right as a preferred remainder beneficiary in the amount of medical assistance provided to the individual. This is described in sections (6) and (7) below,
- If an individual or an individual's spouse purchased or transferred a commercial annuity prior to Jan. 1, 2006, and the individual is in a nonstandard living arrangement, the transaction may be subject to the rules on disqualifying transfers.
  - For an annuity that is not disqualifying, or the disqualification period has already been served, the annuity is not counted as a resource.
  - If the individual is in a standard living arrangement, the annuity is not counted as a resource.
- Section 6 applies to a commercial annuity if:
  - The individual is in a nonstandard living arrangement, and the individual or the spouse of the individual purchases an annuity from Jan. 1, 2006, through June 30, 2006, or
  - The individual is in a standard living arrangement, and the individual or the spouse of an individual purchases an annuity on or after Jan. 1, 2006.
- A commercial annuity covered by section (5) above is counted as a resource unless the annuity is excluded by

meeting the following requirements:

- If a married individual is an annuitant, the annuity must meet the requirements of subsection (6)(d).
- If an unmarried individual is an annuitant, the annuity must meet the requirements of subsection (6)(d), and the annuity must specify that upon the death of the individual, the first remainder beneficiary is either of the following:
  - ODHS|OHA, for all funds remaining in the annuity up to the amount of medical assistance provided on behalf of the individual, or
  - The individual's child, if ODHS|OHA is the next remainder beneficiary (after this child), up to the amount of medical assistance provided on behalf of the individual, in the event that the child does not survive the individual.
- If a spouse of an individual is the annuitant, the annuity must meet the requirements of subsection (6)(d), and the annuity must specify that, upon the death of the spouse of the individual, the first remainder beneficiaries are either of the following:
  - The individual, in the event that the individual survives the spouse; and ODHS|OHA, in the event that the individual does not survive the spouse, for all funds remaining in the annuity up to the amount of medical assistance provided on behalf of the individual, or
  - A child of the spouse and the individual in the event that this child does not survive the spouse.
- An annuity covered by section (5) of this rule may not be excluded unless the annuity meets all of the following requirements:
  - The annuity is irrevocable.
  - The annuity must be actuarially sound.
  - The annuity is issued by a business that is licensed and approved to issue a commercial annuity by the state in which the annuity is purchased.

- This section lists the requirements for a commercial annuity purchased by the individual or the individual's spouse on or after July 1, 2006, when an individual is in a nonstandard living arrangement, and the annuity names the individual or the community spouse as the annuitant. Annuities that meet all of the requirements of this section are counted as unearned income to the payee. The treatment of annuities that do not meet all requirements of this section is covered in sections (9) and (10).
  - The annuity must comply with one of the following paragraphs:
    - The first remainder beneficiary is the individual's spouse; ODHS|OHA is named as the second remainder beneficiary for up to the total amount of medical assistance paid on behalf of the individual; and in the event that the spouse transfers any of the remainder of the annuity for less than fair market value, ODHS|OHA is the second remainder beneficiary for up to the total amount of medical assistance paid on behalf of the individual.
    - The first remainder beneficiary is the annuitant's child; ODHS|OHA is named as the second remainder beneficiary for up to the total amount of medical assistance paid on behalf of the individual; and in the event that the child or a representative on behalf of the child transfers any of the remainder of the annuity for less than fair market value, ODHS|OHA is the second remainder beneficiary for up to the total amount of medical assistance paid on behalf of the individual.

    - » The first remainder beneficiary is ODHS|OHA for up to the total amount of medical assistance paid on behalf of the individual.
  - The annuity must be irrevocable.
  - The annuity must be non-assignable.
  - The annuity must be actuarially sound.
  - The annuity is issued by a business that is licensed and approved to issue a commercial annuity by the state in which the annuity is purchased.
- If the individual is the annuitant and a commercial annuity does not meet all of the requirements of subsections (8)(a), (8)(d), and (8)(e), or the spouse of the individual is the annuitant and a commercial annuity does not meet the requirements of subsections (8)(a), (8)(d), and (8)(e), there is a disqualifying transfer of assets. To the extent to which there is a disqualifying transfer of assets under this section, the annuity is not counted as a resource.
- If the annuity does not meet all of the requirements of subsections (8)(b) or (8)(c), the annuity is counted as a resource.

For HSD medical programs, taxable annuities are counted in both monthly and annual income. Exclude non-taxable annuities.

For all programs except HSD medical:

- If an annuity is a countable resource under this rule, the cash value is equal to the amount of money used to establish the annuity, plus any additional payments used to fund the annuity, plus any earnings, minus any regular payments already received, minus any early withdrawals and minus any surrender fees.
- If an annuity is not counted as a resource, payments from the annuity are counted as unearned income to the payee.

For HSD medical programs and MSP, resources are not considered in the eligibility determination.

Oregon Administrative Rule(s)

461-145-0020 — Annuities; Not OSIPM
461-145-0022 — Annuities; OSIPM
461-145-0380 — Pension and Retirement Plans
410-200-0015 (54) and (55) — General Definitions

Bank account

A bank account includes a money market account and an account in a financial institution. Accounts in financial institutions for stocks, bonds and certificates of deposit (CDs) are covered under Stocks, bonds and other securities.

Money in a bank account belonging to one or more members of the financial group is counted as a resource per Availability of resources, unless excluded in this or any other section.

Money in a bank account is excluded as a resource when:

- In an approved account excluded under OAR 461-145-0025
- A burial fund excluded under OAR 461-145-0040
- A designated bank account is an excluded asset for OSIPM-IC if:
  - The account is designated to receive program benefits by direct deposit through electronic funds transfer, and
  - The benefit funds are not commingled with other assets of the participant.
- Funds from excluded income are excluded as a resource under OAR 461-140-0070
- Funds are an individual education account if excluded under OAR 461-145-0145
- Money for a plan for self-support is excluded under OAR 461-145-0405
- Proceeds from the sale of a home are excluded as a resource under OAR 461-145-0460.

Treat bank accounts held jointly with people not in the financial group as follows:

- **For SNAP**, count all funds in the account unless the participant proves some or all are not available. Count the available amount.
- **For all other programs**, count only those funds contributed to the account by the participant. Exclude other funds unless there is clear evidence they are available to the participant.

For all programs except OSIPM and MSP, interest and dividends earned on funds in a bank account are counted as unearned income, unless the account is excluded as a resource.

For HSD medical programs:

- Interest and dividends earned on funds in a bank account are excluded as income.
- Resources are not considered in eligibility determination.

Oregon Administrative Rule(s)

461-145-0030 — Bank Account
461-140-0020 — Availability of Resources

Black lung benefits

Black Lung Benefits paid to miners or their survivors under the provisions of the Federal Mine Safety and Health Act are counted as unearned income.

In ONE, black lung benefits are coded on the Unearned Income screen:

- Unearned Income Category – Other Income
- Unearned Income Type – Black Lung

Oregon Administrative Rule(s)

461-145-0035 — Black Lung Benefits
410-200-0015 (54) and (55) — General Definitions

Burial arrangements and burial funds

Burial arrangements may include prepaid arrangements that make allowance for burial costs. They are generally made with a licensed funeral director, burial insurance or burial trust funds designating a funeral director as the beneficiary. Burial arrangements do not include a burial space.

Burial funds are an identifiable fund set aside for a participant's burial costs. A burial fund does not include a burial space.

For all programs except OSIPM, burial insurance is considered a form of life insurance.

A burial arrangement is treated as follows:

- **For ERDC, REF, REFM, SNAP and TANF**, exclude the equity value of one prepaid burial arrangement for each member of the filing group.
- **For OSIPM individuals who were blind or disabled eligible for SSI in December 1973**, exclude up to $1,000 combined equity value of burial arrangements with a licensed funeral director (plus accrued interest) and life insurance policies. Count the combined amount of cash and equity value of all life insurance and burial arrangements exceeding $1,000 as a resource.
- **For OSIPM:**
  - Exclude the amount in an irrevocable burial trust or any other irrevocable arrangement to cover burial costs.

    Note: The cash surrender value (CSV) of a life insurance policy can be excluded if the ownership of the policy has been irrevocably assigned to a funeral home. If a funeral home is named as the irrevocable beneficiary (instead of an irrevocable transfer of ownership), the policy can only be excluded if the assignment contains specific language that prevents the owner of the policy from accessing the cash surrender value of the policy by loan or policy cancellation.
  - Burial insurance that does not generate a cash surrender value or generates cash surrender value to which the owner does not have access, is considered an irrevocable arrangement and excluded.
  - Burial insurance that generates a cash surrender value to which the owner has access is considered life insurance and is treated in accordance with the policy on life insurance and, as applicable, burial insurance as noted in the bullet above.
- **For OSIPM (except as provided above), HSD medical programs and MSP**, treat a burial arrangement the same as a burial fund.

A burial fund is treated as follows:

- **For OSIPM:**
  - A burial fund can only be established from cash, bank accounts, burial contracts, stocks, bonds or life insurance policies.
  - A burial fund is counted as a resource if it is commingled with assets unrelated to a burial. The amount set aside for burial must be in a separate account to be considered excluded from resource consideration.
  - A burial fund may be established if the countable resources of the participant exceed allowable limits. A burial fund is excluded from the resource calculation to the following extent:

» The following calculation determines the exclusion for a burial fund:

- Exclude up to $1,500 of a burial fund from resources for each of the following:
  - The individual
  - The individual's spouse.
- Subtract both of the following from the amount each participant may set aside for a burial fund:
  - The face value of life insurance policies owned by the individual that have already been excluded from resources. This does not include term life insurance policies that do not generate a cash surrender value.
  - The amount in an irrevocable burial trust or any other irrevocable arrangement to cover burial costs, including the face value of burial insurance considered an irrevocable arrangement. Burial costs do not include burial spaces or merchandise.
  - If the $1,500 exclusion is applied to the CSV of a whole life insurance policy, and a remaining amount will be considered a countable resource, it is not considered commingling of a burial fund with another countable resource.
- Exclude all interest earned on excluded burial funds or increases in the value of excluded burial arrangements if left in the fund.

There is no penalty or overpayment for the time period during which the burial arrangement or burial fund existed if an individual:

- Cancels an excluded burial arrangement, or
- Uses excluded burial funds for any purpose other than burial costs.

Note: From Sept. 27, 1987, to Nov. 5, 1989, Oregon law prohibited establishing irrevocable burial trust funds. Burial trust funds established on or after Nov. 5, 1989, may be irrevocable.

Beginning July, 2016 all prepaid irrevocable burial arrangements, including those funded by an irrevocable assignment of a life insurance policy, must include a contract for the goods and services that are funded by the prepayment. If the prepayment does not include a contract that it funds there is a potentially disqualifying transfer, which could impact Medicaid eligibility. Additionally, if the amount of the prepayment exceeds the value of the contract that it funds, there is a potentially disqualifying transfer.

For life insurance funded burial arrangements where there is an irrevocable assignment, the amount of the assignment is considered to be equal to the face value (FV) of the policy assigned. This means, for instance, if the FV of the policy that funds the contract is $10,000, the cost of the goods and services provided for in the contract must be at least equal to $10,000. In determining the amount of the disqualifying transfer, though, the value of the burial contract is compared to the cash surrender value (CSV) of the life insurance policy, not the FV of the policy.

For all other programs except HSD medical and MSP, the value of the burial fund is counted as a resource.

For HSD medical programs and MSP, resources are not considered in eligibility determination.

Click here for examples: Burial arrangements and burial funds.

Oregon Administrative Rule(s)

461-145-0040 — Burial Arrangements and Burial Funds

Burial space and merchandise

For the purpose of this rule, burial spaces include conventional gravesites, crypts, mausoleums, urns, niches, burial vaults and other repositories traditionally used for the remains of deceased individuals. Burial spaces also include headstones, the opening and closing of the gravesite, and the reasonable and necessary improvements or additions to such spaces. Burial merchandise includes, but is not limited to, urns, caskets, liners, headstones, markers, plaques and foundations.

- **In ERDC, REF, REFM, SNAP and TANF**, exclude as a resource the equity value of all burial space or merchandise for each member of the financial group. For burial space and merchandise that serves the same purpose, only one item per person is excluded.
- **For OSIPM,** exclude as a resource the equity value of all burial space or merchandise if owned by the participant and designated for the participant, the spouse of the participant, minor and adult children, siblings, parents, and the spouse of any of these individuals. For burial space and merchandise that serves the same purpose, only one item per person is excluded.

Examples of serving the same purpose:
A casket and an urn
A gravesite and crypt
A headstone and a plaque
Examples of not serving the same purpose:
A casket and liner
A gravesite and headstone
Opening/closing of gravesite and a gravesite

For MSP and HSD medical programs,, resources are not considered in eligibility determination.

Oregon Administrative Rule(s)

461-145-0050 — Burial Spaces and Merchandise

Cash

For all programs, in the month of receipt, cash is counted as income unless the source of the cash qualifies for an exclusion under another rule.

For all programs except HSD medical and MSP, after the month of receipt, count cash (including cash on hand, cash in a safe deposit box and cash held by others) as a resource, unless the source of the cash qualifies as an excluded resource under another rule.

For HSD medical programs and MSP:

- Resources are not considered in eligibility determination.

- Foreign currency that can be converted to U.S. currency is treated in the same manner as cash. The value of foreign currency is its value in U.S. currency, determined by the current exchange rate.
- The treatment of a check is based on the source of the funds.

Oregon Administrative Rule(s)

461-145-0060 — Cash

Child support and cash medical support

Child support and cash medical support paid by an absent parent for a dependent child or minor parent in the financial group are considered income of the dependent child or minor parent, whether the support is paid voluntarily or in accordance with an order to pay child support.

- "Disregard" means child support, up to $50 per dependent child or minor parent per financial group per
- Month. It is not to exceed $200 per financial group per month and is not counted as participant income. Disregard includes current child support only.
- "Pass-through" means child support, up to $50 per dependent child or minor parent per financial group per month and not to exceed $200 per financial group per month, sent to the participant before any remaining amount of current child support is withheld by the state. Pass-through includes current child support only.
- "Absent parent" means an individual who does not live in the same household as the child. The household includes:
  - A biological parent whose parental rights have not been legally severed; or
  - A stepparent currently married to a biological parent of a child

In ONE, child support and cash medical support are coded on the Specific Income screen:

- Specific Income Category – Other Income
- Specific Income Type – Child Support, Cash Medical Support and Any Other Support from Absent Parent

For ERDC, child support is considered countable unearned income if it is received by the financial group or is countable as in-kind income per OAR 461-145-0280. Otherwise it is excluded.

For SNAP, child support and cash medical support are treated as follows:

- Child support payments the group receives that must be assigned to ODHSIOHA to maintain TANF eligibility are excluded, even if the group fails to turn the payments over to DCS.
- Child support payments received by a filing group with at least one member working under a TANF JOBS Plus agreement are excluded, except:
  - If it is considered countable unearned income in the calculation of the wage supplement; and
  - Any pass-through is considered countable unearned income.
- All other child support, including any pass-through, is considered countable unearned income.
- Cash medical support is considered countable unearned income except to the extent it is used to reimburse an actual medical cost.

- Payments made by an absent parent to a third party for the benefit of the financial group are treated in accordance with OAR 461-145-0280 (In-Kind Income).
  - Payments made to a third party that are not legally obligated to be made directly to a member of the financial group and the financial group does not have the option of taking payments as cash are excluded unless they are transitional housing payments for the homeless.
  - Payments made by the absent parent to a third party that are court-ordered are excluded unless they are transitional housing payments for the homeless.

For TANF:

- In determining initial eligibility, except for disregard, child support received by the DCS is considered countable unearned income, if continued receipt of the child support is reasonably anticipated. These payments are excluded when determining the benefit amount.
- In determining ongoing eligibility, except for individuals working under a TANF JOBS Plus agreement and except for child support passed through to the participant and disregarded, child support received by the DCS is considered countable unearned income, if continued receipt of the child support is reasonably anticipated. These payments are excluded when determining the benefit amount.
- For individuals working under a TANF JOBS Plus agreement:
  - Child support is excluded in determining countable income.
  - Child support is excluded when calculating the TANF portion of the benefit equivalency standards.
  - All child support paid directly to the participant is considered countable unearned income in the calculation of the wage supplement.
- All other child support payments:
  - Paid directly to the financial group and turned over to DCS are considered countable unearned income except for any amount of pass-through and disregard.
  - Paid directly to the financial group and not turned over to DCS are considered countable unearned income.
  - Paid to a third party for the benefit of the financial group are considered countable unearned income. This includes but is not limited to payments made by an absent parent to a third party for rent, mortgage, utilities or child care.
- Cash medical support is excluded in determining countable income.

For OSIPM and MSP, all child support and cash medical support paid to the financial group are considered countable unearned income, except as follows:

- Exclude one-third of all cash child support paid to an individual. This applies to all individuals, not just those applying for or actually receiving benefits. Effective July 6, 2020, this exclusion also applies to child support paid in arrears (past due).
- Child support paid in arrears is considered countable income to the individual receiving the payments, unless the money is given to the child, in which case it is countable income to the child.
- Exclude all in-kind child support paid to the financial group.

- Child support collected from an absent parent by ODHS Child Welfare on behalf of a child in the custody of Child Welfare (i.e., foster care) that is not given to the child or the child's custodial parent is excluded.
- Child support payments collected by the State that are given to the individual or to the custodial parent are counted in accordance with the first bullet above.

Child support and cash medical support paid by the financial group are generally not deductible from income, except when calculating the countable income of the ineligible spouse of an adult OSIPM applicant, or the non-applying spouse of an applicant for Medicare Savings Program. The child support is deducted from unearned income first, and any remaining balance is deducted from earned income.

For SFPSS, for ongoing eligibility and benefit determination:

- Except for disregard, child support is considered countable unearned income.
- Cash medical support is excluded in determining countable income.
- Payments made by an absent parent to a third party for the benefit of the financial group are considered countable unearned income. This includes but is not limited to payments made by an absent parent to a third party for rent, mortgage, utilities or child care.

For ongoing eligibility and benefit determination for TANF individuals of a two-parent family:

- Except for disregard, child support is considered countable unearned income.
- Cash medical support is excluded in determining countable income.
- Payments made by an absent parent to a third party for the benefit of the financial group are considered countable unearned income. This includes but is not limited to payments made by an absent parent to a third party for rent, mortgage, utilities or childcare.
- For a filing group with at least one member working under a TANF JOBS Plus agreement:
  - Child support is excluded in determining countable income.
  - Child support is excluded when calculating the TANF portion of the benefit equivalency standards.
  - All child support paid directly to the participant is considered countable unearned income in the calculation of the wage supplement.

For HSD medical programs, exclude child support, cash medical support and any other support from absent parent in monthly and annual income.

Click here for examples: Child support and cash medical support.

Oregon Administrative Rule(s)

410-200-0015 (51) and (52) — General Definitions
461-145-0080 — Child Support and Cash Medical Support
461-145-0280 — In-Kind Income
410-200-0015 (54) and (55) — General Definitions

Other resources

Child Support QRG: How to enter child support income in ONE, verifying child support, and child support as it relates to each program.

Contributions

Contributions are monies — not gifts or winnings — given voluntarily to a financial group member by someone who is not in the group.

In ONE, payments and benefits from annuities are coded on the Unearned Income screen:

- Unearned Income Category – Annuities
- Unearned Income Type – there are two types to choose from, select the one which is applicable to the type being reported:
  - Contributions - from private, non-profit charitable organizations
  - Contributions - Money from Others

For all programs except SNAP and HSD medical, count contributions as unearned income.

For SNAP, count contributions as unearned income. However, exclude cash contributions from charitable sources if all the following are true:

(a) The contribution is from a private, nonprofit charitable organization.

(b) The contribution is based on need.

(c) The contribution does not exceed $300 per quarter.

For HSD medical programs, exclude contributions from private, nonprofit charitable organizations, and money from others in monthly and annual income.

Oregon Administrative Rule(s)

461-145-0086 — Contributions
410-200-0015 (54) and (55) — General Definitions

Corporations and other business entities

Identifying corporations

- A closely held corporation is usually incorporated by one or a small number of owners. For example, a farmer or a farming family incorporates their farming business.
- A Subchapter S-corporation is incorporated under Chapter S of the Internal Revenue code. Each shareholder is responsible for filing their own taxes on the profits the corporation distributes. For example, a law firm or other partnership may incorporate their business under Chapter S.
- Other corporations include companies that sell stock to investors. Proctor & Gamble, AT&T and Starbucks are examples of businesses that sell stock to investors. Owning stock in a corporation does not make the individual self-employed.

When a participant's corporation is considered self-employment

For SNAP, the owner or shareholders of a corporation are not self-employed.

For all other programs, an individual with an ownership interest in a corporation is not considered self-employed unless they meet self-employment criteria listed per OAR 461-145-0910.

Treatment of income

For all programs except MSP and OSIPM:

- If an individual works for the corporation, that person is considered an employee of the corporation. In that case, treat the profits distributed to shareholders of a closely held or Subchapter S-corporation as earned income. If profits for the current year are expected to be similar to the prior year, treat the profits reported on the most recent IRS 1040 as periodic income.
- If a shareholder of a corporation is not an employee of the corporation and not receiving a salary, count any dividends as unearned income.

For SNAP, income from business entities and corporations is treated as follows:

- If a participant is actively working in a corporation, the income is treated as earned income.
- If a participant is actively working in an unincorporated business entity, determine if the income is treated as earned or as self-employment.
- If a participant is no longer actively working to produce the income, the income is treated as unearned.
- Income from a limited liability company is treated as follows:
  - If a participant is a member or a manager member and owner, the income is treated as self- employment income.
  - If a participant is a manager and owner of the LLC but not a member, the income is treated as earned income.
  - If a participant is a manager but not an owner of the LLC, the income is treated as earned income.
- If a participant owns stock in a corporation, the value of the stock is a countable resource. However, if ownership of the stock is necessary for the participant to be employed by the corporation, the resource is excluded.

For MSP and OSIPM:

- For an individual with an ownership interest in, and actively working for, a corporation:
  - Count wages paid by the corporation as earned income
  - Count dividend or profits received as unearned income
  - Exclude any income the corporation generates and retains (does not pay as wages or dividends).
  - Exclude the equity value of the stock if maintaining the ownership in the corporation is required to continue working for the corporation (this is usually the case with a closely held corporation). Otherwise, treat stock in accordance with the rules for stocks, bonds, and other securities (does not apply to MSP).
- For an individual with part or full ownership of a corporation who does not work:

- Count the equity value of their interest in the corporation as a resource (does not apply to MSP)
- Count any income received as unearned income.
- Count any items gifted or given by the corporation, such as a car or furniture, as unearned in-kind income.

Note: The use of something is generally not considered in-kind income, except the use of shelter and utilities, which is considered shelter in-kind.

Other business entities

This includes all other business arrangements that are not considered corporations - sole proprietorships, partnerships, and unincorporated limited liability companies (LLC).

For MSP and OSIPM:

- If an individual is part or full owner of any type of a business entity other than a corporation, can be considered a principal, and is working for the business, the individual is considered self-employed and income and resources should be evaluated under the self-employment rules.
- If the individual has an ownership interest in any type of business entity other than a corporation, does not meet the definition of a principal (e.g. they are not responsible for its success or failure or have no authority in its daily operation), but works for the business:
  - The income is treated as earned income, except:
  - Any dividends or profits are treated as unearned income.
  - If the individual has to maintain ownership of the business in order for him or her to work there, the value of the ownership interest is excluded; otherwise, the equity value of the ownership interest is treated as a resource.
- If the individual has an ownership interest in any type of business entity other than a corporation (regardless of principal status), but does not work for the business:
  - The equity value of the ownership interest is a countable resource
  - Any income from the business is considered unearned income

Corporation and other business entity expenditures benefiting a principal

For all programs, an expenditure by a business entity or corporation that benefits a principal, such as a car or housing payment, is considered available when the expenditure is made and is counted as earned income.

For purposes of this rule, a principal is a person with significant authority in a business entity or corporation, including a sole proprietor, a self-employed person, a partner in a partnership, a member or manager of a limited liability company and an officer or principal stockholder of a closely held corporation.

Corporate assets

Except in cases where the owners of corporations are considered self-employed, assets held and owned by the corporation are not considered the participant's assets.

Note:

- To locate information on the business, see the Secretary of State website at http://sos.oregon.gov/business/Pages/business-information-center.aspx, Business Information. If the business is licensed as a corporation in Oregon, the business name should appear in a business name search.
- The owner of a closely held corporation will have legal documents showing the date the business was incorporated.

For HSD medical programs, income from corporations and business entities are counted in both monthly and annual income.

Click here for examples: Corporations and business entities.

Oregon Administrative Rule(s)

461-145-0088 — Corporations and Business Entities; Income and Resources; Not OSIP, OSIPM, or QMB
461-145-0089 — Corporations and Other Business Entities; Income and Resources, Not Self-Employment; OSIP, OSIPM, QMB
461-145-0910 — Self-Employment; General; Not OSIP, OSIPM, or QMB
461-145-0915 — Self-Employment; General; OSIP, OSIPM, QMB
410-200-0015 (54) and (55) — General Definitions

Disability benefits

This policy covers public and private disability benefits, except the following:

- Agent Orange disability benefits
- Radiation Exposure Compensation Act payments
- Social Security based on disability or SSI
- Veterans' benefits
- Workers' compensation.

In ONE, disability payments covered in this section are coded on the Specific Income screen:

- Specific Income Category – Disability or Worker's Comp
- Specific Income Type – Other Disability Payments

For each disability payment covered under this policy:

- If received monthly or more frequently:
  - **For ERDC, REF, REFM, SNAP and TANF**., income from employer-sponsored disability insurance is counted as earned income if paid to a participant who is still employed while recuperating from a temporary illness or injury.
  - **For OSIPM and MSP**, income from employer-paid disability insurance is counted as earned income if received within six full calendar months after stopping work.
  - **For HSD medical programs:**

    - » If the disability benefit is from an employer-sponsored insurance plan and the individual paid premiums for this disability insurance on a pre-tax basis, or their employer paid the premium for them, the taxable portion of the disability payment is counted for both monthly and annual income.
    - » If the disability benefit is not from an employer-sponsored insurance plan, the payments are excluded for monthly and annual income.
  - Except as provided above, the payment is counted as unearned income.
- All payments other than those noted in the first bullet of this section are counted as periodic or lump-sum income.

Oregon Administrative Rule(s)

461-145-0090 — Disability Benefit
410-200-0015 (54) and (55) — General Definitions

Disaster relief

A major disaster is any natural catastrophe such as a hurricane or drought or, regardless of cause, any fire, flood or explosion the President determines causes damage of sufficient severity and magnitude.

An emergency is any occasion or instance for which the President determines federal assistance is needed to supplant state and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe.

Disaster Unemployment Assistance is emergency assistance authorized under P.L. 100 107 and received by individuals who are unemployed as a result of a major disaster. Individuals receiving Disaster Unemployment Assistance are not eligible for other unemployment compensation and cannot receive both at the same time. Payments are limited to 26 weeks.

In ONE, payments and benefits from Disaster Relief are coded on the Unearned Income screen:

- Unearned Income Category – Disaster Relief
- Unearned Income Type – there are several types to choose from, select the one which is applicable to the type being reported:
  - Disaster Relief payments from Disaster Assistance Act of 1988 to farmers for crop losses/failures
  - Disaster Relief payments from Federal Emergency Management Agency (FEMA)
  - Disaster Relief payments from Individual & Family Grant Assistance program
  - Disaster Relief payments from Small Business Administration (SBA)
  - Disaster Relief payments from state or local governments or disaster assistance organizations
  - Disaster Relief payments from voluntary disaster assistance organizations such as Red Cross
  - Disaster Relief payments under Disaster Relief & Emergency Assistance Amendments of 1988 (P.L. 100-707)
  - Disaster Relief payments under Disaster Relief Act of 1974 (P.L 93-288)
  - Disaster Relief payments under the National Flood Insurance Act of 1968
  - Disaster Unemployment Compensation

For all programs except HSD medical:

- The following payments, precipitated by an emergency or major disaster, are not counted as income or resources when determining eligibility for or benefit levels:
  - Payments received under the Disaster Relief Act of 1974 (P.L. 93-288, Section 312(d)) as amended by the Disaster Relief and Emergency Assistance Amendments of 1988 (P.L. 100-707, Section 105(i)).
  - Disaster assistance comparable to subsection (a) of this section provided by states, local governments, and disaster assistance organizations.
  - Payments from the Federal Emergency Management Agency (FEMA).
  - Individual and Family Grant Assistance program (IFG).
  - Grants or loans by the Small Business Administration (SBA).
  - Voluntary disaster assistance organizations, such as the Red Cross.
  - Private insurance payments for losses due to a major disaster such as flood, wind, land movement.
- Government payments designated for the restoration of a home damaged in a disaster are excluded as income or resources in the month of receipt and as a resource in subsequent months, if the household is subject to a legal sanction if the funds are not used as intended.
- Each payment made to farmers under the Disaster Assistance Act of 1988 (Public Law (P.L.) 100-387) for crop losses or failure in a disaster is excluded.
- Income received from public and private organizations by individuals working in disaster relief efforts and funded under a National Emergency Grant by Work Investment Act (WIA) Title 1 (P.L. 105-220) is excluded. An individual is eligible under this funding source if they are a dislocated worker, a long-term unemployed individual, or temporarily or permanently laid off as a consequence of the disaster. Eligibility under this

funding source is limited to a period of up to six months per disaster.

- Disaster Unemployment Assistance is excluded as both income and a resource.
- Payments for flood mitigation received by a homeowner under the National Flood Insurance Act of 1968, as amended by P.L. 109-64, are not counted as income or resources.

For For HSD medical programs, exclude all disaster relief payments for monthly and annual income, except for Disaster Unemployment Compensation, which is counted for both.

Oregon Administrative Rule(s)

461-145-0100 — Disaster Relief
410-200-0015 (54) and (55) — General Definitions

Disqualifying income; SNAP

SNAP benefits received by TANF recipients may not increase when the TANF cash payment ends or is reduced due to a penalty. Eligibility for and the level of SNAP benefits is determined as if the participant were receiving benefits without the reduction in TANF benefits due to the penalty.

TANF disqualifying income is the difference between the TANF cash payment prior to the penalty and the TANF cash payment once the penalty is imposed.

The disqualifying TANF income is counted as unearned income when the TANF cash payment is reduced due to any of the following reasons:

- Failure to pursue assets
- Failure to help the Oregon Department of Justice Division of Child Support obtain child support from a noncustodial parent
- Failure to obtain medical coverage
- Failure to comply with requirements of the employment programs
- Failure to seek treatment for substance abuse or mental health evaluation and treatment
- TANF intentional program violation (IPV) imposed
- Repayment of a TANF participant-caused or IPV overpayment. Do not include repayment on an overpayment resulting from aid paid pending due to a hearing request.

Oregon Administrative Rule(s)

461-145-0105 — Disqualifying Income; SNAP

Dividends, interest, royalties

In ONE, these incomes are coded as follows:

- Dividends and Interest are coded on the Unearned Income screen:
  - Dividends from a business entity, not self-employed:
    - » Unearned Income Category – Other Income
    - » Unearned Income Type – Dividends (from Business Entity, not self- employed)
  - Dividends (not including self-employed dividends) and interest:
    - » Unearned Income Category – Dividends/Interest/Capital Gains
    - » Unearned Income Type – there are several types to choose from, select the one which is applicable to the type being reported:
      - Dividends (not including Self Employment Dividends)
      - Interest - Dividends, Municipal Bonds, Private Activity Bonds
      - Interest – Other
- Royalties (Including Mineral Rights) are coded on the Specific Income screen:
  - Specific Income Category – Royalties (Including Mineral Rights)
  - Specific Income Type – Royalties (Including Mineral Rights)

For all programs except OSIPM, MSP and HSD medical:

- Dividends are counted as unearned income.
- Interest income is counted as unearned income.
- Royalties are counted as unearned income, except royalties are counted as earned income if the participant is actively engaged in the activity from which the royalties are accrued

For OSIPM and MSP:

- Dividends and interest earned on mutual funds and securities, including stocks, bonds, educational savings bonds and certificates of deposit (CDs), are excluded as income unless captured differently in another section of the rules.
- Interest earned on other assets is treated according to the rule for that asset. For example, interest and dividends earned on funds in a bank account are covered under the rule for bank accounts.
- Royalties include compensation paid to the owner for the use of property, usually copyrighted material or natural resources, such as coal, oil or natural gas, which normally are extracted from the ground. Payments received must be under a formal or informal agreement where the owner authorizes another individual or company to manage and extract a product (e.g., gas or oil) in an amount dependent on the amount of the product actually extracted. For example, an individual receives royalties from a percentage of ownership of oil or gas production.
- Royalties received by an individual in connection with any publication of the individual's work are treated as earned income. Examples include royalties received from publication of a manuscript(s), magazine article(s) or artwork.
- When individuals are actively working in a trade or business that generates royalties:

- If the individual meets the criteria of self-employed, the income is counted as self-employment income.
- Income that doesn't meet the criteria of self-employment is counted as earned income.

For HSD medical programs, royalties and dividends, not including self-employment dividends, are considered unearned income and counted for both monthly and annual income.

Oregon Administrative Rule(s)

461-145-0108 — Dividends, Interest and Royalties
410-200-0015 (54) and (55) — General Definitions

Domestic Volunteer Services Act (VISTA, RSVP) and Small Business Act (SCORE, ACE)

Volunteers in Service to American (VISTA) was founded in 1965. VISTA merged with the Peace Corps under the Domestic Volunteer Service Act (DVSA) in 1973. In 1993 when the National and Community Service Trust Act (NCSTA) was signed, AmeriCorps was created, and VISTA was incorporated into AmeriCorps. There are three types of AmeriCorps: AmeriCorps State and National, AmeriCorps National Civilian Community Corps (NCCC) and AmeriCorps VISTA. All references in this section to VISTA mean AmeriCorps VISTA.

In ONE, these incomes are coded as follows:

- Domestic Volunteer Programs are coded on the Specific Income screen:
  - Specific Income Category – Domestic Volunteer Programs
  - Specific Income Type – there are two different types to choose from, select the one which is applicable to the type being reported:
    - » Domestic Volunteers Service Act: Title 1
    - » Domestic Volunteers Service Act: Title 2
- Small Business Act - ACE/SCORE are coded on the Unearned Income screen:
  - Unearned Income Category – Small Business Act - ACE/SCORE
  - Unearned Income Type – Small Business Act - ACE/SCORE

Note: Individuals join VISTA as of the date they take the oath. If the individual has a previous VISTA contract and received SNAP benefits in another state, use the date they begin the new assignment in Oregon.

Exclude programs under Title II (National Senior Corps Association), which include:

- Retired Senior Volunteer Program (RSVP) Title II, Section 201
- Foster Grandparents Program Title II, Section 211
- Senior Companions program.

Exclude programs under 15 USC 637(a)(1)(the Small Business Act), which include:

- Service Corps of Retired Executives (SCORE)
- Active Corps of Executives (ACE)

For payments under Title I (VISTA, University Year of Action, and Urban Crime Prevention):

- **For OSIPM and MSP**, exclude the payments.
- **For ERDC**, exclude these payments unless the total value of all VISTA compensation is equal to or greater than compensation at the state minimum wage. If so, count as earned income.
- **For REF, REFM and TANF,** the value of the educational award is excluded; all remaining payments count as earned income.
- **For HSD medical programs,** exclude Domestic Volunteer Services Act payments, both title I and title II, for monthly and annual income.
- **For all other programs**:
  - Exclude VISTA payments if the individual is receiving program benefits when they join VISTA. Continue to exclude the payments until the individual has a break in receiving benefits of more than one month.
  - Count VISTA payments as earned income for individuals who joined VISTA before applying for program benefits.

Oregon Administrative Rule(s)

461-145-0110 — Domestic Volunteer Services Act (VISTA, RSVP) and Small Business Act (SCORE, ACE)
461-145-0365 — National and Community Service Trust Act (NCSTA), including AmeriCorps (other than AmeriCorps VISTA)
410-200-0015 (54) and (55) — General Definitions

Earned income; defined

In ONE, the incomes covered in either of the next two sections, Earned Income Defined and Earned Income Treatment are coded on the Earned Income screen:

- Earned Income Category – Wages

  There are several types of income listed in the Earned Income Defined and Earned Income Treatment sections that are coded under the Earned Income Category – Wages. Refer to the "Earned Income Type" bullet below to determine which of those covered in these sections should be coded under Wages.

  - Earned Income Type – there are several types to choose from, select the one which is applicable to the type being reported:
    - Wages
    - Tips
    - Commissions
    - Draw Against Future Pay
    - Vacation Pay - Cash Out
    - OJT (on the job training) pay
    - JOBS Plus Wages
    - Welfare-to-Work – Work Experience
    - Representative Payee Fee
- Profit Sharing
  - Earned Income Category – Profit Sharing
  - Earned Income Type - Profit Sharing
- Cafeteria Plan Benefits
  - Earned Income Category – Cafeteria Plan Benefits
  - Earned Income Type - Cafeteria Plan Benefits

Earned income is income received in exchange for an individual's physical or mental labor. Earned income includes all of the following:

- Compensation for services performed, including wages, salaries, per-diem, commissions, tips, representative payee fees, sick leave, vacation pay, draws or the sale of one's blood or plasma, also including Health Engagement Model (HEM) payments or other similar payments
- Income from on-the-job training, paid job experience, JOBS Plus work experience or Welfare-to-Work work experience
- In-kind income, when the participant is an employee of the person providing the in-kind income and the income is in exchange for work performed by the participant
- For self-employment, gross receipts and sales, including mileage reimbursements, before costs.
- Income from work-study: treatment from work-study, see Educational income
- Income from profit sharing the participant receives monthly or periodically.

- The fee for acting as an individual's representative payee, as long as the individual is not included in the filing group
- The income a principal earns working for a corporation, unless the individual can be considered self-employed under OAR 461-145-0910 or OAR 461-145-0915.

For SNAP:

- The cafeteria plan benefits and funds placed in a flexible spending account.
- An expenditure by a business entity that substantially benefits principal (see Corporations and other business entities)
- Use the Gross Wage field amount for In-Home Service Home Care Workers. This amount can be found on the In-Home Service Wage Detail screens. Do not count any mileage reimbursement because this is not part of the HCW's income

For all programs except SNAP:

- Cafeteria plan benefits an employee takes as cash as well as funds placed in a flexible spending account.

For OSIPM, MSP:

- A non-business expenditure – including, but not limited to, a personal car or housing payment – paid by an individual's corporation or business entity that benefits the individual.

Note: A cafeteria-style benefit is an amount above base earnings that can be spent on a limited menu of options, usually related to health insurance. Unspent dollars are added to gross wages when the employee's selected option costs less than the full cafeteria benefit amount.

Note: Health insurance purchased with flexible benefits must be assigned to ODHS|OHA, per OAR 461-120-0315.

In-kind income may include rent or utilities credit a participant receives in exchange for work performed. To determine the amount, subtract the amount the participant pays for rent from the amount of the dwelling's usual rent. For example, the rent is $550, but the participant pays only $100 because of work done for the landlord. The earned in-kind income is $450 ($550 - $100).

Oregon Administrative Rule(s)

461-145-0280 — In-kind Income
461-120-0315 — Medical Assignment
461-145-0088 — Corporations and Business Entities; Income and Resources; Not OSIP, OSIPM, or QMB
461-145-0120 — Earned Income; Defined
410-200-0015 (54) and (55) — General Definitions

Earned income; treatment

All earned income not specifically identified below is counted as earned income.

Treat JOBS Plus income as follows:

(a) **For all programs**, count the individual's wages received under the Oregon Employment Department UI

JOBS Plus or the Tribal TANF JOBS Plus programs.

(b) **For all programs except SNAP and TANF**, count the JOBS Plus income from TANF-PLS.

(c) **For all programs except TANF**, count the JOBS Plus income from NCP-PLS.

(d) **For SNAP:**

(A) When JOBS Plus income is earned by TANF-PLS individuals:

(i) Count it in determining initial SNAP eligibility.

(ii) Exclude it in determining ongoing eligibility.

Note: When a person is receiving TANF JOBS Plus, continue to code the TANF grant and the extra JOBS Plus $10 payment as unearned income.

(e) **For TANF:**

(A) When JOBS Plus income is earned by NCP-PLS individuals, count it in determining initial TANF eligibility.

(B) When determining the need for TANF supplements for TANF-PLS individuals, treat the income as follows:

(i) Exclude it in determining the countable income limit and in calculating the benefit equivalency standards.

(ii) Count it in calculating the wage supplement.

(f) **For SNAP, TANF, OSIPM and MSP**, count any JOBS Plus wages received after the month the participant last worked under a JOBS Plus agreement

Note: When a JOBS Plus participant whose selection is based on receiving UI is eligible for TANF or SNAP, switch them to TANF-PLS. TANF individuals are a higher priority for JOBS Plus selection.

Treat Welfare-to-Work work experience income as follows:

(a) **For REF, REFM and TANF**, exclude the first $260 earned per month. Count the remainder as earned income.

(b) **For SNAP,** count all Welfare-to-Work income as earned income.

(c) **For all other programs**, exclude welfare-to-work income.

For ERDC, exclude all earned income of children.

(a) For ERDC, a child must be in the care and custody of the caretaker. They do not need to have a biological or legal relationship to the caretaker. The child must be:

(A) Under the age of 18; or

(B) Under the age of 19 and in secondary school or vocational training at least half time.

For OSIPM and, MSP, exclude documented net losses from a self-employment business from any other source of earned income of the financial group. This does not include dividends or profits.

For SNAP, exclude:

(a) A cafeteria plan benefit, including flexible spending plans, that an employee cannot elect to receive as cash which is designated and used to pay for child care, medical care, or health insurance unless it is reimbursed by ODHS|OHA; or allowed as an earned income deduction.

Note: In SNAP, cafeteria plan benefits taken as cash or used to pay for a service paid by ODHS|OHA are counted as earned income. The intent is not to allow "double-dipping" by the participant; that is, being reimbursed twice for the same cost.

(b) The earned income of an individual under age 18 if they are under the parental control of another member of the household and:

(A) Attending elementary or high school;

(B) Attending GED classes recognized by the local school district;

(C) Completing home-school elementary or high school classes recognized by the local school district; or

(D) Too young to attend elementary school.

(c) In-kind earned income, except as provided in section (7).

(d) Any amount deducted from base pay for future educational costs under P.L. 99-576, 100 Stat. 3248 (1986), for individuals on active military duty.

(e) Income remaining after the month of receipt is a resource.

For REF, REFM and TANF:

(a) Exclude the earned income of the following financial group members in the month of receipt. Count any money remaining after the month of receipt as a resource.

(A) Dependent children under age 19, or minor parents (under age 18), who are full-time students in grade 12 or below (or the equivalent level of vocational training, GED courses or home schooling approved by the local school district).

(B) Dependent children under age 18 who are part-time (as defined by the institution) students in grade 12 or below (or the equivalent level of vocational training, GED courses, or home schooling approved by the local school district) and are not employed full time.

(C) Dependent children too young to be in school.

(b) Income remaining after the month of receipt is a resource.

(c) In-kind earned income is excluded.

For REF, REFM and TANF, exclude all in-kind income except unearned third-party payments.

For SNAP, earned in-kind income is excluded unless it is an expenditure by a business entity that benefits a principal. If it benefits a principal, it is treated as countable earned in-kind reimbursement.

For all programs except for HSD medical, the income of a temporary employee of the U.S. Census Bureau employed to assist in taking the census is excluded.

For HSD medical programs, earned Income, as defined, is counted in monthly and annual income.

Oregon Administrative Rule(s)

461-145-0130 — Earned Income; Treatment
461-145-0280 — In-Kind Income
461-145-0120 — Earned Income; Defined
410-200-0015 (54) and (55) — General Definitions

Earned Income Tax Credit (EITC)

Earned Income Tax Credit (EITC) are federal and state tax programs for low-income families. EITC may be received in one of two ways:

- As an advance in the employee's paycheck, or
- As one annual payment received at the time of the normal income tax returns.

In ONE, these incomes are coded as follows:

- Advanced Earned Income Tax Credit received as part of an employee's paycheck is coded on the Earned Income screen:
  - Earned Income Category – Wages
  - Earned Income Type – Advanced Earned Income Tax Credit
- The Earned Income Tax Credit received annually is coded on the Unearned Income screen:
  - Unearned Income Category – Refunds and Rebates
  - Unearned Income Type – Earned Income Tax Credit

The EITC is excluded from assets in the month of receipt and then for a maximum of 12 calendar full months starting with the month following the month of receipt of the refund or payment. All funds remaining after the 12-month period are counted as a resource.

For HSD medical programs, exclude the Earned Income Tax Credit in monthly and annual income.

Oregon Administrative Rule(s)

461-145-0140 — Earned Income Tax Credit (EITC)
410-200-0015 (54) and (55) — General Definitions

Educational income

The following is cited from Oregon Administrative Rule 461-145-0150 — Educational Income:

Educational income is income designated specifically for educational expenses. To be considered educational income, the income must be given to one of the following:

(a) A student at a recognized institution of post-secondary education. Post-secondary education is education offered by institutions primarily to individuals age 18 or older (Admission may or may not require a high school diploma or equivalent.)

(b) A student at a school for people with disabilities

(c) A student in a vocational education program

(d) A student in a program that provides for completion of secondary school diploma or the equivalent

To determine the amount of educational income to exclude, use education expenses listed in the financial aid award letter unless one of the following is true:

(a) The information is not available in the award letter, or the student provides verification of amounts different from those listed in the award letter. In these situations, use the verified amounts from the student.

(b) The student receives child care benefits (i.e., ERDC or other child care subsidies). In that situation, exclude from educational income the amount the student actually pays for child care (e.g., the ERDC copay) instead of the amount shown in the award letter.

(c) The student states actual transportation costs exceed the amount allowed for the expense in the award letter. In that situation, calculate the number of commuting miles to and from school and multiply by 20 cents. Exclude the calculated amount or the amount from the award letter, whichever is greater.

Exclude the following items:

(a) Educational income authorized by the Carl D. Perkins Vocational and Applied Technology Education Act, Title IV of the Higher Education Act, or made available by the Bureau of Indian Affairs (BIA)

(b) All income from educational loans.

(c) OSIPM, MSP. The augmented portion of a shelter stipend from the Department of Veterans Affairs designated for the individual's dependent.

Exclude the cost of the following items from remaining educational funds (including non-title IV work study):

(a) Tuition, mandatory fees, books and supplies, transportation, required rental or purchase of equipment or materials charged to students enrolled in a specific curriculum, other miscellaneous personal expenses (except room and board) and loan originator fees and insurance premiums required to obtain an educational loan

(b) For all programs except ERDC, also exclude dependent care costs.

For a participant in the Parents as Scholars (PAS) component of the JOBS program who is approved for PAS pursuant, exclude all remaining educational funds, including those funds intended for room and board:

In ONE, these incomes are coded as indicated below. Code the gross amount of income received. Expenses will be entered on the Education Expense screen and the system will deduct these from the total income as applicable per program:

- With the exception of Work Study, Educational income is coded on the Unearned Income screen:
  - Unearned Income Category – Educational Assistance
  - Unearned Income Type – there are several different types to choose from, select the one which is applicable to the type being reported:
    - » Educational Income: Carl D. Perkins Vocational & Applied Technology Education Act
    - » Educational Income: from the Bureau of Indian Affairs (BIA)
    - » Educational Income: Loans
    - » Educational Income: Non-Title IV (not loans)
    - » Educational Income: Title IV
- Work Study is coded on the Earned Income screen:
  - Earned Income Category – Educational Income (Earned)
  - Earned Income Type – there are two different types to choose from, select the one which is applicable to the type being reported:
    - » Educational Income -Federal/State Funded Work Study
    - » Educational Income -Other Work Study

For all programs, after allowing exclusions, treat the remaining income as follows:

(a) Count work study, fellowships and teaching-assistant income not excluded in another section of this rule as earned income. This may include work study provided through the VA program or other educational programs.

(b) For all programs, count other educational income (grants, Montgomery GI Bill [VA Chapters 30, 32, 35, 1606 or 1607, Veterans Retraining Assistance Program (VRAP)], Post 9-11 (9/11) GI Bill [VA Chapter 33], etc.) by prorating it over the period it is intended to cover, then begin counting the prorated amount in the first month of the period if the participant has already received the income. If income has not been received, begin counting the prorated amount in the month of the period it is expected to be received.

(c) Count the VA Chapter 31 subsistence allowance. When participating in this program, the VA pays all tuition, books and fees. All education costs are provided for the student except transportation and child care.

(d) Individuals may be attending school under the displaced workers program. In this instance, the student will continue to receive weekly UC benefits while attending school. Treat displaced worker payments the same as UC benefits.

Note: If a SNAP participant begins receiving ERDC, remember to recalculate SNAP educational income because the exclusion for child care expenses has changed.

Educational awards paid under the National and Community Service Trust Act of 1993 (including AmeriCorps) are treated in accordance with OAR 461-145-0365.

In ONE, code this on the Specific Income screen as follows:

- Specific Income Category – Domestic Volunteer Programs
- Specific Income Type – National and Community Service Trust Act (NCSTA): Educational Award

For OSIPM and MSP, distributions from a Coverdell Education Savings account and gifts used for education purposes in accordance with OAR 461-145-0145.

For HSD medical programs, exclude education income, for monthly and annual income, except for non-title IV (not loans) educational income, which is excluded from monthly but counted for annual income.

Oregon Administrative Rule(s)

461-145-0150 — Educational Income
461-150-0060 — Prospective or Retrospective Eligibility and Budgeting; ERDC, REF, REFM, SNAP, TANF
461-145-0580 — Veterans' Benefits
461-160-0430 — Income Deductions; SNAP
461-145-0550 — Unemployment Compensation Benefits
410-200-0015 (54) and (55) — General Definitions

Energy assistance

For all programs, exclude all energy assistance payments or allowances made under any federal, state or local law. These payments include:

- Energy assistance payments provided through a U.S. Department of Health and Human Services Low-Income Assistance Program.
- Energy assistance payments provided through the Low-Income Energy Assistance Act of 1981 under P.L. 97-35, Section 2605(F) (LIEAP).
- Payments made under PL99-425, Section (e), the Low Income Energy Assistance Act of 1986.

See Housing and Urban Development on how to treat utility payments received by the U.S. Department of Housing and Urban Development and the U.S. Department of Agriculture Rural Housing Service.

In ONE, energy assistance payments are coded on the Unearned Income screen:

- Unearned Income Category – Housing/Energy Assistance
- Unearned Income Type – there are several different types to choose from, select the one which is applicable to the type being reported:
  - Energy Assistance - Not from TANF
  - Energy Assistance - TANF
  - HUD Payments: Cranston-Gonzalez National Affordable Housing Act Service Payments

Oregon Administrative Rule(s)

461-145-0170 — Energy Assistance Payments
461-145-0230 — Housing and Urban Development
410-200-0015 (54) and (55) — General Definitions

Family Abuse Prevention Act (FAPA) payments

FAPA payments are court-ordered payments to victims of domestic violence made under authority of ORS 107.718(1)(h). A payment is considered available when actually received by the victim of abuse.

In ONE, family abuse prevention payments (FAPA) are coded on the Unearned Income screen:

- Unearned Income Category – Other Income
- Unearned Income Type – Family Abuse Prevention Payments (FAPA)

For all programs except HSD medical programs, the first $2,500 is excluded. The excess above $2,500 is counted as a resource.

For HSD medical programs, exclude Family Abuse Prevention Act (FAPA) payments for monthly and annual income.

Oregon Administrative Rule(s)

461-145-0175 — Family Abuse Prevention Act (FAPA) Payments
410-200-0015 (54) and (55) — General Definitions

Floating homes and houseboats

Floating homes and houseboats that are the individual's home are treated as a home. Otherwise, they are treated as real property or income-producing property, depending on the use.

For HSD medical programs, resources are not considered in eligibility determination.

Oregon Administrative Rule(s)

461-145-0185 — Floating Homes and Houseboats
461-145-0420 — Real Property
461-145-0220 — Home
461-145-0250 — Income-Producing Property; Not OSIP, OSIPM, or QMB
461-145-0252 — Income-Producing Property; OSIP, OSIPM, and QMB
410-200-0015 (54) and (55) — General Definitions

Food programs; other than SNAP

For all programs, exclude the following:

- Benefits from the Special Supplemental Food Program for Women, Infants and Children (WIC) (Also, exclude WIC demonstration project coupons that may be exchanged for food at farmers' markets.)

- The value of supplemental food assistance under the Child Nutrition Act and the National School Lunch Act (This includes the Special Milk Program, School Breakfast Program, the Summer Food Service Program, the Commodity Program and the Child and Adult Food Program.)
- Benefits from the WIC Farm Direct Nutrition Program
- Nutrition Assistance Program benefits received in Puerto Rico, American Samoa or the Commonwealth of the Northern Mariana Islands.

For SNAP, individuals receiving Tribal Food Distribution Program products are not eligible to receive SNAP in the same month.

For all other programs, Tribal Food Distribution Program benefits are excluded.

Oregon Administrative Rule(s)

461-145-0190 — Food Programs Other Than the SNAP Program
461-165-0030 — Concurrent and Duplicate Program Benefits
333-052-0030 — Oregon Farm Direct Nutrition Program; Program Overview
410-200-0015 (54) and (55) — General Definitions

Foster care/guardianship assistance payment

Foster care is when an individual is placed in the home of relatives or other individuals or families by a federal, state or local governmental foster care program. This could be child or adult foster care.

Guardianship Assistance payments are made by Child Welfare for children under age 18 when a person has agreed to be the child's guardian. These payments are authorized under a foster care waiver.

A foster care payment is:

- The payment the foster care provider receives from the foster care program, and
- For adults in foster care, this also includes their room and board payment and any service payment the participant is required to pay the provider.

Note:

- An adult in foster care is required to pay the room and board part of the foster care payment. Children in foster care do not make this separate payment.
- Per OAR 461-110-0630, parents in foster care for whom foster care payments are being made cannot have their needs counted for TANF.
- Proctor care administered by or under contract to a state agency is a form of foster care. Treat these situations and income the same as foster care.
- Child Welfare foster care payments pay the costs necessary for providing care for the child. The entire payment is designated by CW to provide for the child's room and board, personal incidentals and special needs. The provider does not receive additional compensation for their service as a child foster care provider.

In ONE, payments from Foster Care/Guardianship Assistance are coded on the Specific Income screen:

- Specific Income Category – Foster Care/Guardianship Assistance
- Specific Income Type – Foster Care/Guardianship Assistance

Treat foster care/guardianship assistance payments as follows:

- **For all programs except ERDC, REF, REFM, SNAP and TANF:**
  - If the provider of foster care/guardianship is in the financial group:
    - » Exclude the amount the placement agency identifies as room and board, clothing and personal incidental needs (including recreational expenses) of the foster care/guardianship assistance participant.
    - » Exclude the amount designated for special need items of the foster care/guardianship assistance participant.
    - » Count the remaining amount as earned income.
  - If the provider of foster care/guardianship is not in the financial group, exclude the foster care payments.
- **For ERDC,** exclude foster care and guardianship payments.
- **For SNAP,** count the payments for foster care or guardianship assistance as follows:
  - If the person receiving the foster care or assistance is a member of the household group, but not the filing group, exclude the income.
  - If the person receiving the foster care or assistance is a member of the filing group, count the payment from the foster care program as unearned income for the care provider.

    Note: Do not count the room and board or service payment as income the foster care recipient is paying to the provider when they are in the same filing group. This is because the foster care person's income has been counted already and income that changes hands between financial group members is not counted.
  - If the person receiving the foster care or assistance is not a member of the household group, count the payment (both parts) as self-employment income for the foster care provider.
- **For REF, REFM and TANF**, count the payments for foster care or guardianship as follows:
  - If the person receiving adult foster care or assistance is a member of the household group but not the filing group, exclude the income.
  - If the person receiving adult foster care or assistance is a member of the filing group, count the payment from the foster care program as unearned income for the care provider.
  - For children in foster care, exclude the payments or benefits.

For HSD medical programs, foster care payments and Guardianship Assistance are treated as follows:

- If the income is being received for a child, the payments are excluded for monthly and annual income.
- If the income is being received for an adult, and the individual receiving the income cares for six or more qualified foster individuals, the payments are counted for monthly and annual income.

Oregon Administrative Rule(s)

461-145-0200 — Foster Care Payments and Guardianship Assistance Benefits
410-200-0015 (51) and (52) — General Definitions
410-200-0015 (54) and (55) — General Definitions

Gifts and winnings

Gifts are items given to or received by an individual on or for a special occasion, such as a holiday, birthday, graduation or wedding. They are not given or received on a regular basis.

Winnings are prizes given to an individual in a contest, game of chance or similar event. Winnings in the form of money may be distributed periodically (e.g., monthly) or in a lump sum.

Gifts and winnings in the form of either a gift card or certificate are excluded.

For employment-related items, see OAR 461-145-0130.

In ONE, Gifts and Winnings are coded on the Unearned Income screen:

- Unearned Income Category – Winnings/Gifts
- Unearned Income Type – there are two different types to choose from, select the one which is applicable to the type being reported:
  - Gifts
  - Winnings

For all programs except ERDC, treat in-kind gifts and winnings according to policy for the specific type of asset. Treat gifts and winnings in the form of money as periodic or lump-sum income.

For ERDC, exclude all gifts and winnings.

For HSD medical programs, gifts are excluded for monthly and annual income. Winnings are counted.

Oregon Administrative Rule(s)

461-145-0210 — Gifts and Winnings
461-145-0130 — Earned Income; Treatment
410-200-0015 (54) and (55) — General Definitions

Groundfish disaster benefits

People working in the commercial fishing industry may qualify for groundfish disaster benefits. These benefits are disbursed through the Oregon Employment Department to persons involved in the commercial fishing industry in Oregon's coastal communities.

To qualify for groundfish disaster benefits, a ground fisher must be working with the Oregon Employment Department as a displaced worker. They must also commit to not return to work in the commercial fishing industry.

The ground fisher eligible for these benefits may receive assistance for up to nine months. The monthly payments

can be as much as $1,500 for a family or $1,000 for an individual. The payments may be less if the person is receiving unemployment compensation.

Groundfish disaster benefits are counted as unearned income for all programs.

For HSD medical programs, resources are not considered in eligibility determination.

Oregon Administrative Rule(s)

461-140-0010 — Assets; Income and Resources

Home

Home defined

A home is the place where the filing group lives. A home can be a house, boat, trailer, mobile home or other habitation. A home also includes the following:

- Land on which the home is built and contiguous property
  - **For all programs except OSIPM, MSP and SNAP**, property must meet all the following criteria to be considered contiguous property:
    - » It must not be separated by land owned by people outside the financial group.
    - » It must not be separated by public rights-of-way, such as roads.
    - » It must be property that cannot be sold separately from the home.
  - **For OSIPM, MSP, and SNAP**, contiguous property is property not separated by land owned by people outside the financial group. In addition:
    - » Contiguous property may be separated by public rights-of-way, such as roads, and
    - » Property is contiguous even when it can be sold separately from the home.
  - Other dwellings on the land surrounding the home that cannot be sold separately from the home
  - Additionally, for SNAP, land on which the financial group is building, or plans to build, their home.

Exclusion of home and other property

For a participant who has an initial month of long-term care or waivered services on or after Jan. 1, 2006:

- For purposes of this subsection “child” means a biological or adoptive child who is:
  - Under age 21, or
  - Any age and meets the Social Security Administration criteria for blindness or disability.
- The equity value of a home is excluded if the requirements of at least one of the following are met:
  - The child of the individual or relative dependent on the individual for support occupies the home
  - The spouse of the individual occupies the home
  - The equity in the home is $$603,000 or less and the requirements of at least one of the following are met:
    - » The individual occupies the home.

  - » The home equity is excluded under the income-producing property rules.
  - » The home is listed for sale per the real property rule.
- The equity in the home is more than $$603,000 and the individual is unable legally to convert the equity value in the home to cash.

For all other filing groups, the value of a home is excluded when the home is occupied by any member of the filing group.

For SNAP, exclude the value of a home when it is occupied by the financial group. Additionally, for SNAP, exclude the value of land on which the group is building, or plans to build, their home. If the SNAP financial group owns (or is buying) the home they live in and has separate land they intend to build on, only exclude the home in which they live. Treat the land they intend to build on as real property.

Exclusion during temporary absence

If the value of the home is excluded above, the value of a home remains excluded in each of the following situations:

- For the purposes of this section, "evidence" includes a written statement from a competent individual.
- **In all programs except OSIPM**, during the temporary absence of all members of the filing group from the property, if the absence is due to illness or uninhabitability from casualty or natural disaster, and the filing group intends to return home
- **For SNAP,** if the financial group's absence is due to employment or training for future employment.
- **For OSIPM:**
  - ◆ When the individual is absent to receive long-term care or home and community-based care, under one of the following conditions:
    - » The absent individual has provided convincing evidence they will return to the home. The evidence must reflect the subjective intent of the participant, regardless of the participant's medical condition. A written statement from a competent participant is sufficient to prove the intent.
    - » The home remains occupied by the participant's spouse, child or a relative dependent on the participant for support; and the child must be under age 21 or, if over age 21, blind or an individual with a disability as defined by SSA criteria
  - ◆ When the individual is absent due to illness, employment or training for future employment, seasonal employment, or uninhabitability; and both of the following conditions are met:
    - » The absent individual has provided evidence that the absent individual will return home, and
    - » The evidence reflects the subjective intent of the individual, regardless of the individual's medical condition.

For REF, REFM and TANF, if all members of the financial group are absent due to one of the following:

- The members are employed in seasonal employment and intend to return to their home when the employment ends, or
- The members are searching for employment and the search requires the filing group to relocate away from

their home. Exclude the home for up to six months from the last date all members left their home to search for employment. After the six months, if a member of the financial group does not return, the home is no longer excluded.

Note: If a home is sold or transferred, review the transaction to determine its effect on the participant's eligibility.

For HSD medical programs, resources are not considered in eligibility determination. If a home is owned by a member of the EDG and is considered income-producing property, refer to that section for information on how to code the income.

Oregon Administrative Rule(s)

461-145-0220 — Home
461-145-0420 — Real Property
461-145-0250 — Income-Producing Property; Not OSIP, OSIPM, or QMB
461-145-0252 — Income-Producing Property; OSIP, OSIPM, and QMB

Housing and Urban Development (HUD)

Treat payments from HUD made to a third party as follows:

- **For EA, ERDC, OSIPM, MSP and SNAP**, exclude these payments.
- **For REF, REFM and TANF**, use the payment in determining shelter-in-kind income.

Treat HUD payments made directly to a member of the financial group, except Youthbuild Program payments and Family Investment Centers payments, as follows:

- **For EA**, count as unearned income.
- **For ERDC, OSIPM and MSP**, exclude these payments.
- **For SNAP**, exclude payments for utilities. Count other payments as unearned income.
- **For REF, REFM, and TANF**, use the payment in determining shelter-in-kind income. If the payments are made in a lump sum, count as unearned income.

Exclude the equity value of escrow accounts established for families participating in the Family Self-Sufficiency (FSS) program sponsored by HUD.

Treat payments issued under the Cranston-Gonzalez National Affordable Housing Act, Public Law 101-625 (Family Investment Centers) as follows:

- Count wages as earned income and stipends as unearned income.
- Exclude service payments for items such as child care, basic education, literacy or computer skills training, employment training or counseling assistance in attaining a GED.

In ONE, service payments made under the Cranston-Gonzalez National Affordable Housing Act are coded on the Unearned Income screen:

- Unearned Income Category – Housing/Energy Assistance
- Unearned Income Type – HUD Payments: Cranston-Gonzalez National Affordable Housing Act Service Payments

Note: Groups that receive utility reimbursements are still eligible for the utility allowance (FUA) if they pay heating costs above the reimbursement.

For HSD medical programs, HUD payments issued under the Cranston-Gonzalez National Affordable Housing Act are excluded for monthly and annual income.

Oregon Administrative Rule(s)

461-145-0230 — Housing and Urban Development
410-200-0015 (54) and (55) — General Definitions

Income-producing property

Income-producing property is any real or personal property that generates income for the financial group. Examples of income-producing property are:

- Livestock, poultry and other animals
- Farmland, rental homes (including a room or other space in the home or on the property of a member of the financial group), vacation homes, condominiums
- **SNAP** If an individual is receiving rent for the property they live in, do not count this as income unless it exceeds the expense for the property.

In ONE, income from Income-producing property is coded on the Self-Employment Income screen. The Income Category and Income type are the same depending on what type of is being reported, select the one which is applicable to the type being reported:

- Self-Employment Income Category and Self-Employment Income Type– Income from Income Producing Animals
- Self-Employment Income Category and Self-Employment Income Type – Rental Property
- Self-Employment Income Category and Self-Employment Income Type –Room Rental
- Self-Employment Income Category and Self-Employment Income Type – Room & Board Rental

For all programs except TANF, count the income from income-producing property as follows:

- If a financial group member actively manages the property 20 hours or more per week, treat as self-employment income.
- If a financial group member does not actively manage the property 20 hours or more per week, count as unearned income with exclusions allowed only in accordance with OAR 461-145-0920.
  - Necessary costs are the actual costs allowable in determining countable self-employment income.

  - **For SNAP**, financial groups with more than one income-producing property, review each property and the expenses separately to determine the countable income.
- **For TANF,** the income from income-producing property is treated as self-employment income.

Treat the equity value of income-producing property as follows:

- **For REF, REFM and TANF**, count it as a resource.
- **For EA and ERDC**, exclude it.
- **For SNAP**, count as a resource unless one of the following is true:
  - Exclude the equity value of property that produces an annual countable income similar to other properties in the community with comparable market value.
  - Exclude the equity value of income-producing livestock, poultry and other animals.
  - Exclude the equity value if selling the resource would produce a net gain to the financial group of less than $1,500.
  - Exclude the value of work-related property or capital assets under OAR 461-145-0600.
- **For OSIPM**, count as a resource, except as follows:
  - Exclude up to $6,000 of the equity value if the property produces an annual countable income of at least six percent of its equity value. If the income drops below that for reasons the individual cannot control, they have 2 years from the end of the tax year in which the earnings first dropped to increase it up to 6% or more.
  - Exclude any government permits issued to the individual for the purpose of making money (such as a commercial fishing permit). This means the value of the permit is excluded, not the fishing boat, equipment, or supplies (unless we can exclude $6,000 per the previous bullet).

For HSD medical programs, income from income-producing property is counted for monthly and annual income.

Note:

- When the income from income-producing property is treated as unearned income, actual costs are allowed to offset the income. Allow the 50 percent self-employment deduction for SNAP only when the income is counted as earned income and the household has allowable costs.
- For SNAP, when a filing group is renting out rooms in their home, they are not eligible for more than one deduction using the same costs. So if interest on the mortgage payment is used to reduce the income, it cannot also be allowed as a shelter costs.

Click here for examples: Income-producing property.

Oregon Administrative Rule(s)

461-145-0250 — Income-Producing Property; Not OSIP, OSIPM, or QMB
410-200-0015 (51) and (52) — General Definitions
461-145-0600 — Work-Related Capital Assets, Equipment, and Inventory
461-145-0930 — Self-Employment; Determination of Countable Income
461-145-0920 — Self-Employment; Costs That Are Excluded To Determine Countable Income
461-145-0252 — Income-Producing Property; OSIP, OSIPM, and QMB
461-145-0250 — Income-Producing Property; Not OSIP, OSIPM, or QMB
461-145-0910 — Self-Employment; General; Not OSIP, OSIPM, or QMB
461-140-0020 — Availability of Assets
410-200-0015 (54) and (55) — General Definitions

Income-producing sales contract

An income-producing contract is an agreement between two parties where one party is to pay the other party on an ongoing basis for property or goods. A common income-producing contract exists when the participant sells land or a home to another party and the other party pays the participant an agreed upon monthly or periodic payment.

For all programs, count the income received from the sales contract as a sale of a resource.

Treat the equity value of an income-producing sales contract as follows:

For OSIPM:

- Exclude the equity value of a contract resulting from the sale of a home if the entire principal portion of the payments received from the contract is used to purchase another home within three calendar months of receipt of the payments.
- Otherwise, count the outstanding principal balance of the contract as a resource unless the individual provides convincing evidence of a lower cash value or there is a legal bar to the sale of the contract. If there is a legal bar to the sale of the contract, the equity value of the contract is a transfer of assets for less than fair market value.
- Except as provided in the previous bullets, exclude it.

For HSD medical programs, sale of a countable resource is counted for monthly and annual income.

Oregon Administrative Rule(s)

461-145-0240 — Income-Producing Sales Contract
461-145-0460 — Sale of a Resource
410-200-0015 (54) and (55) — General Definitions

Independent living subsidies/Chafee Housing Program

Independent living subsidies are payments made and services provided by Child Welfare to children ages 16 through 20. These payments also include payments under the Chafee Housing Program. The subsidies are to assist

the individuals to live independently when their foster care payments were discontinued on or after the date they reached 16 years of age.

Note: For a description of these payments, see OARs 413-030-0400 to 0455.

In ONE, Independent Living Subsidies including Chafee Housing Payments are coded on the Unearned Income screen:

- Unearned Income Category – Other Income
- Unearned Income Type – Youth Transitions Program Subsidies including Chafee Housing Payments

For all programs except EA and SNAP, exclude all independent living subsidies issued by Child Welfare.

For EA and SNAP, count the payments as unearned income.

For HSD medical programs, exclude Youth Transitions program subsidies, including Chafee Housing Payments for monthly and annual income.

Note: See Educational income for Chafee Education and Training Grant.

Oregon Administrative Rule(s)

461-145-0255 — Youth Transitions Program Subsidies
410-200-0015 (54) and (55) — General Definitions

Tribal (Native American) benefits

Individuals enrolled as a member in a tribe or band may receive income from the tribe. The income may or may not be prescribed by law. The recipient should have documentation showing the type of payment and where it originated.

Process to determine Tribal (Native American) income
Anytime a participant states they are Native American, determine the following:
Name of the tribe the person has a membership
What benefits they receive from the tribe or from Bureau of Indian Affairs (BIA)
Ask if they receive any kind of income, including per capita payments, and how often it is received
Verify the kind of payment and if it issued under a specific public law number. The treatment of income for some public laws is noted in this policy. If the public law number is not present in this policy, contact a program analyst with the public law number to research and determine if the income is counted or excluded.

Some Tribal benefits are issued under a public law. The public laws treat income in these four ways:

- Exclude all of the payments.
- Exclude the first $2,000 of each payment received by each individual of the financial group. Any remaining balance is countable income.
- Exclude the first $2,000 received in a year by each individual of the financial group. Any remaining balance is

countable income.

- Count all of the payments.

Note: The tribal office may also verify if the payment is made under a specific public law (P.L.) and the P.L. number.

Income — treatment of Tribal benefits

For HSD medical programs, exclude all income from tribal benefits for monthly income. All types are countable for annual income.

For all other programs, consult the chart below:

Public law	Description	1. Exclude all payments	2. Exclude first $2,000 of each payment	3. Exclude first $2,000 per year	4. Count all payments
84-736	Payments from the distribution of funds held in trust to the Seminole Indians of Florida	All programs			
85-794	Distribution of per capita funds to the Red Lake Band of Chippewa Indians from the proceeds of the sale of timber and lumber on the Red Lake	ERDC REF TA-DVS TANF OSIPM MSP	SNAP		
84-926	Payments from the distribution of funds held in trust to the Pueblos of Zia and Jemez tribes of Florida	All programs			
91-259	Payments from the distribution of judgment funds to members of the Confederated Tribes of the Umatilla Indian Reservation	OSIPM MSP			ERDC SNAP TANF\ TA-DVS REF
92-203	Payments from the Alaska Native Claim Settlement Act			All programs	
92-254	Distribution of per capita funds by the Blackfeet and Gros Ventre tribal governments to members, which resulted from judgment funds to the tribes.	ERDC REF TA-DVS TANF OSIPM MSP		SNAP	

Public law	Description	1. Exclude all payments	2. Exclude first $2,000 of each payment	3. Exclude first $2,000 per year	4. Count all payments
92-480	Payments from the distribution of funds held in trust to the Stockbridge Munsee Indian Community of Wisconsin.	All programs			
92-488	Payments from the distribution of funds held in trust to the Burns Indian Colony in Oregon.	All programs			
93-134	Indian Judgement Funds Distribution Act payments received from trust or restricted lands under 25 USC 1408 This does not include payments of funds distributed or held in trust (i.e., in the possession or care of a trustee) according to public laws enacted before October 19, 1973.	ERDC REF TA-DVS TANF OSIPM MSP	SNAP		
93-531	Relocation assistance payments to members of the Navaho or Hopi Tribes.	All programs			

Public law	Description	1. Exclude all payments	2. Exclude first $2,000 of each payment	3. Exclude first $2,000 per year	4. Count all payments
94-114, section 6	Distribution of receipts from lands held in trust by the United States for the following tribes: i. Assiniboine and Sioux Tribe of Montana ii. Bad River Band of the Lake Superior Tribe of Chippewa Indians of Wisconsin iii. Blackfeet Tribe of Montana iv. Cherokee Nation of Oklahoma v. Cheyenne River Sioux Tribe of South Dakota vi. Chippewa Tribe of Minnesota vii. Crow Creek Sioux Tribe of South Dakota viii. Devil's Lake Sioux Tribe of North Dakota ix. Fort Belknap Indian Community of Montana x. Keweenaw Bay Indian Community of Michigan xi. Lac Courte Oreilles Band of Lake Superior Chippewa Indians of Wisconsin xii. Lower Brule Sioux Tribe of North Dakota xiii. Navajo Tribe of New Mexico xiv. Oglala Sioux Tribe of South Dakota xv. Rosebud Sioux Tribe of South Dakota xvi. Shoshone – Bannock Tribes of Idaho; xvii. Standing Rock Sioux Tribe of North Dakota.	All programs			

Public law	Description	1. Exclude all payments	2. Exclude first $2,000 of each payment	3. Exclude first $2,000 per year	4. Count all payments
94-189	Judgment funds distributed to members of the Sac and Fox Indian Nation.	REF SNAP TA-DVS TANF OSIPM MSP	ERDC		
94-540	Judgment funds distributed to members of the Grand River Band of Ottawa Indians	All programs			
95-433	Judgment funds distributed to members of the Confederated Tribes and Bands of the Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation	All programs			
95-498	Receipts derived from trust lands awarded to the Pueblo of Santa Ana and distributed to members of that tribe.	All programs			
95-499	Receipts derived from trust lands awarded to the Pueblo of Zia and distributed to members of that tribe.	All programs			
95-608	Indian child welfare foster care payments.	All programs			
96-305	Relocation assistance payments to members of the Navaho or Hopi Tribes.	All programs			
96-318	Judgment funds distributed to members of the Delaware Tribe of Indians and the absentee Delaware Tribe of Western Oklahoma.	All programs			
96-420	Funds and distributions to members of the Passamaquoddy Tribe, the Penobscot Nation, and the Houlton Band of Maliseet Indians under the Maine Indian Claims Settlement Act.	All programs			
97-95	Distributions of judgment funds to members of the San Carlos Tribe of Arizona.	OSIPM MSP			

Public law	Description	1. Exclude all payments	2. Exclude first $2,000 of each payment	3. Exclude first $2,000 per year	4. Count all payments
97-371	Distributions of judgment funds to members of the Wyandot Tribe of Indians of Oklahoma.	OSIPM MSP			
97-372	Distributions of judgment funds to members of the Shawnee Tribe of Indians (Absentee Shawnee Tribe of Oklahoma, the Eastern Shawnee Tribe of Oklahoma, and the Cherokee Band of Shawnee descendants.	All programs			
97-376	Judgment funds distributed per capita to members of the Miami Tribe of Oklahoma and the Miami Indians of Indiana.	All programs			
97-402	Distributions of judgment funds to members of the Clallam Tribe of Indians of the State of Washington (Port Gamble Indian Community, Lower Elwha Tribal Community, and the Jamestown Band of Clallam Indians).	OSIPM MSP			
97-403	Payments on judgments funds to the Turtle Mountain Band of Chippewas, Arizona	All programs			
97-408	Payments on judgment funds to the Blackfeet, Gros Ventre, and Assiniboine tribes (Montana) and the Papago (Arizona)	All programs			
97-436	Per capita distributions of judgment funds to members of the Confederated Tribes of the Warm Springs Reservation		All programs		
97-458	Payments received from trust or restricted lands under 25 USC 1408	ERDC REF TA-DVS TANF OSIPM MSP	SNAP		
98-64	Payments from judgement funds held in trust by the US Secretary of the Interior	All programs			

Public law	Description	1. Exclude all payments	2. Exclude first $2,000 of each payment	3. Exclude first $2,000 per year	4. Count all payments
98-123	Judgment funds held in trust and per capita and interest payments disbursed to the Red Lake Band of Chippewa Indians.	All programs			
98-124	Judgment funds held in trust and per capita and interest payments made to the members of the Assiniboine Tribe of the Fort Belknap Indian Community (Montana) and the Assiniboine Tribe of the Fort Peck Indian Reservation (Montana).	All programs			
98-432	Judgment funds and income distributed to members of the Shoalwater Bay Indian Tribe.	All programs			
98-500, section 8(b)	Payment from the Old Age Assistance Claims Settlement Act.	ERDC OSIPM MSP	REF SNAP TA-DVS TANF		
98-602	Per capita distributions of judgment funds or funds made available for any tribal program to members of the Wyandotte Tribe in Oklahoma and absentee Wyandotte.	REF SNAP TA-DVS TANF OSIPM MSP	ERDC		
99-130	Per capita and dividend payment distributions of judgment funds to members of Santee Sioux Tribe of Nebraska, Flandreau Santee Sioux Tribe, Prairie Island Sioux, Lower Sioux and Shakopee Mdewakanton Sioux Communities of Minnesota.	All programs			

Public law	Description	1. Exclude all payments	2. Exclude first $2,000 of each payment	3. Exclude first $2,000 per year	4. Count all payments
99-146, section 6(b)	Funds distributed per capita or held in trust for members of the Chippewas of Lake Superior. The funds are distributed to the following reservations: i. i. Wisconsin: Bad River Band of the Lake Superior Tribe of Chippewa Indians of the Bad River Reservation, Lac Courte Oreilles Band of Lake Superior Bands of Chippewa Indians of the Lac du Flambeau Reservation, Sokaogon Chippewa Community of the Mole Lake Band of Chippewa Indians, Red Cliff Reservation, St. Croix Chippewa Reservation ii. Michigan: Keweenaw Bay Indian Community (L'Anse, Lac Vieux Desert and Ontonagon Bands), and iii. Minnesota: Fond du lac Reservation, Grand Portage Reservation, Bois Fort Reservation (including Nett Lake, Vermillion Lake and Deer Creek), White Earth Reservation.	All programs			
99-264	Payments and funds held in trust to the White Earth Band of Chippewa Indians in Minnesota under the White Earth Reservation Land Settlement Act of 1985, Section 16	All programs			
99-346, section 6(b)(2)	Per capita payments and income from a distribution of funds held in trust to the Saginaw Chippewa Tribe of Michigan	All programs			

Public law	Description	1. Exclude all payments	2. Exclude first $2,000 of each payment	3. Exclude first $2,000 per year	4. Count all payments
99-377, section 4(b)	Per capita payments distributed or held in trust to the Chippewas of Mississippi under P.L. 99-377 Section 4(b), to those with affiliation with the Mille Lacs, White Earth and Leech Lake Reservations in Minnesota, and paid by the Indian Claims Commission	All programs			
100-139	Judgment payments disbursed to the Umpqua Tribe Cow Creek Band	All programs			
100-241	Payments from the Alaska Native Claim Settlement Act Amendment of 1987			All Programs	
100-383	Per capita restitution payments made to eligible Aleuts who were relocated or interned during World War II	All programs			
100-411	Per capita payments of claims settlement funds to members of the Coushatta Tribe of Louisiana	REF TA-DVS TANF OSIPM MSP	ERDC SNAP		
100-580	Funds distributed to the Hoopa Valley Tribe and the Yurok Tribe under the Hoopa-Yurok Settlement Act and paid by the Indian Claims Commission	OSIPM MSP	REF TA-DVS TANF ERDC SNAP		
100-581	Judgment funds distributed to members of the Wisconsin Band of Potawatomi (Hannahville Indian Community and Forest County Potawatomi)	REF TA-DVS TANF OSIPM MSP	ERDC SNAP		
101-41	Funds, assets or income received from the trust fund established and paid to the Puyallup Tribe of the State of Washington under Section 9(b) of the Puyallup Tribe of Indians Settlement Act of 1989	All programs			

Public law	Description	1. Exclude all payments	2. Exclude first $2,000 of each payment	3. Exclude first $2,000 per year	4. Count all payments
101-277	Judgement funds distributed per capita, held in trust, or made available for programs to the Seminole Indians and paid by the Indians Claims Commission to members of the Seminole Nation of Oklahoma, Seminole Tribe of Florida, the Miccosukee Tribe of Indians of Florida and the independent Seminole Indians of Florida.	SNAP OSIPM MSP	ERDC REF TA-DVS TANF		
101-503, section 8(b)	Settlement payments, funds distributed or held in trust to members of the Seneca Nation under the Seneca Nation Settlement Act of 1990.	All programs			
101-618	Per capita distributions of settlement funds under the Fallon Paiute Shoshone Indian Tribes Water Rights Settlement Act of 1990.	REF TA-DVS TANF OSIPM MSP	ERDC SNAP		
102-171	Payments to the Aroostook Band under the Micmac Settlement Act.	All programs			
103-66	Payments from individual interests in trust or restricted lands by the Secretary of the Interior under 25 USC 1408.	ERDC REF TA-DVS TANF	SNAP	OSIPM MSP	
103-116	Settlement funds, assets, income, payments or distributions from trust funds to members of the Catawba Indian Tribe under the Catawba Indian Tribe of South Carolina Land Claims Settlement Act of 1993.	All programs			
103-436	Payments from the Confederated Tribes of the Colville Reservation Grand Coulee Dam Settlement Act	All programs			
103-444	Payments made, or benefits granted, by the Crow Boundary Settlement Act of 1994	All programs			

Public law	Description	1. Exclude all payments	2. Exclude first $2,000 of each payment	3. Exclude first $2,000 per year	4. Count all payments
105-143	Distributions of judgment funds to the Ottawa and Chippewa Indians of Michigan under the Michigan Indian Land Claims Settlement Act.	All programs			
108-270	Per capita distribution of judgment funds to members of the Western Shoshone Indians.				
111-291, section 101	Payments from the Tribal Trust Accounting and Management Lawsuits. If the funds are comingled with other funds the resource is excluded for only 12 months and counted thereafter.	All programs			
n/a	Tribal Benefits from timber sales or oil reserves from land held in trust by the Secretary of the Interior.	All programs			
n/a	Payments from the Bureau of Indian Affairs for the General Assistance program.	ERDC REF TA-DVS TANF			OSIPM MSP ($20 monthly general income exclusion does not apply)
n/a	Payments from land designated as Indian trust land and not addressed elsewhere in this OPEN section	ERDC REF TA-DVS TANF		SNAP OSIPM MSP	
n/a	Tribal child care payments — consider for the participant	All programs			
n/a	Tribal child care payments —consider for the provider if paid to the provider				All programs
n/a	Commercial fishing income under one of the Columbia River Fishing Treaties for Yakima, Warm Springs, Umatilla and Nez Perce tribes				All programs

Public law	Description	1. Exclude all payments	2. Exclude first $2,000 of each payment	3. Exclude first $2,000 per year	4. Count all payments
n/a	Tribal TANF	REF TANF			ERDC SNAP TA-DVS OSIPM MSP ($20 monthly general income exclusion does not apply)
n/a	All other Indian (Native American) benefit payments distributed by the tribe and not excluded by public law are counted as unearned income. This includes the following: a. Profit share or per capita income from tribal casinos b. Income derived from land not held in trust by the secretary of the interior such as timber sales or sale of oil reserves.				All programs

For all programs except HSD, OSIPM and MSP, Tribal benefits treated as excluded income remain excluded as an asset while it is kept in a separate account and not commingled. If commingled it is excluded for six months.

For OSIPM, excludable funds must be identifiable in order to be excluded. Identifiable does not require that excluded funds be kept physically apart from other funds.

See OAR 461-140-0070 – Treatment of Excluded Assets.

Indian benefits counted as income cannot be treated as a resource in the same month (see OAR 461-145-0010) but any remaining during subsequent months may be counted as a resource, depending on the source.

Indian lands held jointly with the tribe or land that may not be sold without the approval of the Bureau of Indian Affairs (BIA) are excluded resources.

For Alaska Native Claims Settlement Act Distributions (P.L. 100-241):

- Exclude up to $2,000 of retained distributions received in the current calendar year and for each year beginning in 1988.
- Exclude stock (including stock issued or distributed by a native corporation as a dividend or distribution on stock), a partnership interest, land or an interest in land (including land or an interest in land receive from a native corporation as a dividend or distribution on stock), and an interest in a settlement trust.

For HSD medical programs, resource are not considered.

Oregon Administrative Rule(s)

461-145-0260 — Indian (Native American) Benefits; Not OSIP, OSIPM, and QMB

Individual development account (IDA)

An individual development account (IDA) is a trust-like savings account established under P.L. 105-285 designed to help low-income individuals save for specified purposes. The individual makes deposits from their earnings, and these are matched by a combination of government and private-sector funds.

In ONE, earnings deposited into an Individual Development Account are coded on the Earned Income screen:

- Earned Income Category – Wages
- Earned Income Type - Earnings Deposited into an Individual Development Account

For all programs except SNAP, deposits from the account holder's earnings are excluded from gross income.

For SNAP, the deposits remain countable earned income.

For all programs:

- Matching deposits and interest earned by the IDA accounts are excluded from income.
- IDA accounts are excluded from resources.
- Interest earned by the IDA savings account is excluded from income.

For OSIPM, count all income deposited into an IDA savings account as earned income for patient liability calculations.

For all programs except OSIPM and MSP, if an individual makes an emergency withdrawal from the IDA savings account, that income is counted as lump-sum income.

For OSIPM and MSP, emergency withdrawals from an IDA savings account are excluded.

For HSD medical programs, earnings deposited into an individual development account are counted for monthly and annual income.

Oregon Administrative Rule(s)

461-145-0259 — Indian (Native American) Benefits; OSIP, OSIPM, and QMB
461-145-0261 — Individual Development Account (IDA)
410-200-0015 (54) and (55) — General Definitions

Individual education account (IEA)

The IEA is an asset accrued by JOBS Plus participants. Exclude the IEA while it accumulates, while it is saved, and when it is withdrawn for educational purposes.

Educational expenses are tuition, fees, and other necessary expenses for education at any educational institution. Educational expenses do not include the cost of shelter. Examples of educational expenses include:

- Books
- Lab fees
- Student activity fees
- Transportation
- Stationary supplies
- Technology fees
- Impairment-related expenses necessary to attend school or perform schoolwork

For OSIPM:

- The value of funds in 529 Plan (otherwise known as a qualified tuition plan or program) is counted as a resource to the owner of the fund, but not to the beneficiary (the person who is going to college), unless the beneficiary is also the account owner.
- Funds in a Coverdell Education Savings Accounts are treated as follows:
  - They are excluded as a resource to the designated beneficiary.
  - If the contributor is not a designated beneficiary, funds deposited into the account are no longer the resource of the contributor beginning with the month after the month the cash is transferred. The transfer may be considered a disqualifying transfer of resources by the contributor
- Distributions from a Coverdell Education Savings Account to a designated beneficiary are treated as follows:
  - They are excluded as income in the month of receipt if used for educational expenses.
  - If the excluded distribution is retained into the month following the month of receipt, it is excluded as a resource for nine months beginning with the month after the month of receipt.
  - If the beneficiary spends any portion of a distribution for a purpose other than the educational expenses of the beneficiary, or no longer intends to use the funds for the educational expenses of the beneficiary, the non-education portion of the funds is countable as unearned income at the earlier of the following:
    - The month the funds are spent.
    - The month the beneficiary no longer intends to use the funds for educational expenses.
  - If a countable distribution is retained into the month following the month of receipt, it is a countable resource of the designated beneficiary.
- Gifts that are set aside to pay educational expenses are treated in accordance with subsection (c) of this section, except that the exclusion does not apply to any portion set aside or actually used for food or shelter. See OAR 461-145-0150 for information on other types of educational income.

For MSP:

- Funds held in a Qualified Tuition Program under Section 529 of the Internal Revenue Code or a Coverdell Education Savings Accounts are excluded as a resource.
- Distributions from a Coverdell Education Savings Account to a designated beneficiary are treated as follows:
  - They are excluded as income in the month of receipt.
  - They are excluded as a resource
  - If the beneficiary spends any portion of a distribution for a purpose other than the educational expenses of the beneficiary, or no longer intends to use the funds for the educational expenses of the beneficiary, the non-education portion of the distribution is countable as unearned income at the earlier of the following:
    - » The month the funds are spent.
    - » The month the beneficiary no longer intends to use the funds for educational expenses.

For SNAP:
Also exclude funds in a qualified tuition program under section 529 of the Internal Revenue Code or in a Coverdell education savings account.

Oregon Administrative Rule(s)

461-145-0145 — Educational Account
410-200-0015 (54) and (55) — General Definitions

Inheritance

An inheritance may be received in the form of monies, property or other assets.

In ONE, Inheritance is coded on the Unearned Income screen:

- Unearned Income Category – Inheritance & Trust
- Unearned Income Type – Inheritance

An inheritance is treated as follows:

- **For all programs except ERDC**:
  - A noncash inheritance is treated according to the policy for a specific type of asset inherited.
  - A cash inheritance is counted as periodic or lump-sum income.
- **For ERDC**, an inheritance is excluded.

For HSD medical programs, exclude inheritance for monthly and annual income.

Oregon Administrative Rule(s)

461-145-0270 — Inheritance
410-200-0015 (54) and (55) — General Definitions

In-kind income

In-kind income is compensation in a form other than money (e.g., food, clothing, cars, furniture and payments made to a third party).

In ONE, In-kind payments are coded on the Specific Income screen:

- Specific Income Category – Third Party/In Kind Income
- Specific Income Type – Third Party/In Kind Income

For all programs, treat unearned third-party payments as follows:

(a) Count payments made to a third party that should legally be paid directly to a member of the financial group as unearned income. This includes court-ordered support payments that the noncustodial parent makes voluntarily to the landlord or mortgage company on behalf of the financial group.

(b) Treat payments made to a third party that the payee is not legally obligated to pay directly to a member of the financial group and that the group does not have the option of taking as cash, and payments made by the noncustodial parent to a third party that are court-ordered but not designated as child support, as follows:

(A) **For SNAP**, exclude these third-party payments unless they are transitional housing payments for the homeless.

(B) **REF, REFM and TANF**, except for child support, these third-party payments are excluded.

(C) **For all other programs**, exclude these third-party payments.

For all programs except REF, REFM and TANF, treat earned in-kind income according to OAR 461-145-0130

For all programs except REF, REFM and TANF, treat unearned in-kind income (except third-party payments) as follows:

(a) Exclude court-ordered community service work or bartering. Bartering is the exchange of goods of equal value.

(b) Treat items such as cars and furniture according to the administrative rule for the specific type of asset.

For REF, REFM and TANF, exclude all in-kind income (except unearned third-party payments).

For SNAP, exclude in-kind income except count as income child support or the expenditures (payments for food, clothing, cars, furniture, shelter, etc.) by a business entity that substantially benefits a principal who is a member of the financial group. A "principal" is a person with significant authority in the business entity, such as the proprietor of a sole proprietorship, including a person who is self-employed, or a partner of a partnership, or a member or manager of a limited liability company, or an officer or principal stockholder of a closely held corporation.

Note: Transitional housing for the homeless is a shelter or residence for homeless individuals as they transition to regular housing. There is generally a time limit for transition period and it may be 24 hours.

For HSD medical programs, in-kind income/third-party payments are treated as follows:

If the in-kind income/third-party payment is legally obligated to be paid to the applicant, then it is counted for monthly and annual income.

If the in-kind income/third-party payment is not legally obligated to be paid to the applicant, and they have the option to receive the payment as money, then it is counted for monthly and annual income.

If the in-kind income/third-party payment is not legally obligated or the individual cannot receive the money as income, then it is excluded for monthly and annual income.

If the income is being received for an adult, and the individual receiving the income cares for six or more qualified foster individuals, the payments are counted for monthly and annual income..

Oregon Administrative Rule(s)

461-145-0280 — In-Kind Income
461-145-0120 — Earned Income; Defined
461-145-0470 — Shelter-in-Kind Income
461-145-0080 — Child Support and Cash Medical Support
410-200-0015 (54) and (55) — General Definitions

Japanese American restitution payments

For OSIPM and MSP: The following restitution payments are excluded from income and resources:

- Restitution payments made by the U.S. government to individual Japanese-Americans, or the spouse or parent of an individual of Japanese ancestry
- Payments to a survivor of a deceased recipient of restitution payments (above)
- Restitution payments from the Canadian government to individual Japanese-Canadians who were interned or relocated during World War II
- Interest earned on payments covered above section is excluded from income and resources.

Oregon Administrative Rule(s)

461-145-0285 — Japanese-American Restitution Payments; OSIP, OSIPM, and QMB
410-200-0015 (54) and (55) — General Definitions

Job Corps

In ONE, Job Corps Payments are coded on the Specific Income screen:

- Specific Income Category – Job Corps Payments
- Specific Income Type – Job Corps Payments

Job Corps payments are treated as follows:

- A living allowance payment is counted as earned income.
- A readjustment allowance payment is treated as follows:
  - **For all programs except SNAP**, this payment is counted as earned income.
  - **SNAP**, this payment is counted as lump-sum income.

A support service payment for an item already covered by the benefits of the benefit group is counted as unearned income. All other support service payments (including clothing allowances) are excluded.

A reimbursement is treated as provided in the reimbursement policy.

PIVOT (Partners in Vocational and Occupational Training) is a Job Corps program for participants 17–21 years of age who have had a child by age 17. Treat PIVOT living allowance payments as (1) above.

Note: JOBS participants in Job Corps get JOBS child care payments instead of a TANF child care payment.

For HSD medical programs, job Corps payments are counted for monthly and annual income.

Oregon Administrative Rule(s)

461-145-0290 — Job Corps
461-145-0440 — Reimbursement
410-200-0015 (54) and (55) — General Definitions

Life estate

A life estate is the right to property limited to the lifetime of the person holding it or the lifetime of some other person. In general, a life estate enables the owner of the life estate to possess, use and obtain profits from property during the lifetime of a designated person while actual ownership of the property is held by another individual. A life estate is created when an individual owns property and then transfers their ownership to another while retaining, for the rest of their life, certain rights to that property. In addition, a life estate is established when a member of the financial group purchases a life estate interest in the home of another individual.

For all programs except OSIPM and MSP, if a financial group is living in real property while a member holds a life estate in this property, the property is treated as a home. In all other situations, a life estate is treated as real property.

For OSIPM, for purposes of this rule, the value of the rights conferred by the life estate is established by the Life Estate and Remainder Interest Table, Life Estate and Remainder Interest Table (use the individual's current age).

A life estate owned by a member of the financial group is treated as follows:

- If a member of the financial group is living on the property, the value of the life estate is treated as a home
- If a member of the financial group is not living on the property, the value of the life estate is counted as a resource. The life estate is considered unavailable if other parties with an ownership interest in the property refuse to sell their interest or refuse to purchase the life estate interest in the property.

For those in a non-standard living situation:

- A transfer for less than fair market value in which a member of the financial group retains a life estate is a disqualifying transfer. A transfer is considered for less than fair market value if the fair market value of the transferred resource on the day prior to the transfer is greater than the sum of the value of the rights conferred by the life estate plus the compensation received for the transfer.
- If a member of the financial group purchases a life estate interest in the home of another individual on or after July 1, 2006, the purchase is considered a transfer of resources unless the individual resides in this home for

at least 12 consecutive months after the date of the purchase. The value of the transfer for an individual who does not reside in the home for at least 12 consecutive months is calculated by using the purchase price of the life estate.

For MSP and HSD medical programs, resources are not considered in eligibility determination.

Note: It is possible for an individual to have an interest in a life estate and not reside in the home. This does not diminish the legal interest in the property. The individual's name is still on the property and they would be entitled to part of the proceeds from the sale of the home as an interest holder. Use the life estate table to determine the portion of the proceeds that would be an appropriate share. Maintenance costs, repairs and taxes are the responsibility of the life estate holder — so the share can be offset by those. Costs of improvements to the home are not costs that a life estate holder is responsible for and can't be used to diminish the share of the proceeds.

Oregon Administrative Rule(s)

461-145-0310 — Life Estate
410-200-0015 (54) and (55) — General Definitions

Life insurance

In ONE, Life Insurance Proceeds are coded on the Unearned Income screen:

- Unearned Income Category – Other Income
- Unearned Income Type – Life Insurance Proceeds

Benefits paid to the beneficiary of a life insurance policy

Count as unearned income in the month received.

ODHS|OHA counts benefits as received when the insured individual dies or when the insured individual is eligible for and receives accelerated payments before death, such as when the insured individual has a terminal illness.

When the payment is a lump sum due to the death of the insured individual a deduction is allowed, not to exceed $1,500, for the cost of the deceased individual's last illness and burial if these costs were not otherwise insured.

For all programs except MSP, count any amount retained into the following month as a resource.

Owner of a life insurance policy

Burial insurance that generates a cash surrender value is treated in the same manner as life insurance.

Burial insurance that does not generate a cash surrender value is treated as follows:

- **For all programs except OSIPM**, it is excluded.
- **For OSIPM,** it is considered an irrevocable burial arrangement.

Treat the value of a life insurance policy as follows:

- **Cash surrender value** means the equity that the policy acquires over time.
- **Dividend** means a payment of surplus company earnings from the insurer.

- **Dividend accumulation** means a dividend left with the insurer to accumulate interest that may be withdrawn without affecting the policy's face value or cash surrender value.
- **Dividend addition** means the amount of insurance purchased with a dividend that increases the policy's death benefit and cash surrender value.
- **Face value** means the amount of the death benefit contracted for at the time the policy was purchased and does not include a dividend addition added after purchase of the policy.
- **Viatical settlement** means an agreement allowing a third party to acquire a life insurance policy from a terminally ill individual at an agreed upon percentage of the life insurance policy's face value.

(a) Exclude all term insurance that has no cash surrender value.

(b) **For all programs except OSIPM**, exclude the cash surrender value of the life insurance policy.

(c) **For OSIPM:**

- Exclude the cash surrender value of life insurance policies owned by the financial group if the total face value of all policies for the insured individual is less than or equal to $1,500.
- If the total face value of all policies is more than $1,500, count the entire cash surrender value as a resource to the owner of the policy.
- The total face value does not include dividend addition. A dividend accumulation must count as a resource even if the face value of the policy that generated the dividend accumulation is excluded.
- The face value of term life insurance policies excluded under (a) of this section are not counted in determining if the $1,500.00 life insurance exclusion limit is exceeded.
- The cash surrender value of a policy acquired through a viatical settlement is excluded.

For HSD medical programs, if any of the life insurance payments are from interest accrued on the life insurance plan, the portion of the payment from interest is counted for monthly and annual income. All other payments are excluded for monthly and annual income.

Oregon Administrative Rule(s)

461-145-0320 — Life Insurance
410-200-0015 (54) and (55) — General Definitions

Loans and repayment of loans

This policy covers proceeds of loans, loan repayments and interest earned by a lender. If the proceeds of a loan are used to purchase an asset, the asset is evaluated under the policy for that specific asset.

In ONE, income addressed in this section is coded on the Unearned Income screen:

- Unearned Income Category – Loan
- Unearned Income Type – there are several different types to choose from, select the one which is applicable to the type being reported:
  - Loans (Borrower)
  - Loans: Lender Interest Payments
  - Loans: Lender Principal Payment
  - Reverse-annuity Mortgage: Cranston-Gonzalez National Affordable Housing Act Service Payments

For OSIPM and MSP:

- A "negotiable loan agreement" means a loan agreement in which the instrument ownership and the whole amount of money expressed on its face can be transferred from one person to another (i.e., sold) at prevailing market rates.
- A "Bona fide loan agreement" means an agreement that:
- Is enforceable under state law; and
- Is in effect at the time the cash proceeds are provided to the borrower; and
- Includes an obligation to repay and a feasible repayment plan.

For all programs:
A "reverse-annuity mortgage" means a contract with a financial institution under which the financial institution provides payments against the equity in the home that must be repaid when the homeowner dies, sells the home or moves. A "reverse-annuity mortgage" is sometimes referred to in the private sector as a reverse mortgage or a home equity loan. The proceeds of a home equity loan or reverse-annuity mortgage are considered loans.

Note: A reverse mortgage can be received by a person age 62 or older as a loan against the equity in their home. The loan is due for repayment when the borrower permanently moves out or sells the property or upon death of the borrower.

A loan is defined as:

- **For all programs except OSIPM, MSP and SNAP**, a written loan agreement signed by the borrower and lender. The written agreement must stipulate a repayment plan and be signed and dated before the receipt of money.
- **For OSIPM, MSP and SNAP**, the loan agreement may be written or oral and must state when repayment is due to the lender.
- Payments for a purported loan that do not meet these requirements are treated as unearned income.

When the financial group receives cash proceeds as a borrower from a loan:

- **For all programs**, treat educational loans according to the educational income policies.
- **For ERDC, REF, REFM, SNAP and TANF**, exclude loans obtained by the financial group in the month received. If retained after the month of receipt, treat in accordance with OAR 461 140 0070.

For OSIPM:

- If the loan is a bona fide loan agreement, the money provided by the lender is not income but is counted as the borrower's resource if retained in the month following the month of receipt (notwithstanding OAR 461-140-0070).
- If the loan is not a bona fide loan agreement, the money provided by the lender is counted as income in the month received and is counted as a resource if retained in the month following the month it was received.

For MSP:

- If the loan is a bona fide loan agreement, the money provided by the lender is not considered income.
- If the loan is not a bona fide loan agreement, the money provided by the lender is counted as income in the month received.
- All money provided by the lender is excluded as a resource.

For loans that a member of the financial group makes as a lender:

For OSIPM:

- For those in a standard living arrangement:
  - If the loan is both a negotiable loan agreement and a bona fide agreement:
    - Only the interest portion of payments made by the borrower to the lender is counted as unearned income, the principal portion of any payments is excluded.
    - The outstanding principal balance is counted as a resource.
  - If the loan is not both negotiable and bona fide:
    - Both the principal and interest payments are treated as unearned income.
    - The balance of the loan is excluded as a resource.
- For those in a non-standard living arrangement:
  - For transactions occurring before July 1, 2006, loans are treated as they are with OSIPM in a standard living arrangement (see above).
  - For transactions after July 1, 2006, if a loan meets the following requirements, then the loan is still treated as they are with OSIPM in a standard living arrangement:
    - The total value of the transaction is being repaid to the individual or spouse of the individual within three months of the life expectancy of the person (individual or spouse) according to the Life Estate and Remainder Interest Table. If jointly owned, the requirements are met if the transaction is repaid according the life expectancy of either the individual or the individual's spouse.
    - Payments are made in equal amounts over the term of the transaction without any deferrals or balloon payments.
    - The contract is not canceled upon the death of the individual receiving the payments

under this transaction.

- No one other than the estate of the lender is designated as the remainder beneficiary.

» For transactions after July 1, 2006, if all the above requirements are not met:

- The loan balance is considered a disqualifying transfer of assets.
- When the disqualification period has been served, the principal and interest portion of payments made by the borrower are treated as unearned income. The outstanding loan balance is excluded as a resource.

» Transactions for this section include when an individual or community spouse uses funds to:

- Purchase another's mortgage
- Purchase a promissory note or loan from another, or
- Lend money via promissory note or loan.

For MSP:

- The interest portion (if any) of payments received from the borrower is treated as unearned income.
- Payments made by the borrower against the principal of all loans are excluded as income.

For all programs other than OSIPM and MSP, count as unearned income payments made to the financial group on the interest portion of a loan the group has made to someone else. Exclude payments received on the principal.

For HSD medical programs, exclude loans for monthly and annual income.

Oregon Administrative Rule(s)

461-145-0330 — Loans and Interest on Loans
461-140-0070 — Treatment of Excluded Assets
410-200-0015 (54) and (55) — General Definitions

Lodger income

A lodger is a member of the household who is not a member of the filing group and pays the filing group for room (rent) with or without board (meals). Lodger income is the amount the lodger pays the filing group for room or room and board.

In ONE, lodger income is coded on the Self-Employment Income screen. The Income Category and Income type are the same depending on what type of is being reported, select the one which is applicable to the type being reported:

- Self-Employment Income Category and Self-Employment Income Type –Room Rental
- Self-Employment Income Category and Self-Employment Income Type – Room & Board Rental

Lodger income is treated as follows:

- **For REF, REFM and TANF**, lodger income not excluded under OAR 461-155-0350 is treated as self-

employment income.

- **For all programs except OSIPM, MSP, REF, REFM and TANF**, lodger income is treated as self-employment income.
- **For OSIPM and MSP**, lodger income is treated as unearned income and can be reduced by certain expenses. The allowable expenses are prorated based on the number of rooms for rent compared to the number of rooms in the home (excluding bathrooms, but including attics and basements if they have converted to living spaces). The allowable expenses include:
  - Interest and escrow portions of a mortgage payment
  - If the home is rented, the monthly amount the filing group pays for rent
  - Real estate insurance
  - Repairs (such as a minor correction to an existing structure)
  - Property taxes (if not included in the escrow portion of a mortgage payment)
  - Lawn care
  - Snow removal
  - Advertising for tenants
  - Utilities

For HSD medical programs, room and board rental income is counted for monthly and annual income.

Click here for examples: Lodger income.

Oregon Administrative Rule(s)

461-145-0340 — Lodger Income
410-200-0015 (54) and (55) — General Definitions

Manufactured and mobile homes

Manufactured and mobile homes that are the individual's home are treated as a home. Otherwise, they are treated as real property or income-producing property, depending on the use.

For HSD medical programs, resources are not considered in eligibility determination.

Oregon Administrative Rule(s)

461-145-0343 — Manufactured and Mobile Homes
461-145-0420 — Real Property
461-145-0220 — Home
461-145-0250 — Income-Producing Property; Not OSIP, OSIPM, or QMB
410-200-0015 (54) and (55) — General Definitions

Military income

This policy is regarding pay and allowances of a member of a uniformed service.

In ONE, military income is coded on the Specific Income screen:
• Specific Income Category – Veteran's Benefits/Military Income
• Specific Income Type Military Income

This income is treated as follows:

For all programs, military pay and allowances of a member of the U.S. Armed Forces in the financial group is counted as earned income. **Except for SNAP**, the amount reduced from basic pay for the GI Bill is excluded per P.L. 99-576, Veterans Education Act of 1984.

For all programs except SNAP, the military pay and allowances of a member of the U.S. Armed Forces, who is not in the filing group but available to the financial group, is counted as unearned income.

For SNAP:

If the member of the U.S. Armed Forces is not included in the filing group, income available to the financial group from this source is counted as unearned income. The additional pay made, due to deployment to a designated combat zone per the Consolidated Appropriations Act of 2005 (P.L. 108-447), is excluded. The additional pay must be the result of the deployment to a designated combat zone and not received immediately prior to serving in the combat zone.

The absent military member of a household is not included in the SNAP filing group. Only the money they send home, or make available to the group at home, is counted as unearned income. This income is generally made available to the SNAP filing group in one of several ways:

- Via a direct deposit of all or a portion of the military person's pay into a joint bank account
- Via an allotment arrangement made by the military person for a portion of their pay to be sent to the filing group, or
- Via a direct payment (such as a check) from the military person to the filing group.

  All three of these methods are called military service allotments. Regardless of the arrangement made by the absent military member, only the portion of their pay, to which the filing group has access, is counted as unearned income to the group.

  Workers are required to determine if any of the military allotment available to the filing group should be excluded for SNAP because the military person is deployed to a designated combat zone.

Procedures for determining the amount of military allotment to count:

- Establish the amount of the military person's pay available to the filing group prior to deployment to a designated combat zone.
  - Available means income the filing group received and could spend as well as any of the income that may have been direct deposited and automatically used to pay the mortgage, utilities, common bills, etc.

Note: If, in the unlikely instance the military person was a member of the filing group immediately prior to deployment, that person's military income needs to change from the gross earned income to their net military pay for this step.

- Next, determine the amount of military pay the deployed person is making available to the filing group now:
  - If the current amount is equal to or less than the amount the household was receiving prior to the deployment to a combat zone, count all of the allotment as unearned income.
  - Exclude any portion of the deployed person's military pay that exceeds the amount the group received prior to deployment to a combat zone.
  - Code the countable part of the military allotment as WAR on page 2 of the FCAS screen.

The additional pay is excluded when an absent military person with one of these two pay codes is deployed to one of the following combat zones.

301 Incentive Pay: Hazardous duty
310 Special pay: Duty subject to hostile fire or imminent danger

Combat zones that allow exclusion			
301	The Adriatic Sea	320	Kuwait
302	Afghanistan	321	Kyrgyzstan
304	Albania	322	Macedonia
305	Arabian Sea Portion that lies north of 10 N. Latitude and West of 68 East Longitude	323	Oman
306	Bahrain	324	Pakistan
307	Bosnia	325	Persian Gulf
308	Croatia	326	Philippines (only troops with orders that reference Operation Enduring Freedom (OEF))
310	Djibouti	327	Qatar
311	Egypt	328	Red Start
312	The Federal Republic of Yugoslavia (Serbia and Montenegro)	329	Saudi Arabia
313	Gulf of Aden		Somalia
314	Gulf of Oman	330	Tajikistan
315	Herzegovina	331	Turkey
316	The Ionian Sea, North of the 30th Parallel	332	United Arab Emirates
317	Iraq	333	Uzbekistan
318	Israel	334	Yemen
319	Jordan		

How to verify this income

There are several ways the family at home can verify the situation:

- The deployed person's military pay record (Leave and Earnings Statement – LES) is sometimes sent directly

to the family at home or can be mailed to the family by the deployed person. The LES will identify the combat zone and if combat pay is being received.

- Deployment to a combat zone can also be established via a copy of the deployment orders.
- If the family does not have a copy of the LES, they may be able to access the information via the Web at https://mypay.dfas.mil. To do this, they need the SSN of the deployed person and their password.
- The filing group may also seek assistance from the local base financial office for the needed combat zone and pay information.
- If the payment is coming to the filing group via direct deposit, the bank statement can also verify the monthly allotment.

For HSD medical programs, military Income is counted for monthly and annual income.

Oregon Administrative Rule(s)

461-145-0345 — Military Income
410-200-0015 (54) and (55) — General Definitions

Mineral rights

Mineral rights represent ownership interest in natural resources such as coal, oil, or natural gas, which normally are extracted from the ground.

In ONE, payments from mineral rights are coded on the Specific Income screen:

- Specific Income Category – Royalties (Including Mineral Rights)
- Specific Income Type - Royalties (Including Mineral Rights)

For OSIPM:
If the individual owns the property to which the mineral rights pertain, the current market value of the property is assumed to include the value of the mineral rights and is treated as real property

If the individual does not own the land where the mineral rights pertain, the current market value of the mineral rights is counted as a resource.

For OSIPM and MSP:
Income received from mineral rights, including compensation paid to the owner for the use or lease of property or natural resources, is considered royalty income.

Oregon Administrative Rule(s)

461-145-0348 — Mineral Rights; OSIP, OSIPM, QMB
410-200-0015 (54) and (55) — General Definitions

Motor vehicle

The value of disability-related apparatus, optional equipment or low mileage is not considered in determining the fair market value of an automobile, truck, or van. The fair market value of an automobile, truck, or van is presumed

to be the "average trade-in value" established in the National Automobile Dealers Association's (NADA) Used Car Guide, Kelley Blue Book, or similar publication. An individual may rebut the presumption with a statement from a car dealer, mechanic, or other reliable source. If the vehicle is not listed in the NADA Used Car Guide, Kelley Blue Book, or a similar publication, the estimate of the value by the individual may be accepted unless it appears questionable, in which case additional evidence of the value is required.

For REF, REFM, SNAP and TANF, exclude up to $10,000 equity value of all licensed and unlicensed motor vehicles. Count the remaining equity value as a resource. **For SNAP**, this is only done if the filing group is not categorically eligible.

For EA and ERDC, exclude all motor vehicles.

For OSIPM:

- Exclude the total value of a vehicle selected by the financial group if it is used for transportation of the individual or a member of the individual's household.
- Count the total equity value of all other vehicles as a resource.

For OSIPM-EPD, if a vehicle was purchased as an employment and independence expense (see OAR 461-001-0035), or with monies from an approved account, exclude the total value of the vehicle.

For HSD medical programs, resources are not considered in eligibility determination.

Oregon Administrative Rule(s)

461-145-0360 — Motor Vehicle
461-145-0433 — Recreational Vehicles

Determining the resource value of motor vehicles

Motor vehicles (cars, trucks and vans) are often important tools for participants to use to attain self-sufficiency. They are critical employment tools for participants who:

- Live in areas not served by public transportation
- Are fleeing domestic violence, or
- Cannot access public transportation due to physical disabilities.

For REF, REFM, SNAP and TANF, there are five steps to determine the countable resource value of a motor vehicle:

- **Step 1: Determine the availability of the vehicle as a resource**. Participants might own or co-own a vehicle, but it may not be available to them as a resource. This is especially true if the participant is a survivor of domestic violence.
- **Step 2: Determine the equity value**. ODHS|OHA will exclude $10,000 in equity value for all licensed motor vehicles excluded when determining the value of motor vehicles (see Step 4).
- **Step 3: Determine the equity value of the vehicle**. The equity value of the vehicle is the fair market value of the car minus any encumbrances. Using the National Automobile Dealers Association's (NADA) Used Car Guide (or similar publication), workers should review the average trade-in value for the vehicle. The

Kelley Blue Book is also available on the internet at the Self-Sufficiency Staff Tools page. Disability-related apparatus, optional equipment or low mileage should not be added to increase the value of the vehicle. From the fair market value amount, any amounts the participant owes on the vehicle or other costs, such as liens, should be subtracted. The remainder is the equity value.

- **Step 4: Exclude $10,000 in equity value**. The equity value of all licensed vehicles should be totaled. The first $10,000 should be deducted from the total equity value of all vehicles combined. The remainder is the resource value of the vehicle or vehicles.
- **Step 5: Compare the resource value of the vehicle to the resource limits**. If the amount exceeds the resource limit, the applicant is not eligible. In addition to the equity value that exceeds $10,000, any other vehicles and resources are counted toward the resource limit for each program.

National and Community Service Trust Act (NCSTA/AmeriCorps)

The National and Community Service Trust Act (NCSTA) of 1993 (P.L. 103-82) amended the National and Community Service Act (NCSA) of 1990 (P.L. 101 610) that established a Corporation for National and Community Service. The corporation administers national service programs providing living allowance, educational award, child care and in-kind benefits. NCSTA also created AmeriCorps and incorporated VISTA. AmeriCorps contains three parts – one is State and National, another is NCCC and the other is VISTA. All references to AmeriCorps in this section mean AmeriCorps State and National or AmeriCorps NCCC unless specifically stated as AmeriCorps VISTA.

In ONE, child care payments from the National and Community Service Trust Act are coded on the Specific Income screen:

- Specific Income Category – Child Care
- Specific Income Type - National and Community Service Trust Act (NCSTA): Child Care Payments

In ONE, all other payments from payments from the National and Community Service Trust Act are coded on the Specific Income screen:

- Specific Income Category – Domestic Volunteer Programs
- Specific Income Type – there are several different types to choose from, select the one which is applicable to the type being reported:
  - National and Community Service Trust Act (NCSTA): Educational Award
  - National and Community Service Trust Act (NCSTA): In Kind
  - National and Community Service Trust Act (NCSTA): Living Allowance/Stipend

NCSTA payments, including AmeriCorps (except AmeriCorps VISTA) are treated as follows:

- The living allowance (stipend benefits) is excluded.
- Educational award and in-kind benefits are excluded.

The child care allowance is treated as follows:

- **For ERDC, REF, REFM and TANF**, individuals who are eligible for direct provider payment of child care, the allowance is counted as unearned income. The allowance is excluded only if the participant already pays the provider. The provider may be paid for only the costs not covered by the allowance.

- **For SNAP**, individuals who are receiving a child care deduction, the deduction is allowed only for the costs not covered by the allowance.
- **For all other programs**, the allowance is excluded.

For HSD medical programs, exclude National and Community Service Trust Act payments for monthly and annual income.

Note: The programs administered by the corporation under the NCSTA include AmeriCorps State and National, AmeriCorps NCCC and AmeriCorps VISTA. The corporation also oversees the Senior Corps, the Earth Corps, and Learn and Serve. For information on how to treat AmeriCorps VISTA benefits, see Domestic Volunteer Services Act.

Oregon Administrative Rule(s)

461-145-0365 — National and Community Service Trust Act (NCSTA), including AmeriCorps (other than AmeriCorps VISTA)
410-200-0015 (51) and (52) — General Definitions
410-200-0015 (54) and (55) — General Definitions

Older Americans Act

In ONE income from the:

- Older Americans Act Title III are coded on the Unearned Income screen:
  - Unearned Income Category – Other Income
  - Unearned Income Type – Older Americans Act Title III
- Older Americans Act Title V is coded on the Earned Income screen:
  - Earned Income Category – Wages
  - Earned Income Type – Older Americans Act Title V: Experience Works, AARP, National Assoc. of SP-Speaking Elderly, Nat. Council on Aging, Nat Council on Black Aging, Nat Council of Senior Cits, Nat Urban League, US Forest Serv, Green Thumb, Seniors Make Sense, SCSEP

For all programs except SNAP:

- Exclude benefits under title III of the Older Americans Act of 1965 (Nutrition Program for the Elderly).
- Count as earned income wages or salary paid under title V of this act. The organizations receiving title V funds are Experience Works, Seniors Make Sense, American Association of Retired Persons, National Association for Hispanic Elderly, National Council on Aging, National Caucus and Center on Black Aging, National Council of Senior Citizens, National Urban League, Senior Community Service Employment Program (SCSEP), and the U.S. Forest Service.
- Exclude payments under Title V that are not a wage or salary.

For SNAP:

- Count benefits under title III of the Older Americans Act of 1965 as unearned income.

- Exclude all payments made under title V of this act.

Note: In Oregon, some seniors working for Easter Seals may also be paid using title V funds. Confirm the funding source before excluding the income.

For HSD medical programs: older Americans Act benefits under title V are counted in monthly and annual income, benefits under title III are excluded.

Oregon Administrative Rule(s)

461-145-0370 — Older Americans Act
410-200-0015 (54) and (55) — General Definitions

Pension and retirement plans

In ONE income from pensions and retirement are coded on the Unearned Income screen:

- Unearned Income Category – Retirement
- Unearned Income Type – there are two different types to choose from, select the one which is applicable to the type being reported:
  - Pension/Retirement Payments - Non-Taxable
  - Pension/Retirement Payments - Taxable

1. Pension and retirement plans include the following:
   (a) Benefits employees receive only when they retire. These benefits can be disbursed in lump-sum or monthly payments.
   (b) Benefits employees are allowed to withdraw when they leave a job before retirement.
   (c) The following retirement plans and annuities if purchased by a participant with funds from the plans authorized by section 401 of the Internal Revenue Code of 1986:
      (A) Traditional Defined-Benefit Plan.
      (B) Cash Balance Plan.
      (C) Employee Stock Ownership Plan.
      (D) Keogh Plan.
      (E) Money Purchase Pension Plan.
      (F) Profit-Sharing Plan.
      (G) Simple 401(k).
      (H) 401(k).
   (d) Retirement plans authorized by section 403 of the Internal Revenue Code of 1985 at subsections (a) or (b).
   (e) The following retirement plans and annuities authorized by section 408 of the Internal Revenue Code of 1986.
      (A) Individual Retirement Annuity.

(B) Individual Retirement Account (IRA).

(C) Deemed Individual Retirement Account or Annuity under a qualified employer plan.

(D) Accounts established by employers and certain associations of employees.

(E) Simplified Employee Pension (SEP).

(F) Simple Individual Retirement Account (Simple-IRA).

(G) Roth IRA.

(f) The following retirement plans offered by governments, nonprofit organizations or unions:

(A) 457(b) Plan.

(B) 501(c)(18) Plan.

(C) Federal Thrift Savings Plan under 5 USC 8439.

(g) **For all programs except OSIPM and MSP**, an annuity purchased by an individual with funds from a plan authorized under subsection (c), (d), or (f) of this section.

2. An annuitized retirement plan described in subsection (1)(e) of this policy, purchased by the spouse, is not considered a retirement plan and is treated in accordance with the Annuities policy.

3. Treat benefits the participant receives from pension and retirement funds as follows:

(a) Count monthly payments as unearned income.

(b) Count all other payments as periodic or lump-sum income.

(c) **For OSIPM**, if the equity value of the pension or retirement plan is counted as a resource under section (4) of this policy, any payments received are considered the conversion of a resource and are not counted as income.

4. **For OSIPM:**

(a) Except for an annuity purchased with funds from a retirement plan described in subsection (1)(e) of this rule:

(A) The equity value of a pension or retirement plan is excluded as a resource if the individual is eligible for monthly or periodic payments under the terms of the plan and has applied for those payments. When an individual is permitted to choose or change a payment option, the individual must select the option that:

(i) Provides payments commencing on the earliest possible date; and

(ii) Completes payments over the actuarial life expectancy, as published in the Periodic Life Table of the Office of the Chief Actuary of the Social Security Administration, of the individual.

(B) The equity value of all pension and retirement plans not covered by paragraph (A) of this subsection that allows an individual to withdraw funds, minus any penalty for withdrawal, is counted as a resource.

(b) The equity value of an annuitized retirement plan described in subsection (1)(e) of this rule is excluded as a resource if it meets the payout requirements of OAR 461-145-0022(10)(c). Otherwise, the equity value is

counted as a resource.

(c) For an individual in a standard living arrangement, the equity value of pension and retirement plans owned by a non-applying spouse or parent is excluded as a resource. Dividends and interest earned on pension funds owned by a non-applying spouse or parent are excluded as income.

5. **For MSP,** dividends and interest earned on pension funds owned by a nonapplying spouse are excluded as income.

6. **For SNAP and TANF**, the value of retirement accounts identified in sections 401(a), 401(k), 403(a), 403(b), 408, 408(k), 408(p), 408A, 457(b), 501(c)(18), or 529A of the Internal Revenue Code are excluded as resources. The value of retirement accounts designated as a Federal Thrift Savings Plan account, IRA, myRA, Roth IRA, SEP, Simple IRA, and any other retirement plan designated as tax-exempt under a successor or similar provision of the Internal Revenue Code of 1986 are excluded resources.

7. **For all programs except OSIPM, MSP, SNAP and TANF**, the equity value of a pension and retirement plan that allows an individual to withdraw funds before retirement, minus any penalty for early withdrawal, is counted as a resource.

For HSD medical programs, exclude non-taxable pension and retirement plan payments for monthly and annual income; taxable payments are counted.

Oregon Administrative Rule(s)

461-145-0380 — Pension and Retirement Plans
410-200-0015 (54) and (55) — General Definitions

Personal belongings

Personal belongings are items needed to occupy and/or maintain a home such as household furnishings and yard care equipment. Also included are personal items that are used on a regular basis, worn or carried by the individual, or have some other personal relation to the individual such as clothing, heirlooms, keepsakes and hobby equipment.

The value of such items is excluded except when they were acquired or are held for their monetary value or as an investment. When acquired or held for their monetary value or as an investment, items are not considered personal belongings and their value is countable. Such items may include gems, jewelry that is not worn or held for family significance, collectibles and other items.

For HSD medical programs, resources are not considered in eligibility determination.

Oregon Administrative Rule(s)

461-145-0390 — Personal Belongings

Personal injury settlement

In ONE, payments from personal injury settlements/accident insurance are coded on the Unearned Income screen:

- Unearned Income Category – Personal Injury Settlement/Accident Insurance
- Unearned Income Type – Personal Injury Settlement/Accident Insurance

For all programs except ERDC, treat personal injury settlements as follows:

- Count monthly payments as unearned income.
- **For individuals in all programs except individuals with blindness or disability eligible for SSI in December 1973 in OSIPM**, count all other payments as periodic or lump-sum income.
- **For individuals with blindness or disability eligible for SSI in December 1973 OSIPM recipients**, count the balance from personal injury claims after ODHS|OHA's lien is satisfied as lump-sum income. If the lien was not filed due to the recipient's failure to notify ODHS|OHA of the claim, count the payment as unearned income.

For ERDC, exclude all personal injury settlements.

This rule does not apply to workers compensation payments.

For HSD medical programs, exclude Personal Injury Settlement/Accident Insurance payments for monthly and annual income.

Oregon Administrative Rule(s)

461-145-0400 — Personal Injury Settlement
410-200-0015 (54) and (55) — General Definitions

Plan for self-support

A plan for self-support allows a participant to retain a part of their assets for a specific period of time so they can meet specific occupational goals. The Social Security Administration may establish a plan for self-support with SSI recipients. APD may also establish a plan for self-support with OSIPM and MSP individuals who meet disability criteria (established by SSA or PMDDT) but are not eligible for SSI.

Assets listed in an approved plan for self-support are excluded.

For HSD medical programs, resources are not considered in eligibility determination.

Oregon Administrative Rule(s)

461-145-0405 — Plan for Self-support

Program benefits

It's not necessary to code payments from public assistance programs when the payment for that program is made from ONE. For payments from public assistance programs that are not issued from ONE, code these on the Unearned Income screen:

- Unearned Income Category – Public Assistance
- Unearned Income Type – there are several different types to choose from, select the one which is applicable to the type being reported:
  - Public Assistance benefits - General Assistance (GA)
  - Public Assistance benefits - REF/TANF incentive pmts
  - Public Assistance benefits - TA-DVS- dual or 3rd party payment
  - Public Assistance benefits - TA-DVS- paid to participant
  - Public Assistance Benefits: Out of State TANF
  - Public Assistance Benefits: Special Needs
  - Public Assistance Benefits: Tribal TANF

Treat Pre-TANF Program payments as follows:

(a) **For SNAP,** count a payment for basic living expenses made directly to the participant as unearned income. Exclude all other payments.

Note: For individuals being certified for SNAP at the same time Pre-TANF Program payments are being made, count payments for basic living expenses that can reasonably be anticipated. For other individuals with ongoing prospectively budgeted SNAP benefits, count these payments after giving 10-day notice only if the payments can be anticipated for next month.

(b) **For all programs except SNAP**, exclude these payments.

For EA payments:

(a) **For ERDC**, count a payment made directly to the participant as unearned income. Exclude dual payee and provider-direct payments.

(b) **For all programs except ERDC and SNAP**, exclude these payments.

Treat Employment Payments (see OAR 461-001-0025 and 461-135-1270) payments as follows:

(a) **For REF, REFM, SNAP and TANF**, count these payments as unearned income in the month received.

(b) **For all other programs**, exclude these payments.

Exclude payments from ERDC and TANF child care unless the participant is the provider. Exclude payments from MAGI medical (including MAGI-CHIP), OSIPM, MSP and REFM.

For SNAP payments:

(a) **For all programs except EA**, Exclude the value of a SNAP benefit .

(b) **For EA**, count the value as a resource when determining the emergency food needs of the filing group.

(c) Exclude OFSET service payments:

Treat benefits from GA, OSIP (except OSIP-IC), Post-TANF, REF, SFPSS, TANF and tribal-TANF as follows:

(a) **EA**, count these payments as unearned income, except when they are for a benefit group whose emergent need is the result of domestic violence.

(b) **ERDC**:

(A) Post-TANF payments are excluded.

(B) All other payments are counted as unearned income.

(c) **MSP** Exclude these payments.

(d) **SNAP**:

(A) Treat these payments as unearned income.

(B) Treat an amount received as a late processing payment as lump-sum income.

(C) Treat payments made to correct an underpayment as lump-sum income.

(D) Treat ongoing special needs payments for laundry allowances, special diet or meal allowance, restaurant meals, accommodation allowances and telephone allowances as unearned income. Exclude all other special needs payments (e.g., Transportation Services Payment (TSP) and Prescription Co-Pay Coverage (PCC)) as reimbursements.

Notes as follows:

- SNAP: The Manual (MNL) HH-type to prevent the system from counting excluded special needs payments.
- SNAP: For telephone allowances: if a participant was receiving a check each month for a telephone allowance that included payment for a basic telephone and a life line, the amount for basic telephone would be considered unearned income, and the amount for the life line is considered a reimbursement
- SNAP: If a participant is eligible for a special need but rather than receiving a check has their pay-in reduced, the pay-in amount is considered a medical deduction plus any other out-of-pocket expenses that may be allowable medical deductions

(e) **For all programs except EA, ERDC and SNAP**:

(A) Exclude these payments in the month received, and count any portion remaining following the month of receipt as a resource.

(B) Exclude payments made to correct an underpayment.

(f) **For all programs**:

(A) Exclude JOBS, REF and TANF JOBS Plus support service payments.

(B) For the treatment of JOBS Plus income, see OAR 461-145-0130.

(g) Exclude Job Participation Incentive (JPI) for all programs. (See OAR 461-135-1260.)

Note: When a person is receiving TANF JOBS Plus, continue to code the TANF grant and the extra JOBS Plus $10 payment as unearned income.

Payments from OSIPM-IC are treated as follows:

(a) **SNAP** These payments are counted as unearned income and assets held in a contingency fund (see OAR

411-030-0020) are counted as a resource.

(b) **For all other programs**, these payments and funds held in a contingency fund are excluded.

Note: OSIPM-IC is the Independent Choices Program.

Exclude all payments from TA-DVS for all programs regardless if paid to the participant or as a third-party payment.

For HD medical programs, exclude program benefits for monthly and annual income.

Oregon Administrative Rule(s)

461-145-0410 — Program Benefits
410-200-0015 (54) and (55) — General Definitions

Qualified partnership policy

For OSIPM, when an individual in a non-standard living arrangement applies, exclude a resource amount equal to the insurance payments received under a qualified partnership policy (QPP) as of the initial month of eligibility, unless the policy was purchased in a state that does not participate in reciprocity.

The exclusion:

- Does not apply when home equity exceeds the limit in OAR 461-145-0220 (2)(a), and
- Applies to all other resources (see Long-term care insurance worker guide for additional information).

For the amount of resources excluded under this rule, ODHS|OHA will not establish a claim against the estate of the deceased individual in accordance with OAR 461-135-0835.

Oregon Administrative Rule(s)

461-160-0855 — Excluded Resources for Payments Received Under a Qualified Partnership

Radiation Exposure Compensation Act

Radiation Exposure Compensation Act payments are issued to compensate individuals for injuries or deaths resulting from exposure to radiation from nuclear testing or uranium mining.

In ONE, payments from the Radiation Exposure Act are coded on the Unearned Income screen:

- Unearned Income Category – Other Income
- Unearned Income Type – Radiation Exposure

For all programs, these payments are excluded.

Oregon Administrative Rule(s)

461-145-0415 — Radiation Exposure Compensation Act
410-200-0015 (54) and (55) — General Definitions

Railroad retirement payments

In ONE income from railroad retirement plans are coded on the Unearned Income screen:

- Unearned Income Category – Retirement
- Unearned Income Type – there are two different types to choose from, select the one which is applicable to the type being reported:
  - Railroad Retirement and Pension - Non-Taxable
  - Railroad Retirement and Pension - Taxable

For OSIPM and MSP, count railroad retirement payments made by the Railroad Retirement Board as unearned income.

Oregon Administrative Rule(s)

461-145-0417 — Railroad Retirement Payments; OSIP, OSIPM, and QMB
410-200-0015 (54) and (55) — General Definitions

Resource Assistance for Rural Environments (RARE) program

Resource Assistance for Rural Environments (RARE) is a program administered through the University of Oregon. The program assists rural communities in their efforts to improve their economic, social and environmental conditions. Local communities request they work in this program for 11 months and receive monthly living stipend and medical health insurance, the assistance of this program and provide part of the funding. The program is supported through grants from various federal and state agencies. In addition, this program sometimes includes funding from The National and Community Service Trust Act (AmeriCorps).

The stipend may include funding from the Corporation for National and Community Service (AmeriCorps). The stipend may be counted differently depending on their participation in AmeriCorps. If the RARE participant is also getting funding from AmeriCorps, they will have a signed agreement showing this participation.

In ONE, payments to those individuals working in the RARE program are coded on the Specific Income screen:

- Specific Income Category – Stipends
- Specific Income Type – Research Assistance for Rural Environments

Note: For HSD medical programs, an additional step needs to be taken when coding this income. If the individual has proof they are working with the RARE program as an AmeriCorps participant (they will have a letter from the University of Oregon program with this information), please take the following steps after coding the income as indicated above:

- Code the full amount of RARE income as instructed above.
- Code the full amount of the RARE income as a deduction on the MAGI Deduction screen as “Other allowable tax deduction/expense.”

Enter a case note that the system does not allow you to indicate that the RARE income is from AmeriCorps. As a result, you had to list the income as a MAGI deduction so that it wouldn’t be considered in the MAGI income calculation.

For all programs except OSIPM and MSP:

- With proof of AmeriCorps participation, exclude the RARE living allowance (stipend benefits)..
- Without proof of AmeriCorps participation, count the RARE living allowance (stipend benefits) as earned income.

For OSIPM and MSP, RARE living allowance is excluded regardless of funding source.

Note: Ask each RARE participant to provide a copy of the AmeriCorps contract before excluding the stipend income.

Oregon Administrative Rule(s)

461-140-0010 — Assets; Income and Resources
461-145-0365 — National and Community Service Trust Act (NCSTA), including AmeriCorps (other than AmeriCorps VISTA)
410-200-0015 (54) and (55) — General Definitions

Real property

Manufactured, mobile homes, and floating homes and houseboats are treated the same as real property. Real property is land, buildings and whatever is erected or affixed to the land and taxed as real property.

The participant has the burden of proof of establishing the fair market value of real property. Fair market value may be established by any method that accurately reflects the fair market value of the real property, including having an appraisal or comparative market analysis performed by an impartial individual who is certified or licensed in the applicable jurisdiction.

The key to determining fair market value is making sure the value you arrive at is the most accurate one. A current market value given by a tax assessor is a good starting point. When reviewing tax assessor records, be sure not to confuse reduced (or “assessed”) property values with values that are supposed to reflect the current value; “real market value” is the term used in Oregon.

Sometimes tax assessor records are not the best way to determine fair market value. For example, current property tax records may overvalue property that has deteriorated. An appraisal may reflect a more realistic property value. Property tax records may sometimes undervalue property, such as homes, farmland and timberland. If property is appraised at or sells for more than the tax assessor’s listed current market value, the most accurate property value is the greater of the appraisal’s value or its selling price.

If property sells for less than either the tax assessor’s current market value or an appraisal’s value, then that is a red flag to investigate why a sale was for less than fair market value. Sales or transfers of property for less than fair market value are potentially disqualifying transfers. Generally, the following methods can help to accurately determine fair market value:

- Using the highest value identified by the county assessor on the most recent property tax record
- Using the value established by an appraisal or comparative market analysis as the current amount the real property would sell for on the open market, and

- Using the gross sale price of property that has sold.

Treat real property that is not income-producing or the financial group's home as follows:

(a) **For REF, REFM and TANF,** count as a resource the equity value of all real property not excluded under an interim assistance agreement.

(b) **For EA and ERDC**, exclude real property.

(c) **For SNAP**, exclude the equity value of real property the financial group is making a good-faith effort to sell at a fair market price. If the group refuses to make a good-faith effort to sell, count the equity value of the property as a resource. In addition, the resource is excluded if selling it would produce a net gain of less than $1500 to the financial group.

(d) **OSIPM**:

(A) Exclude the equity value of real property that was the home of the financial group as a resource if they are making a good-faith effort to sell at a reasonable price. Do not exclude if the equity value in the home makes the individual ineligible under OAR 461-145-0220(2)(a). If the group refuses to make a good-faith effort, count the equity value of the property as a resource.

(B) Count the equity value of all other real property as a resource unless the financial group is making a good-faith effort to sell the property. The equity value is counted after the property is excluded for nine months unless the failure to sell is for reasons beyond the reasonable control of the financial group.

Note: A good-faith effort to sell property includes listing the property for sale in the local newspaper, putting a "For Sale" sign on the property, and/or listing the property with a real estate company.

For HSD medical programs and MSP:

Resources are not considered in eligibility determination.

Oregon Administrative Rule(s)

461-145-0420 — Real Property

Real property excluded under an interim assistance agreement; REF, REFM, TANF

For REF, REFM and TANF, treat real property where the equity value puts the financial group over the TANF resource limit as follows:

Exclude real property for a maximum of nine months if the financial group signs and complies with the terms of the Interim Assistance Agreement. After the ninth month, count the equity value of the property as a resource.

To comply with the terms of the Interim Assistance Agreement, the financial group must agree to do the following:

(a) Make a good-faith effort to sell the property; and

(b) Use the proceeds from the sale of the property to reimburse ODHS|OHA for all benefits paid under the terms of the Interim Assistance Agreement. The reimbursement will not exceed the net proceeds of the sale of the property.

The amount of benefits paid while the financial group has excess real property is an overpayment if the financial group fails to notify ODHS|OHA they have the property.

The amount of the benefits paid while the financial group has excess real property up to the net proceeds of the sale of the property is an overpayment if the property sells and the group does not repay ODHS|OHA per the terms of the Interim Assistance Agreement.

Note: If the financial group has excess real property, complete a Children, Adults and Families Resource Referral form (DHS 0647B) and file in the case record with the following:

- A signed copy of the Children, Adults and Families Interim Assistance Agreement (DHS 0418A)
- A copy of the legal description of the property
- A copy of the deed or purchase agreement (if available).

Track the case for the entire nine-month exclusion period. Close the case at the end of the exclusion period.

If the participant reapplies, check to see if they still have the property or if the property sold. If the participant still has the property, they remain ineligible. If the property sold while the case was closed and the participant did not reimburse ODHS|OHA, compute an overpayment.

Use receipt code 216 when the participant makes a payment based on the terms of the TANF Interim Assistance Agreement.

For all other programs, this does not apply.

Oregon Administrative Rule(s)

461-145-0430 — Real Property Excluded under an Interim Assistance Agreement; REF, REFM, and TANF

Reception and placement grants

A Reception and Placement (R&P) grant is a payment made by the U.S. Department of State through national refugee resettlement agencies to local resettlement agencies, refugee sponsors and refugees. The R&P grants are provided to the resettlement agencies to help with the costs of initial resettlement of refugees in the United States. These grants are for initial resettlement needs and not for ongoing living expenses.

In ONE, payments from the Reception and Placement grant to refugees are coded on the Unearned Income screen:

- Unearned Income Category – Other Income
- Unearned Income Type – Reception and Placement Grant to Refugees - Received as CASH

For ERDC, REF, REFM and TANF, R&P grants are excluded from consideration as income and resources for purposes of determining program eligibility or benefit levels, except as provided in OAR 461-140-0070.

For SNAP, any amount paid directly to a SNAP household from an R&P grant is unearned income. For in-kind payments made by the resettlement agency, see OAR 461-145-0280.

For OSIPM and MSP, an R&P grant determined to be available to the refugee case is considered unearned income.

For HSD medical programs, exclude Reception and Placement grants to refugees received as cash assistance for monthly and annual income.

Oregon Administrative Rule(s)

410-200-0015 (51) and (52) — General Definitions
461-145-0455 — Reception and Placement (R&P) Grants
410-200-0015 (54) and (55) — General Definitions

Recreational vehicles

Recreational vehicles include the following:

- A vehicle, if used primarily for amusement and not for day-to-day transportation and A vehicle that cannot be licensed as a motor vehicle for use on a public highway (even if registered or licensed as a nonmotor vehicle), or
- An ATV, boat, camper, dune buggy, plane, snowmobile or trailer, unless it qualifies as a capital asset or work-related equipment.

For all programs except ERDC, MSP and HSD medical, count the equity value of recreational vehicles as a resource except in the following circumstances:

- **For SNAP,** the equity value is excluded if, by selling the vehicle, the net gain would be less than $1,500 to the financial group
- **For OSIPM,** items used as a means of day-to-day transportation or used for OSIPM-EPD are treated in accordance with the motor vehicle policy.

For ERDC, exclude the value of recreational vehicles.

FOR HSD medical programs and MSP, resources are not considered in eligibility determination.

Oregon Administrative Rule(s)

461-145-0433 — Recreational Vehicles

Refunds and rebates

In ONE, refunds and rebates are coded on the Unearned Income screen:

- Unearned Income Category – Refunds and Rebates
- Unearned Income Type – there are several different types to choose from, select the one which is applicable to the type being reported:
  - Federal Income Tax Refunds
  - Property Tax refunds
  - Refunds and rebates -all others
  - Refunds and rebates on merchandise received as a gift
  - State Tax Refunds

Exclude the following refunds in the month they are received:

- Refunds on merchandise purchased or received as a gift
- Refunds of utility and rental deposits.

For OSIPM and MSP:

- If the rebate or refund is in the form of cash, and the individual actually paid that amount prior to receiving the rebate or refund, it is excluded.
- If the rebate or refund is not a return of money the individual had already paid, it's countable as unearned income in the month received.
- If the rebate is generated from an investment (i.e. it's a return on an investment), it's treated under the dividends, interest, and royalties policy.
- If the refund is from income tax or property tax, it's treated under the tax refund policy.
- Refunds on merchandise purchased or received as a gift are excluded as income in the month received.
- Refunds of utility and rental deposits are excluded as income in the month received.

For all programs except MSP and HSD medical, count any refund amount remaining after the month of receipt as a resource.

For HSD medical programs, refunds and rebates on merchandise received as a gift are counted in monthly and annual income. All other refunds and rebates are excluded.

Oregon Administrative Rule(s)

461-145-0435 — Refunds and Rebates
410-200-0015 (54) and (55) — General Definitions

Reimbursement

"Reimbursement" means money or in-kind compensation provided specifically for an identified expense.

In ONE, reimbursements are coded on the Specific Income screen:

- Specific Income Category – Reimbursement
- Specific Income Type – Reimbursement

For the treatment of USDA meal reimbursements, go here.

The reimbursement of a business expense for an individual who is self-employed is treated as self-employment income.

Except as provided above, a reimbursement is treated as follows:

(a) **For ERDC,** a reimbursement is excluded, except a reimbursement for child care from a source outside of ODHS|OHA is counted as unearned income.

(b) **For SNAP:**

(A) A reimbursement in the form of money for a normal household living expense, such as rent or payment on a home loan, personal clothing, or food eaten at home, is unearned income.

(B) Any other reimbursement is treated as follows:

(i) An in-kind reimbursement is excluded.

(ii) A reimbursement in the form of money is excluded if used for the identified expense unless the expense is covered by program benefits.

(iii) A reimbursement is counted as periodic or lump-sum income if not used for the identified expense.

(iv) A reimbursement for an item already covered by the benefits of the benefit group is counted as periodic or lump-sum income.

(c) **For OSIPM, MSP and SNAP**, a reimbursement from a business entity that benefits a principal is counted as earned income.

(d) **For all programs except ERDC, HSD medical and SNAP**, a reimbursement is treated as follows:

(A) An in-kind reimbursement is excluded.

(B) A reimbursement in the form of money is excluded if used for the identified expense unless the expense is covered by program benefits.

(C) A reimbursement is counted as periodic or lump-sum income if not used for the identified expense.

(D) A reimbursement for an item already covered by the benefits of the benefit group is counted as follows.

(i) **For all programs except OSIPM and MSP**, it is counted as unearned income.

(ii) **For OSIPM and MSP,** it is counted as unearned income unless the payment is turned over to ODHS|OHA.

Note: Shared shelter is not a cash reimbursement.

Note: Payments for extra expenses, such as meal reimbursements for training or conferences, JTPA lunch payments, ODHS|OHA shelter payments for attendants or housekeepers, and premiums for cost-effective employer- sponsored health insurance are not considered to be expenses paid by program benefits and are excluded as reimbursements. Exclude all jury duty payments.

(e) **For HSD medical programs,,** exclude reimbursements for monthly and annual income.

Oregon Administrative Rule(s)

461-145-0440 — Reimbursement
410-200-0015 (54) and (55) — General Definitions

Representative payee payment

Representative payees receive payments on behalf of other people who are required to have a representative payee. Some representatives charge a fee to the person for whom they are receiving the payments.

In ONE, representative payee fee payments are coded on the Earned Income screen:

- Earned Income Category – Wages
- Earned Income Type - Representative Payee Fee

- When a participant is required by the Social Security Administration to receive payments through a representative payee, fees paid by a participant to a representative payee are excluded. The amount of the exclusion is limited to the amount authorized by the Social Security Administration (information about the allowable fee amount can be found at http://www.socialsecurity.gov/OACT/COLA/RepPayee.html). Criteria for this exclusion are in OAR 461 145 0490 and 461-145-0510.
- Fees received by a financial group member, as a representative payee, are counted as earned income.
- When a representative payee, who is a member of the financial group, receives benefits for another person as their representative payee, treat the income as follows:
  - Excluded as long as the payments are being disbursed as intended for the person requiring the payee per OAR 461-140-0040.
  - Counted as unearned income if the payments are being kept by the financial group member and not being disbursed as intended for the person requiring the payee.

For HSD medical progams, representative payee fees are counted in monthly and annual income.

Sale of a resource

In ONE, income from the sale of a countable resource is coded on the Unearned Income screen:

- Unearned Income Category – Other Income
- Unearned Income Type – Sale of a Countable Resource

Treat proceeds from the sale of a resource (whether a home or not) as follows:

- **For ERDC**, exclude all proceeds from the sale of a resource.
- **For MSP**, count the interest portion as unearned income and exclude the principal portion.
- **For REF, REFM and TANF**, if the proceeds are from the sale of an excluded resource, exclude the amount reinvested in another excluded resource. Count all other proceeds from the sale of a resource as unearned income.

Treat proceeds from the sale of a resource other than a home as follows:

- **For OSIPM:**
  - Count the principal portion of proceeds received on a monthly or other periodic basis as a resource.
  - The principal portion of proceeds received on a lump-sum basis is treated as follows:
    - » If the proceeds are from the sale of an excluded resource, the amount reinvested in another excluded resource is excluded, and the remainder is counted as a resource.
    - » Proceeds from all other sales are counted as a resource.
  - Count the interest portion of proceeds as unearned income.

- **For SNAP:**
  - Count the principal portion of proceeds received on a monthly or other periodic basis as unearned income.
  - Treat proceeds received on a lump-sum basis as follows:
    - » If the proceeds are from the sale of an excluded resource, exclude the amount reinvested in another excluded resource. Count the remainder as a resource.
    - » Count the proceeds from all other sales as a resource. If the proceeds put the benefit group over the resource limit, treat the proceeds as periodic or lump-sum income.
  - If a self-employed participant sells a work-related asset, including equipment and inventory, the proceeds of the sale are treated as self-employment income.

Treat proceeds from the sale of the home of the financial group as follows:

- **For OSIPM and individuals with blindness or disability eligible for SSI in December 1973 OSIPM recipients:**
  - Exclude principal payments, including lump-sum payments, for three full calendar months (for OSIPM individuals with blindness or disability eligible for SSI in December 1973, its 12 full calendar months) from the date of receipt if the financial group intends to use the proceeds to buy another home or for associated costs including:
    - » Down payments
    - » Settlement costs
    - » Loan processing fees and points
    - » Moving expenses
    - » Necessary repairs to or replacement of the new home's structure or fixtures (including roof, furnace, plumbing, built-in appliances) that are identified and documented prior to occupancy
    - » Mortgage payments
    - » Funds for the above costs obligated by contract within the applicable months are also excluded
  - Count the principal portion of proceeds not reinvested in another home is as a resource.
  - Count the interest portion of proceeds as unearned income.
- **For SNAP:**
  - If the financial group intends to use the proceeds to buy another home, they are excluded for three months and counted as a resource thereafter.
  - If not reinvested in another home, they are treated as a resource.
  - Interest received monthly or on another periodic basis from the sale of a home is counted as unearned income.

Any costs excluded under OAR 461-145-0920 are subtracted from the proceeds from the sale of a resource if the proceeds are treated as income under this rule. This is true even though the income is not from self-employment. Use the actual costs and not the allowed self-employment deduction identified in exclusions allowed from self-

employment income.

For HSD medical programs, sale of a countable resource is counted for monthly and annual income.

Click here for examples: Sale of a resource.

Oregon Administrative Rule(s)

410-200-0015 (51) and (52) — General Definitions
461-145-0240 — Income-Producing Sales Contract
461-145-0460 — Sale of a Resource

Shelter-in-kind income

Shelter-in-kind is when an agency or person outside the household financial group provides the financial group's shelter or makes a payment to a third party for some or all of the group's shelter costs. Shelter costs are housing costs (rent or mortgage payments, property taxes) and utility costs, not including cable TV or non-basic telephone charges.

1. Except as provided in section 2 below, shelter-in-kind income is treated as follows:
   - **(a)** **For ERDC**, exclude shelter-in-kind payments, except earned shelter-in-kind.
   - **(b)** **For REF, REFM and TANF**, exclude shelter-in-kind payments, except for child support (see OAR 461-145-0080 and 461-145-0280).
   - **(c)** **For SNAP**, exclude shelter-in-kind housing and utility payments, except an expenditure by a business entity for shelter costs of a principal.
   - **(d)** **For OSIPM and MSP**:
     - (A) Exclude unearned shelter-in-kind, including payments made to a third party for shelter expenses of the financial group.
     - (B) Earned shelter-in-kind income is treated as follows:
       - (i) If shelter is provided on the employer's business premises, living at that location is a reasonable expectation of the job duties, and acceptance of the shelter is a condition of employment with no option to accept the value of the shelter in money, the shelter-in-kind income is excluded.
       - (ii) If the shelter doesn't meet all the conditions above, the fair market value of the shelter or the amount of any payment made to a third party for shelter expenses of the financial group is counted as earned income.
2. **For all programs except OSIPM and MSP**, count a payment for which there is a legal obligation to pay to a member of the financial group that is made to a third party for shelter expenses of a member of the financial group as unearned income.

For HSD medical programs, in-kind income/third-party payments are treated as follows:

- If the in-kind income/third-party payment is legally obligated to be paid to the applicant, it is counted for

monthly and annual income.

- If the in-kind income/third-party payment is not legally obligated to be paid to the applicant and they have the option to receive the payment as money, it is counted for monthly and annual income.
- If the in-kind income/third-party payment is not legally obligated or the individual cannot receive the money as income, it is excluded for monthly and annual income.

See Housing and Urban Development (HUD) for payments made by HUD.

Oregon Administrative Rule(s)

410-200-0015 (51) and (52) — General Definitions
461-145-0470 — Shelter-in-Kind Income
410-200-0015 (54) and (55) — General Definitions

Social Security benefits (SSB and SSDI)

Social Security benefits include Title II — Federal Old-Age (SSB), Survivors (SSB), and Disability Insurance (SSDI) benefits through the Social Security Administration trust funds.

This section does not apply to Title XVI — Supplemental Security Income for the Aged, Blind, and Disabled (SSI) or Social Security death benefits.

For this section, a payment is retroactive if it is issued in any month after the calendar month for which it would normally be received.

In ONE, payments from the Social Security Administration are coded on the Unearned Income screen:

- Unearned Income Category – Social Security Payments
- Unearned Income Type – there are several different types to choose from, select the one which is applicable to the type being reported:
  - Social Security Benefits (Survivor and Retirement)
  - Social Security Death Benefit
  - Social Security Disability Insurance

Treat all SSB as follows:

- Count monthly payments as unearned income.
- Count all other payments as periodic or lump-sum income except as provided below.
- **For OSIPM and MSP**:
  - Count retroactive payments as unearned income in the month of receipt except:
    - When retroactive payments are made through the representative payee of an individual who is required to have a representative payee because of drug addiction or alcoholism. In these situations, the retroactive payments may be required to be made in installments. If the payments are made in installments, the total of the benefits to be paid in installments is considered unearned income in the month in which the first installment is made.

» Except for MSP, any remaining amount from a retroactive payment after the month of receipt is counted as an excluded resource for nine calendar months following the month in which the payment is received. After the nine-month period, any remaining amount is a countable resource.

- **For SNAP,** the representative payee fee paid by a participant who is required by the Social Security Administration to receive payments through a representative payee is excluded. The amount of the exclusion is limited to the amount authorized by the Social Security Administration. The representative payee must be a community-based nonprofit social services agency which is bonded or licensed by the state.

For HSD medical programs, Social Security benefits and Social Security Disability Income are considered in the following way:

Generally, Social Security benefits (SSB) and Social Security Disability Income (SSDI) are countable under both MAGI-based (monthly) and MAGI (annual) income methodology. However, special income exceptions apply to:

(a) Children under age 19 who have income and who reside with their parents;

(b) Adult children (age 19+) who have income and who reside with their parents and are claimed as a tax dependent by their parents; and

(c) Tax dependents of any age who have income and who reside with their tax filers where the tax filers are not the parents of the tax dependent.

The determination of whether a child/tax dependent's income is countable or excluded depends on whether the child/tax dependent's income meets or exceeds the applicable IRS income filing threshold requiring the individual to file federal taxes.

(a) If the child or tax dependent's income meets or exceeds the applicable IRS threshold, requiring the individual to file federal taxes, the child/tax dependent's income is countable for their own EDG and all EDGs for whom they are an EDG member of.

(b) If the child's income is under the applicable IRS threshold, the child is not required to file taxes. Thus, the child's income is excluded for their own EDG and all other EDGs whom the child is an EDG member of.

(c) If the tax dependent's income is under the applicable IRS threshold, the tax dependent is not required to file taxes. The tax dependent's income is excluded for the tax filer and tax filer's children's EDGs, however, is countable for the tax dependent. This is because the tax filer is never included in the tax dependent's EDG. If the tax dependent's EDG includes siblings, the tax dependent's income is also countable towards the siblings' EDG.

When the child/tax dependent receives SSB/SSDI, a calculation must be performed to determine if the SSB/SSDI is taxable before determining if the child/tax dependent is required to file federal taxes. If none of the SSB/SSDI is taxable, none of the SSB/SSDI is countable unless the child/tax dependent has other income requiring the child/ tax dependent to file federal taxes. If any or all of the SSB/SSDI is taxable, only the taxable amount is factored into the requirement to file federal taxes determination.

(a) If the child/tax dependent is determined to be required to file taxes, all of the SSB/SSDI, along with other countable income the child/tax dependent receives, is countable for all EDGs whom the child/tax dependent is an EDG member of.

(b) If the child is determined to not be required to file taxes, none of the SSB/SSDI, along with other income

the child receives, is countable for their own EDG and other EDGs whom the child is an EDG member of.

(c) If the tax dependent is determined to not be required to file taxes, none of the SSB/SSDI, along with other income the tax dependent receives, is countable for their tax filer and tax filer's children. However, all of the SSB/SSDI, along with other income the tax dependent receives, is countable for the tax dependent. If the tax dependent's EDG includes siblings, all of the tax dependent's SSB/SSDI and other income is countable towards the siblings' EDG.

When Social Security income is reported, the full amount as reported, or the gross amount as found in Social Security screens, should be entered into ONE. ONE will perform all calculations necessary to determine if the child/tax dependent's SSB, SSDI, and other income, is countable and apply the outcome towards all EDGs on the case.

Oregon Administrative Rule(s)

461-145-0490 — Social Security Benefits
410-200-0015 (54) and (55) — General Definitions

Social Security death benefit

Money remaining from Social Security death benefits after the payment of burial costs is treated as lump-sum income.

In ONE, the Social Security death benefit is coded on the Unearned Income screen:

- Unearned Income Category – Social Security Payments
- Unearned Income Type – Social Security Death Benefit

Oregon Administrative Rule(s)

461-145-0500 — Social Security Death Benefit
410-200-0015 (54) and (55) — General Definitions

Social Security income (SSI)

In ONE, Supplemental Security Income (SSI) is coded on the Unearned Income screen:

- Unearned Income Category – Social Security Payments
- Unearned Income Type – Supplemental Security Income (SSI)

For ERDC and SNAP, count monthly SSI payments as unearned income. Exclude the representative payee fee for individuals who must receive payments through a representative payee under P.L. 101-508 or P.L 103 296. In this instance, the representative payee must be a community-based nonprofit social services agency bonded or licensed by the state. To check for the current fee amount to exclude, go to http://www.socialsecurity. gov/payee/feefactsheet.htm.

Note: When a disability is based on drug addiction or alcoholism, P.L. 103 296 requires payments to SSA individuals be made through an authorized representative.

For ERDC:

(a) Count SSI monthly payments as unearned income.

(b) Count SSI lump-sum payments according to the specific program policy on lump-sum.

For REF, REFM and TANF:

(a) Exclude SSI monthly and lump-sum payments, even if received by a financial group member, if that person will be removed from the group the following month.

(b) Exclude SSI lump-sum payments in the month paid and the next month, even if the recipient is in the financial group. Count the remainder as a resource after those two months, if the SSI recipient is still in the group.

For SNAP: Count monthly SSI payments as unearned income and exclude any lump-sum SSI payments.

For OSIPM:

(a) Exclude retroactive lump-sum SSI payments for nine months after receipt. After the nine-month period, any remaining amount is counted as a resource. A payment is retroactive if it is issued in any month after the calendar month for which it is intended.

(b) All SSI payments received by members of the financial group are counted as unearned income in the month received.

For MSP, all SSI payments received by members of the financial group are counted as unearned income in the month received.

For HSD medical programs, exclude Supplemental Security Income for monthly and annual income.

Oregon Administrative Rule(s)

461-145-0510 — SSI
410-200-0015 (54) and (55) — General Definitions

Spousal support

"Spousal support" is income paid (voluntarily, per court order or per administrative order) by a separated or divorced spouse to a member of the financial group.

In ONE, income from spousal support is coded on the Unearned Income screen:

- Unearned Income Category – Spousal Support
- Unearned Income Type – Spousal Support/Alimony

For ERDC, OSIPM and MSP, spousal support is counted as unearned income

For SNAP:

(a) Payments made by the separated or divorced spouse to a third party for the benefit of the financial group are excluded, except a payment for which there is a legal obligation to pay to a member of the financial group made to a third-party for shelter expenses of a member of the financial group is counted as unearned income.

(b) Spousal support is counted as unearned income.

For REF, REFM and TANF:

(a) For individuals not working under a TANF JOBS Plus agreement, if the spousal support is received by ODHS|OHA or the Oregon Department of Justice, and if continued receipt of the spousal support is reasonably anticipated, the spousal support is:

i. Counted as unearned income when determining eligibility; and

ii. Excluded when determining the REF and TANF benefit amount.

(b) For individuals working under a TANF JOBS Plus agreement:

i. Spousal support is excluded in determining countable income.

ii. Spousal support is excluded when calculating the TANF portion of the benefit equivalency standards.

iii. Spousal support received by the participant is counted as unearned income when calculating the wage supplement.

(c) Other spousal support payments (not covered under subsections (a) or (b) of this section) are counted as unearned income.

Note: Receipt of spousal support can be reasonably anticipated if the support is secured by wage garnishment or if it has been received in each of the two months before the payment month.

For HSD medical programs, spousal support is counted for monthly and annual income.

Oregon Administrative Rule(s)

461-145-0505 — Spousal Support
410-200-0015 (54) and (55) — General Definitions

Stipends

A stipend is a fixed or regular payment for services rendered. The stipend may include a living allowance, personal expenses or reimbursement to a person for their costs, such as their time or transportation.

A stipend may be excluded or counted as earned or unearned income. How it is treated depends on the funding source of the stipend and the program.

In ONE, for stipends not identified elsewhere in this section (for example, National and Community Service Trust Act (NCSTA) stipends), code income from stipends on the Specific Income screen:

- Specific Income Category – Stipends
- Specific Income Type – Stipends - Other

First, determine the funding source. The participant may not know; you will need to ask the organization. For example, a community agency, college or university may obtain AmeriCorps, Work Investment Act or some other type of funding to fund the stipend.

- The stipend income is countable if it is not specifically excluded elsewhere in this section of the manual.

- If the funding source is not covered in this section of the manual:
  - **For SNAP,** it is counted as earned income.
  - **For all other programs**, it is counted as unearned income.

Some of the stipend funding sources identified are:

- VISTA (including AmeriCorps VISTA) or various programs under the Domestic Volunteer Service Act
- YouthBuild Program
- Job Corps
- Programs under the National and Community Service Trust Act (including AmeriCorps)
- Programs funded by the Older Americans Act
- RARE
- Veterans' Administration
- Vocational Rehabilitation
- WIA.

Some examples of stipend income that may or may not be funded by sources are:

- A tribal member receives a stipend to attend training or GED classes. This income is from the tribe and not funded under a law that excludes the stipend.
- A college or university may pay a stipend to a student in a faculty fellowship program. This income may be from the college or university using state or grant funds and is not funded by a law that excludes the stipend.
- A volunteer in a community program receives a stipend for the time they worked on a project. This income may be from the community via a grant, state or local funds and is not funded under a law that excludes the stipend.
- A student is receiving an income from ROTC funds each month while attending school. This income is considered a stipend and is not excluded.

For HSD medical programs, stipends are counted for monthly and annual income.

Oregon Administrative Rule(s)

410-200-0015 (54) and (55) — General Definitions

Stocks, bonds and other securities

Except as provided below, the equity value of mutual funds and securities — including stocks, bonds, educational savings bonds and certificates of deposit (CDs) — is counted as a resource. Interest and dividends on these items are treated as provided in Dividends, interest and royalties.

See the Dividends, interest, royalties for how to code this income in ONE.

For OSIPM, the value of a savings bond issued by the U.S. Department of the Treasury is excluded during the minimum retention period.

For all other programs, the value of a savings bond issued by the U.S. Department of the Treasury is excluded during the minimum retention period if the owner has received a denial of a request for a hardship waiver based on financial need.

Oregon Administrative Rule(s)

461-145-0520 — Stocks, Bonds, and Other Securities
410-200-0015 (54) and (55) — General Definitions

Strikers' benefits

Strikers' benefits are payments made to strikers by their union, whether or not based on the striker's participation in picketing.

In ONE, income from spousal support is coded on the Unearned Income screen:

- Unearned Income Category – Other Income
- Unearned Income Type – Strikers' Benefits

Treat these payments as follows:

- **For all programs except SNAP**, count as unearned income.
- **For SNAP,** exclude these payments, unless the striker's current income is higher than their pre-strike income. If so, count as unearned income.

Oregon Administrative Rule(s)

461-145-0525 — Strikers' Benefits
410-200-0015 (54) and (55) — General Definitions

Tax refund

In ONE, refunds and rebates are coded on the Unearned Income screen:

- Unearned Income Category – Refunds and Rebates
- Unearned Income Type – there are several different types to choose from, select the one which is applicable to the type being reported:
  - Federal Income Tax Refunds
  - Property Tax refunds
  - Refunds and rebates -all others
  - Refunds and rebates on merchandise received as a gift
  - State Tax Refunds

Count tax refunds, except for the Earned Income Tax Credit portion, as follows:

Federal tax refunds:

- **For all programs except MSP**:

- In the month of receipt, consider it excluded income.
- For 12 months following the month of receipt, consider it an excluded resource.
- After the 12 months, consider it a countable resource

- **For HSD medical programs and MSP,** exclude as income and as a resource.

Note: Federal tax refunds are excluded as a resource for eligibility decisions if received before Jan. 1, 2010.

State tax refunds and property tax refunds, including Elderly Rental Assistance (ERA):

- In the month of receipt, consider it lump-sum income.
- After the month of receipt, consider it a countable resource.
- **For OSIPM,** exclude them as income in the month received. All funds remaining after the month of receipt are counted as a resource.
- **For MSP,** exclude them as income and as a resource.
- **For HSD medical programs,** state tax refunds are treated as follows:
  - If deductions are itemized on a Schedule A for the federal income tax return, the amount on the line 5 of the Schedule A is counted for monthly and annual income.
  - If deductions are not itemized on a Schedule A for the federal income tax return, the state tax refund is excluded for monthly and annual income.

For treatment of Earned Income Tax Credit (EITC), see Earned Income Tax Credit (EITC).

Oregon Administrative Rule(s)

461-145-0530 — Tax Refund
410-200-0015 (54) and (55) — General Definitions

Ticket to Work

Ticket to Work is a Social Security program mandated under the Ticket to Work and Work Incentives Improvement Act of 1999. The intent is to enable Social Security beneficiaries to obtain, regain or maintain employment and to reduce their dependency on cash assistance.

Ticket to Work is for most Social Security Disability (SSDI) and Supplemental Security Income (SSI) individuals who are between age 18 and 65. The program is voluntary. Recipients may use the "ticket" to obtain vocational

rehabilitation, employment or other support services from an approved provider of their choice to help them to go to work and achieve their employment goals. The recipient may be placed in on-the-job training or in school.

Most recipients participating in the Ticket to Work program are not receiving money from SSA for Ticket to Work. Instead, SSA is sending payments to the provider to reimburse the provider for their costs to provide the services. The recipient may continue to get SSDI or SSI while in the training, etc. They may be paid a wage when work begins. They lose SSDI or SSI when their income exceeds the allowable limits for SSDI or SSI.

Some recipients of Ticket to Work will receive a stipend or training allowance.

For SNAP, the stipend from a vocational rehabilitation program is counted as earned income.

For all other programs, the stipend is counted as unearned income.

For all programs, count the income from employment as earned income. Count the SSDI or SSI received by the participant as unearned income.

Note: For REF, REFM and TANF, if the Ticket to Work participant receives SSI, the stipend does not count as income because the SSI recipient is not in the financial group.

Oregon Administrative Rule(s)

461-145-0120 — Earned Income; Defined
461-145-0130 — Earned Income; Treatment
461-145-0585 — Vocational Rehabilitation Payment
410-200-0015 (54) and (55) — General Definitions

Transfer on death deed

Oregon allows real estate to be transferred to another person at the owner's death through a transfer on death deed. The change of ownership in the deed takes effect only upon the original owner's death and avoids probate.

Transfer on death deeds are always revocable.

The transfer will not supersede recovery by the Office of Payment Accuracy and Recovery (OPAR) Estates Administration Unit.

Oregon Administrative Rule(s)

461-135-0845 — Transfer on Death Deed
410-200-0015 (54) and (55) — General Definitions

Trusts

Trust funds are money, securities or similar property held by a person or institution for the benefit of another person.

In ONE, payments from a trust should be coded on the Unearned Income screen

- Unearned Income Category – Inheritance & Trust
- Unearned Income Type – there are a few different types to choose from, select the one which is applicable to the type being reported:
  - Payment from Irrevocable Trust
  - Trusts - earnings on irrevocable
  - Trusts - payments from revocable

For MSP, trust funds are excluded as a resource and distributions from trusts that benefit an individual are counted as unearned income.

For HSD medical programs, payments from a revocable trust are excluded for monthly and annual income. Payments and earnings from irrevocable trusts are counted for monthly and annual income.

For ERDC, all trust funds are excluded.

For REF, REFM, SNAP and TANF:

- Trust funds are counted as a resource if the fund is legally available for use by a member of the financial group for items covered by program benefits.
- Trust funds are excluded if the fund is not available for use by a member of the financial group. The financial group must try to remove legal restrictions on the trust, unless that would cause an expense to the group.
- The part of the fund is counted if available for use for medical expenses covered by the medical program for which the financial group is eligible.

For OSIPM:

Trusts other than special needs trusts, income cap trusts and pooled trusts

- Trust funds established before Oct. 1, 1993
  - Count trust funds as a resource if the fund is legally available for use by a member of the financial group for items covered by program benefits. The amount of the trust considered legally available is the maximum amount that could be distributed to the beneficiary under the terms of the trust, regardless of whether or not the trustee exercises their authority to actually make the distributions.
  - Exclude trust funds if the fund is not available for use by a member of the financial group. Require the group to pursue removing legal restrictions on the trust, unless this will cause an expense to them.
  - Count as a resource the part of the fund available for use for medical expenses covered by the medical program for which the financial group is eligible.
- Trust funds established on or after Oct. 1, 1993
  - A trust shall be considered established if the financial group used their resources to form all or part of the trust and if any of the following established a trust, other than by a will:
    - » The individual
    - » The individual's spouse
    - » Any other person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse. or
    - » Any other person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.
  - If the trust contains resources or income of another person, only the share attributable to the individual will be considered available.
  - The following factors are ignored when determining how to treat a trust:
    - » The purpose for which the trust was established
    - » Whether or not the trustees have or exercise any discretion under the trust
    - » Any restrictions on when or if distributions may be made from the trust, and

- » Any restrictions on the use of distributions from the trust.

- If the trust is revocable, treat it as follows:
  - » The total value of the trust shall be considered a resource available to the individual.
  - » Any payments made from the trust to or for the benefit of the individual shall be excluded as income.
  - » Payments from the trust other than to or for the benefit of the individual are considered as a transfer of assets covered in the 140 section of the OARs (beginning with 461-140-0210).
- If the trust is irrevocable, treat it as follows::
  - » For OSIPM individuals in a non-standard living situation, if, under any circumstances, the funds transferred into the trust are unavailable and the trustee has no discretion in which to distribute funds to or for the benefit of the individual, the individual is subject to a transfer of resources penalty as outlined the 140 section of the OARs (beginning with 461-140-0210).
  - » If, under any circumstances, payments could be made to or on behalf of the individual, the share of the trust from which the payment could be made shall be considered a resource. For OSIPM individuals in a non-standard living situation, payments made for any reason other than to or for the benefit of the individual shall be considered a transfer of assets subject to disqualification per the 140 section of the OARs (beginning with 461-140-0210).
  - » If, under any circumstances, income is generated by the trust and could be paid to the individual, such income will be considered as unearned income. For OSIPM individuals in a non-standard living situation, payments made for any reason other than to or for the benefit of the individual shall be considered a transfer of assets subject to disqualification per the 140 section of the OARs (beginning with 461-140-0210).
  - » If any change in circumstance makes assets (income or resources) from the trust unavailable to the individual, a disqualifying transfer will be assessed as of the date of the change (again, for OSIPM individuals in a non-standard living situation).
  - » The provisions of this rule may be waived for an irrevocable trust if ODHS|OHA determines denial of benefits would create an undue hardship on the individual.
    - The local branch may determine undue hardship if, among other things:
      - The absence of the services requested may result in a life-threatening situation, or
      - The individual was a victim of fraud or misrepresentation.
    - An assistant director of ODHS or their designee may otherwise determine that an undue hardship exists, based on the facts presented.

Special needs trust

Special needs trusts are not considered in determining eligibility for OSIPM.

A special needs trust is characterized by all of the following:

- It contains the assets of an individual determined disabled by SSI criteria
- It was created prior to age 65
- It is established by one of the following:

- The individual's parent or grandparent
- The individual's legal guardian or conservator, or
- A court

- It specifies that the state will receive all funds remaining in the trust upon the death of the individual up to the amount of medical benefits provided on behalf of the individual.

Income cap trusts established between Oct. 1, 1993, and March 31, 1995

This applies to trusts established between Oct. 1, 1993, and March 31, 1995, for the individual's benefit and containing only their current and accumulated income. The accumulated amount remaining in the trust shall be paid directly to the state upon the death of the individual up to the amount of medical benefits provided on behalf of the individual. The trust is the total income in excess of the income standard for OSIPM. The remaining income not deposited into the trust shall be available for the following deductions in the order they appear prior to applying the patient liability:

- Personal needs allowance
- Community spouse monthly maintenance needs allowance
- Medicare and other private medical insurance premiums, and
- Other incurred medical.

Income cap trusts established on or after April 1, 1995

These trusts are established for the benefit of the individual whose income is above 300 percent of the full SSI standard and containing the current and accumulated income of the individual. The accumulated amount remaining in the trust shall be paid directly to the state upon the individual's death, up to the amount of medical assistance provided on their behalf. The trust contains all of the individual's income. The income deposited into the trust shall be distributed monthly in the following order:

- Personal needs allowance and applicable room and board standard
- Reasonable administrative costs of the trust, not to exceed a total of $50 per month, including the following:
  - Trustee fees

    Note: If the individual is the trustee, it is not reasonable to allow a trustee fee. That fee is meant for hiring another person to manage the trust, and any such income would raise the individual's income, which would have to be run through the income cap trust.
  - A reserve for administrative fees and costs of the trust, including bank service charges, copy charges, postage, accounting and tax preparation fees, future legal expenses, and income taxes attributable to trust income, and
  - Conservatorship and guardianship fees and costs.
- Community spouse and family monthly maintenance needs allowance
- Medicare and other private medical insurance premiums
- Other incurred medical care costs as allowed under 461-160-0030 and 461-160-0055
- Contributions to reserves or payments for child support, alimony and income taxes

- Monthly contributions to reserves, outside of the trust, or payments for the purchase of an irrevocable burial plan with a maximum value of $5,000. The individual may use one of the following for a burial fund:
  - Up to $1,500, which may be excluded from resources, or
  - Up to $5,000, if the individual has an income cap trust, which can be held in reserve, as described under 461-145-0540(9)(c)(G). (This must be in an account outside of the trust, not part of the income cap trust.)
- Contributions to a reserve or payments for home maintenance if the individual meets the criteria of 461-155-0660 or 461-160-0630
- Patient liability not to exceed the cost of home and community-based care or nursing facility services.

Note: If there is an accumulated excess amount equal to or more than the transfer of assets divisor, a disqualification should be calculated.

For more information on trusts, see Understanding trusts

Pooled trusts

Pooled trusts are not considered in determining eligibility for OSIPM (with one exception below) as long as they meet the following criteria:

- The trust is signed on or after July 1, 2006.
- The trust is established and managed by a nonprofit association.
- A separate account is maintained for each beneficiary of the trust but, for purposes of investment and management of funds, the trust pools these accounts.
- The trust is established by the individual, individual's parent, grandparent or legal guardian, or a court for individuals who have disabilities.
- Upon the death of the beneficiary or by termination of the trust, the trust pays to the state an amount equal to the total medical assistance paid on behalf of the beneficiary under the state plan for Medicaid. The amount paid to the state may be reduced by administrative costs directly related to administering the sub-trust account of the beneficiary.
- The trust contains the resources or income of an individual who has a disability that meets the SSI criteria.

For OSIPM, individuals in a non-standard living situation, if the individual is age 65 or older when the trust is funded or a transfer is made to the trust, the transfer may constitute a disqualifying transfer of assets.

Oregon Administrative Rule(s)

461-145-0540 — Trusts
410-200-0015 (54) and (55) — General Definitions

Unemployment compensation benefit

Count retroactive payments as periodic or lump-sum income. Treat disaster unemployment assistance according to the disaster relief policy, and treat all other UC benefits received weekly or biweekly as unearned income.

In ONE, payments from UC should be coded on the Unearned Income screen

- For UC payments other than disaster unemployment compensation
  - Unearned Income Category – Unemployment
  - Unearned Income Type – there are a couple different types to choose from, select the one which is applicable to the type being reported:
    - » Unemployment
    - » Pandemic Unemployment Compensation (this should only be used when the UC payment was authorized under the CARES Act due to the COVID-19 pandemic)
- For UC disaster unemployment compensation payments
  - Unearned Income Category – Disaster Relief
  - Unearned Income Type – Disaster Unemployment Compensation

Do not anticipate UC benefits when the participant is in their waiting week or there has been a break of a week or more in payment. There is no guarantee they will receive UC benefits. Only anticipate UC income when there are current payments showing on Unemployment Compensation Claim Screen (ECLM).

To calculate countable UC income, use the Weekly Benefit Amount (WBA) on ECLM-Claim Summary Display (F5 from WAGE) as long as the participant does not have any earnings or overpayments withholding.

If the participant has earnings or an overpayment withholding, use the E-PAY-Payment List screen (F13 from ECLM) to determine the amount of countable UC income.

- Add the check amount, amount of overpayment withheld, amount of child support withheld, and amount of federal and state taxes withheld.

Countable UC income when you cannot use the WBA				
E-Pay amounts	**Check amount**	**Overpayment**	**Child support**	**Fed/state taxes**
ERDC	X	X	X	X
SNAP	X		X	X
All TANF	X	X	X	X

Note: Countable UC income includes garnishments and taxes. Work Share is also countable as UC income. UC benefits received while participating in Trade Act activities are also countable income.

For HSD medical programs, unemployment compensation is counted for monthly and annual income.

Oregon Administrative Rule(s)

461-140-0040 — Determining Availability of Income
461-145-0550 — Unemployment Compensation Benefits
410-200-0015 (54) and (55) — General Definitions

Uniform Relocation Assistance Act and Real Property Acquisition Policies Act

In ONE, income from these acts are coded on the Unearned Income screen:

- Unearned Income Category – Other Income
- Unearned Income Type – Uniform Relocation Act

Reimbursements from the federal Uniform Relocation Assistance Act (42 U.S.C 4621 4625) and from the Real Property Acquisition Policies Act of 1970 (42 U.S.C. 4651-4655) are excluded for all other programs.

Oregon Administrative Rule(s)

461-145-0560 — Uniform Relocation Act
410-200-0015 (54) and (55) — General Definitions

USDA meal reimbursement

USDA meal reimbursements are cash reimbursements for family day care providers who serve snacks and meals. The reimbursements are made by the Department of Education, and the amount of the reimbursement is determined by family size and income.

In ONE, information from USDA meal reimbursements is gathered on the Specific Income screen as part of collecting information about child care income. Once you select the category and type below, you will complete information about the child care income, including what amounts are received for USDA meal reimbursements.

- Specific Income Category – Child Care
- Specific Income Type – Child Care Provider

Count USDA meal reimbursements made to child care providers as self-employment income. Exclude the USDA meal reimbursements for a filing group member.

Child care providers often have young children of their own who are present at the same time as children in care. When the provider receives the USDA meal reimbursement, they submit the voucher for both the children in care and their own children who were present for the snacks and meals.

Exclude the part of the meal reimbursement for the provider's own children as follows::

(d) Determine the total number of children (not in filing group) who receive meals or snacks.

(e) Determine the total number of the children (in filing group) also receiving meals or snacks.

(f) Total (a) and (b) above.

(g) Determine the total amount of monthly meal reimbursement.

(h) Divide the total from (c) into the meal reimbursement in (d) to arrive at the amount of reimbursement per child.

(i) Multiply the result of (e) by the number of children in (a) to arrive at the countable USDA meal reimbursement. Count as self-employment with costs.

USDA Meal Reimbursement Worksheet	
_____ (a)	Total number of children who receive meals or snacks (not in filing group).

USDA Meal Reimbursement Worksheet	
_____ (b)	Total number of children, in the filing group, receiving meals or snacks.
_____ (c)	Total children in (a) and (b) above.
_____ (d)	Amount of monthly meal reimbursement.
_____ (e)	_____ (d) divided by _____ (c) = _____ (amount of reimbursement per child).
_____ (f)	_____ (e) X _____ (a) = _____ (count as SEC).

Oregon Administrative Rule(s)

461-145-0570 — USDA Meal Reimbursement
410-200-0015 (54) and (55) — General Definitions

Veterans' benefits

In ONE, veterans' benefits are coded on the Specific Income screen:

- Specific Income Category – Veteran's Benefits/Military Income
- Specific Income Type – there are several different types to choose from, select the one which is applicable to the type being reported:
  - Aid and Attendance
  - Child with birth defects born to female Vietnam Veterans
  - Children of Vietnam Veterans born with Spina Bifida
  - Veteran's Benefits - Educational Housing Stipends
  - Veteran's Benefits: Chapter 31 Subsistence allowance from training and rehab program of USVA
  - Veteran's Benefits: Disability Payments
  - Veteran's Benefits: Education
  - Veteran's Benefits: Housebound payments
  - Veteran's Benefits: Retirement

The following is cited from Oregon Administrative Rule 461-145-0580 — Veteran's Benefits and 461-145-0585 – Vocational Rehabilitation Payment:

Treat veterans' benefits, other than Aid and Attendance and educational or Vocational Rehabilitation training benefits, as follows:

(a) Count monthly payments as unearned income.

(b) Count other payments as periodic or lump-sum.

Treat veterans' Aid and Attendance and housebound payments as follows:

(a) **For SNAP,** the payment is treated as a reimbursement if the payment is used to pay an attendant. Count only the amount that is not being used as a reimbursement as unearned income.

(b) **For MSP and OSIPM,** individuals not receiving long-term care or home and community-based services, exclude these payments. Any remaining veterans' benefits are counted as unearned income unless

excluded under another rule or another section of this rule.

(c) **For OSIPM,** individuals receiving long-term care or home and community-based services, treat as follows:

(A) Exclude the entire payment when determining financial eligibility.

(B) Count the entire payment as unearned income when calculating patient liability.

(C) If an individual receives a retroactive payment, they are required to repay ODHS the full amount of the payments received for costs and services already paid for by ODHS up to the amount of institutional and home- or community-based care provided to the participant during months covered by the payments. A participant's failure to reimburse ODHS in this instance constitutes an overpayment of public assistance. Any unrecovered third-party resource or payment above the actual cost is counted as lump-sum or periodic income. Click here for instructions on how to calculate the amount that must be paid to ODHS.

(d) **For all other programs**:

(A) Exclude payments for services not covered by ODHS|OHA's programs.

(B) Reimbursements paid to the participant for costs and services already paid for by ODHS|OHA are third- party resources and should be recovered from the participant. Count any unrecovered third-party resource or payment above the actual cost as lump-sum or periodic income.

Note: If an applicant/recipient's Aid and Attendance income makes the total income over the 300 percent of SSI, an income cap trust is not needed.

Exclude payments under 38 USC 1805 to biological children of Vietnam veterans who are born with spina bifida.

Exclude payment under 38 USC 1815 to children with birth defects born to female Vietnam veterans.

For OSIPM and MSP, exclude payments made as part of Veterans Administration vocational rehabilitation and Medal of Honor Pension payments.

Treat educational benefits from the Veterans' Administration according to the educational income policy. Housing stipends awarded as part of educational benefits are counted as unearned income for **SNAP**

Note: Educational benefits from the VA include the Montgomery GI Bill (Chapter 30), Survivors and Dependents Educational Assistance (DEA) (Chapter 35), Selected Reserve Educational Assistance Program (Title 10, Chapter 1606), Reserve Educational Assistance Program (Chapter 1607), Active Duty Veterans Educational Assistance Program (VEAP) (Chapter 32) and VA Work Study.

There are other types of VA educational assistance. Please email the appropriate policy box for how to handle the other types for different programs.

For SNAP, count VA Vocational Rehabilitation maintenance payments for food, shelter and clothing as unearned income.

Count the VA Chapter 31 subsistence allowance paid while the veteran with disabilities participates in training or a Vocational Rehabilitation plan as earned income. **For all other programs**, it is unearned income.

Note: The Chapter 31 VA Vocational Rehabilitation program is for veterans with disabilities and a few dependents. Look for VA disability income also.

For HSD medical programs, veteran's benefits are treated as follows:

Veterans' retirement benefits:

(a) If any part of the retirement payment is based on a personal injury or sickness resulting from active service, that portion of the payment is excluded from monthly and annual income. Count the remaining amount of the payment for monthly and annual income.

All other veterans' benefits are excluded for monthly and annual income.

Oregon Administrative Rule(s)

461-145-0580 — Veterans' Benefits
461-145-0585 — Vocational Rehabilitation Payment
410-200-0015 (54) and (55) — General Definitions

Victims' assistance

Payments made under P. L. 103-286 to victims of Nazi persecution and payments under 42 U.S.C 10602, the Crime Act of 1984 (VOCA), are excluded as income and amounts retained are excluded as a resource as long as the amounts are not commingled with other funds.

In ONE, income from this act is coded on the Unearned Income screen:

- Unearned Income Category – Other Income
- Unearned Income Type – Victim's Assistance under the Crime Act of 1984, 42 USC 10602 or Nazi Persecution P.L 103-286

For other types of victims' assistance:

- Treat payments that are considered reimbursement for a lost item according to the policy on reimbursements.
- Treat payments for pain and suffering as personal injury settlements according to the policy of personal injury settlements.

Oregon Administrative Rule(s)

461-145-0582 — Victims' Assistance
410-200-0015 (54) and (55) — General Definitions

Virtual currency or cryptocurrency

"Cryptocurrency" is a type of currency available in virtual or digital form that functions as a medium of exchange with no central banking or regulating authority.

"Mining" is a way to win cryptocurrency through a game of chance. Mining requires a computer, an external hardware setup and a special computer software program. To win cryptocurrency through mining, multiple people worldwide are competing by solving a series of complicated mathematical problems via the mining software, and

each reward could take millions or billions of guesses at mathematical problems. The person to solve the final mathematical problem is the one to win the cryptocurrency.

"Day trading'" is the buying and selling of cryptocurrency within the virtual market. The cryptocurrency market continuously runs because it is a worldwide market.

"Wallet" is a way to store records of cryptocurrency transactions. Each cryptocurrency is assigned a public address and, when stored in a wallet, is assigned a private key for protection. The cryptocurrency public address and private key are stored on a computer, mobile device, internal or external computer hardware or a piece of paper and protected by private keys.

- Cryptocurrency received as a payment from an employer is treated as earned income.
- Cryptocurrency received in exchange for services or products provided is treated as either self-employment income (if the individual meets the definition of self-employed) or earned income.
- Cryptocurrency received as a gift is treated the same as a gift in the form of money.
- Cryptocurrency currency received through mining is considered unearned income.
- Cryptocurrency received through an online casino is treated as winnings.
- **For all program except HSD medical and MSP**, after the month of receipt, cryptocurrency stored in a wallet is counted as a resource. It can be converted to liquid assets and follows the availability of resources provisions.
- **For HSD medical programs and MSP,** resources are not considered in eligibility determination.

Oregon Administrative Rule(s)

461-145-0583 — Virtual Currency or Cryptocurrency
410-200-0015 (54) and (55) — General Definitions

Vocational Rehabilitation payment

In ONE, training allowances or stipends from Vocational Rehabilitation are coded on the Specific Income screen:

- Specific Income Category – Vocational Rehabilitation
- Specific Income Type – Vocational Rehabilitation

Treat a training allowance or stipend from a Vocational Rehabilitation program as follows:

- **For SNAP,** count as an earned income.
- **For all other programs except HSD medical**, count as unearned income.
- **For HSD medical programs,** exclude Vocational Rehabilitation payments for monthly and annual income

Treat educational income not covered above in accordance with the educational income policy.

Count Vocational Rehabilitation maintenance payments for food, shelter and clothing as unearned income.

Treat Vocational Rehabilitation payments for special itemized needs connected with the evaluation, planning or placement activity as a reimbursement.

These special need payments include:

- Child care
- Clothing
- Second residence
- Special diet
- Transportation.

Oregon Administrative Rule(s)

461-145-0585 — Vocational Rehabilitation Payment
410-200-0015 (54) and (55) — General Definitions

Workforce Investment Act (WIA)

In ONE payments from Workforce Investment Act (WIA) are coded on the Specific Income screen:

- Specific Income Category – WIA (Including WIOA and YouthBuild)
- Specific Income Type – there are two different types to choose from, select the one which is applicable to the type being reported:
  - Workforce Innovation and Opportunity Act (WIOA) – Not YouthBuild
  - Workforce Innovation and Opportunity Act (WIOA) – YouthBuild

Treat Workforce Investment Act (WIA) of 1998 (P.L.105-220) payments made under title I-B (see OAR 589-020-0210) as follows:

Count need-based (stipend) payments as unearned income, except as follows:

(a) Exclude for **REF, REFM and TANF** individuals under the age of 19 (or under the age of 20 if the participant is a caretaker relative), and

(b) Exclude **for all SNAP** individuals

Count OJT and work experience payments as earned income, except as follows:

(a) Exclude for **REF, REFM and TANF** individuals under the age of 18 (or under the age of 20 if the participant is a caretaker relative); and

(b) Exclude **for SNAP** individuals who are:

(A) Under the age of 19 and under the control of an adult member of the filing group; or

(B) Receiving OJT payments under the Summer Youth Employment and Training Program.

Note: SNAP individuals age 18 and younger are considered under the control of an adult member of the household when they or the adult state they are under the adult's control.

For SNAP, exclude the training stipend received under Section 402, rehabilitation payment.

Count support service payments for items already covered by the benefits of the benefit group as unearned income. Exclude all other support service payments (including lunch payments and clothing allowances).

See Reimbursement for treatment.

Count YouthBuild payments as follows:

(a) **For SNAP,** if the YouthBuild participant is under age 19 and under the parental control of another filing group member, the payments are excluded. If the participant is age 19 or older or not under the parental control of another filing group member, the payments are treated as follows:

(A) Incentive payments that are reimbursements for specific expenses not covered by program benefits, for instance transportation and school supplies, are excluded.

(B) On-the-job training (OJT) and work experience payments are treated as earned income.

(C) The bonus payment (the incentive payment for attendance) is treated as unearned income.

(b) **For all other programs**, YouthBuild Program payments are excluded.

Oregon Administrative Rule(s)

461-145-0300 — Workforce Investment Act; Workforce Innovation and Opportunity Act

Workers' compensation

In ONE, payments for Worker's Compensation are coded on the Specific Income screen:

- Specific Income Category – Disability or Worker's Comp
- Specific Income Type – Worker's Compensation

For workers' compensation payments received monthly or more frequently:

- **For ERDC, REF, REFM, SNAP and TANF**, income from temporary workers' compensation is counted as earned income if paid to a participant who is still employed while recuperating from a temporary illness or injury.
- **For all other programs except HSD medical programs,** these payments are counted as unearned income.
- **For HSD medical programs,** exclude workers' compensation payments for monthly and annual income.

All workers' compensation payments other than those above are counted as periodic or lump-sum income for all programs except HSD medical programs.

Oregon Administrative Rule(s)

461-145-0590 — Workers Compensation
410-200-0015 (54) and (55) — General Definitions

Work-related capital assets, equipment and inventory

"Work-related equipment" is property essential to the employment or self-employment of a financial group member. Examples are a tradesman's tools, a farmer's machinery and equipment used to maintain an income-producing vehicle.

"Inventory" is goods in stock and available for sale to prospective customers.

A capital asset, other than work-related equipment and inventory, is treated as follows:

(a) **For ERDC,** treat the equity value of all capital assets according to the type of asset it is.

(b) **For SNAP,** exclude the equity value of capital assets used in a business as follows:

(A) For nonfarm assets, as long as the financial group is actively engaged in self-employment activities;

(B) For farm assets, for one year from the date the person quit self-employment as a farmer.

(c) **For REF, REFM and TANF**:

(A) For a self-employed individual participating in the microenterprise component of the JOBS program, the value of a capital asset is excluded.

(B) For all other participants, the value of a capital asset is counted according to what type of asset it is.

(d) **For OSIPM,** a capital asset is excluded.

Treat work-related equipment as follows:

(a) **For EA, ERDC, OSIPM and SNAP**, exclude the equity value of work-related equipment as a resource.

(b) **For REF, REFM and TANF**, the equity value of the equipment is treated as a resource.

Treat inventory as follows:

(a) **For EA, ERDC, OSIPM and SNAP**, exclude the value of inventory as a resource as long as the participant is engaged in self-employment activities.

(b) **For REF, REFM and TANF**, the wholesale value of inventory remaining at the end of a quarter, less encumbrances, is counted as a resource.

3. **For SNAP,** count the full amount received from the sale of work-related equipment or inventory as part of the household's self-employment income.

For HSD medical programs, resources are not considered in eligibility determination.

Oregon Administrative Rule(s)

461-145-0600 — Work-Related Capital Assets, Equipment, and Inventory
410-200-0015 (54) and (55) — General Definitions

Self-employment and microenterprise income

In ONE, code self-employment income on the self-employment income screens

Self-employment; general

The following is cited from Oregon Administrative Rule 461-145-0910 — Self-Employment; General; Not OSIP, OSIPM or QMB:

(A) Self-employment income is income resulting from an individual's business, trade or profession, rather than from a salary or wage paid by an employer. An individual is considered self-employed if the individual meets the criteria in sections (2) or (3) of OAR 461-145-0910. Except as noted in section (3) of this rule

when an individual has established a corporation, determine if the individual is self-employed according to section (2) of this rule. If the individual has more than one self-employment business, trade or profession, the income from each is determined separately.

(B) Except as provided in OAR 461-145-0250(1), an individual is self-employed for the purposes of this division of rules if the individual meets the requirements of one or more of (a), (b), or (c):

- Files taxes as self-employed for their business on their personal taxes
- Is considered an independent contractor by the business
- Meets all the following criteria:
  - Individual is not required by the business to complete an IRS W-4 form.
  - Individual is not required to pay federal income tax or FICA payments from their paycheck(s).
  - Liability or worker's compensation insurance for the individual is not paid by the business.
  - The individual meets at least one of the following:
    - Creates or provides the products or services they sell, or
    - Sets the price for the products or services they sell.
  - Individual is responsible for the business expense and losses.
  - Individual receives profits from the business.

(C) Notwithstanding section (2) of this rule:

- Homecare workers (see OAR 411-031-0020) paid by ODHS are not self-employed.
- Child care providers (see OAR 461-165-0180) paid by ODHS; adult foster home providers (see OAR 411-050-0602) paid by ODHS; realty agents; and individuals who sell plasma, redeem beverage containers, pick mushrooms for sale, or engage in similar enterprises are considered self-employed.

Note: Self-employment may include income from a business, including a microenterprise, hobby, weekly or monthly garage sales, commercial boarding, or other income-producing property. For day care providers, the gross self-employment income includes payments from DPU, individuals, Head Start contracts and USDA meal reimbursements.

(D) In the ERDC, REF, SNAP and TANF programs, self-employment income is counted prospectively to determine eligibility (see OAR 461-001-0000) as follows:

- Self-employment income is annualized when it is:
  - Received during less than a 12-month period but is intended as a full year's income, or
  - From a business that has operated for a full year and the previous year is representative of what the income and costs will be during the budget month.

- Except in the ERDC program, self-employment income is treated as anticipated income when a financial group (see OAR 461-110-0530) begins self-employment and is unable to determine what the income and costs will be during the budget month.

(E) In the REFM program:

- Self-employment income is counted only if received in the month of application.
- If self-employment income counted in the month of application puts the applicant over the income limits for REFM, the income is calculated according to section (4) of this rule.

Note: For SNAP, an individual may choose to not annualize their income. When they make this choice, their income may be averaged. However, peak and low business periods must be considered when doing this average. For example, an individual with a yard maintenance service earns more during the summer months. The summer months must be included in the average.

(F) When determining the amount of countable (see OAR 461-001-0000) self-employment income, use gross receipts and sales, including mileage reimbursements, before costs.

Oregon Administrative Rule(s)

461-145-0910 — Self-Employment; General; Not OSIP, OSIPM, or QMB
410-200-0015 (54) and (55) — General Definitions

Self-employment; general; OSIPM and MSP

The following is cited from Oregon Administrative Rule 461-145-0915 — Self-Employment; General; OSIP, OSIPM, QMB:

1. For purposes of this rule:
   (a) "Business entity" includes a sole proprietorship, a partnership, and an unincorporated limited liability company.
   (b) "Principal" means an individual with significant authority in a "business entity" (see subsection (a) of this section), including a sole proprietor, a general partner in a partnership, or a member or manager of an unincorporated limited liability company.
2. Notwithstanding any other sections of this rule:
   (a) Homecare workers paid by the Department are not self-employed.
   (b) Child care providers paid by the Department, adult foster home providers paid by the Department, realty agents, and individuals who sell plasma, redeem beverage containers, pick mushrooms for sale, or engage in similar enterprises are considered self-employed.
   (c) Self-employment does not include non-business activities such as property rentals or renting a room out of the financial group's primary residence.
3. Self-employment means active engagement in one's own business, trade, or profession, rather than earning a salary or wage paid by an employer or maintaining a passive ownership interest in a business entity. An

individual is considered self-employed if the individual meets the criteria in subsection (2)(b) or section (5) of this rule.

4. A principal (see subsection (1)(b) of this rule) of a corporation or incorporated limited liability company cannot be considered self-employed unless the criteria in either subsection (a) or (b) are met. All other payments for working or performing services for the corporation or holding corporate office are treated in accordance with the policy on corporations and other business entities and earned income.
   (a) The individual files taxes for the incorporated business entity as self-employed on their personal taxes, rather than as a corporation.
   (b) The individual does not file taxes and meets the criteria in section (5)(c) of this rule.
5. Except for corporations and other business entities, an individual is self-employed for the purposes of this division of rules if the individual meets the requirements of one or more of (a), (b), or (c):
   (a) Files taxes as self-employed for their business on their personal taxes.
   (b) Is considered an independent contractor by the business.
   (c) Meets all the following criteria:
      (A) Is not required by the business to complete an IRS W-4 form;
      (B) Is not required to pay federal income tax or FICA payments from their paycheck(s);
      (C) Liability or workers' compensation insurance for the individual is not paid by the business;
      (D) Meets at least one of the following:
         (i) Creates or provides the products or services they sell, or
         (ii) Sets the price for the products or services they sell;
      (C) Is responsible for the business expenses and losses; and
      (D) Receives profits from the business.

Oregon Administrative Rule(s)

461-145-0915 — Self-Employment; General; OSIP, OSIPM, QMB

Self-employment; costs that are excluded to determine countable income

For all programs except HSD medical, the following is cited from Oregon Administrative Rule 461-145-0920 — Self-Employment; Costs that are Excluded to Determine Countable Income:

(A) In all programs except the DSNAP, OSIP, OSIPM, and QMB programs, unless prohibited by section (4) of this rule, and subject to the provisions of sections (7) and (8) of this rule and OAR 461-145-0930, the necessary costs of producing self-employment income are excluded from gross sales and receipts including, but not limited to:

(1) Labor (wages paid to an employee or work contracted out).

(2) Materials used to make a product.

(3) In the SNAP program - principal and interest paid to purchase income-producing property (see OAR 461-001-0000), such as real property, equipment, or capital assets. In all other programs, interest paid to purchase income-producing property, such as equipment or capital assets.

(4) Insurance premiums, taxes, assessments, and utilities paid on income-producing property.

(5) Service, repair, and rental of business equipment, including motor vehicles, and property that is owned, leased, or rented.

(6) Advertisement and business supplies.

(7) Licenses, permits, legal, or professional fees.

(8) Transportation costs at 20 cents per mile if the cost is part of the business expense. Commuting expenses to and from the worksite are not part of the business expense.

Note: Commuting is the process of the person getting themselves to and from work sites. Transportation costs are allowed only if the individual must haul work equipment (lawnmowers, vacuum cleaners, drop cloths, etc.) to a job site.

(9) Charges for telephone service that are a necessary cost for self-employment.

(10) Meals and snacks provided by family day care providers for children in their care, except the provider's own children. The actual cost of the meals is used if the provider can document the cost. If the provider cannot document the actual cost, the USDA meal reimbursement rates are used.

(12) Materials purchased for resale, such as cosmetic products.

(13) For newspaper carriers, the cost of newspapers, bags, and rubber bands.

(B) In the OSIP, OSIPM, and QMB programs, unless prohibited by section (5) of this rule, and subject to the provisions of sections (7) and (8) of this rule and OAR 461-145-0930, the necessary costs of producing self-employment income are excluded from gross sales and receipts including, but not limited to:

(1) Advertising.

(2) Car and truck expenses.

(3) Commissions and fees.

(4) Contract labor.

(5) Depletion.

(6) Depreciation.

(7) Employee benefit programs.

(8) Insurance, other than health.

(9) Mortgage interest.

(10) Legal and professional services.

(11) Office expenses.

(12) Pension and profit-sharing plans.

(13) Rent or lease of vehicles, machinery, equipment, and other business property.

(14) Repairs and maintenance.

(15) Supplies.

(16) Taxes and licenses.

(17) Travel, meals, and entertainment.

(18) Utilities.

(19) Wages, less employment credits.

(20) Meals and snacks provided by family day care providers for children in their care, except the provider's own children. The actual cost of the meals is used if the provider is able to document the cost. If the provider is unable to document the actual cost, the USDA meal reimbursement rates are used.

(21) Materials purchased for resale, such as cosmetic products.

(22) For newspaper carriers, the cost of newspapers, bags, and rubber bands.

(C) In all programs except the OSIP, OSIPM, and QMB programs, the following costs are not excluded from gross sales and receipts:

(1) Business losses from previous months.

(2) Except in the SNAP program, payments on the principal of the purchase price of income-producing real estate and capital assets, equipment, machinery, and other durable goods.

(3) Federal, state, and local income taxes, draws or salaries paid to any financial group member, money set aside for personal retirement, and other work-related personal expenses, such as transportation, personal business, and entertainment expenses.

(4) Depreciation. For purposes of this section, "depreciation" means a prorated lessening of value assigned to a capital asset (see OAR 461-001-0000) based on its useful life expectancy and initial cost.

(5) Costs related to traveling to another area to seek business when there is no reasonable possibility of deriving income from the trip.

(6) Interest or fees on personal credit cards.

(7) Personal telephone charges.

(8) Shelter or utility costs associated with the individual's home, except as authorized by section (7) of this rule.

(D) In the OSIP, OSIPM, and QMB programs, the following costs are not excluded from gross sales and receipts:

(1) Federal, state, and local income taxes.

(2) Costs related to traveling to another area to seek business when there is no reasonable possibility of deriving income from the trip.

(3) Interest or fees on personal credit cards.

(4) Personal telephone charges.

(5) Shelter or utility costs associated with the individual's home, except as authorized by section (7) of this rule.

(E) In the DSNAP (461-101-0010) program, self-employment costs include out of pocket disaster-related expenses the household has paid or is expected to pay during the disaster benefit period authorized by FNS and where the expenses are not expected to be reimbursed during the disaster period. If the household has received or reasonably anticipates receiving a reimbursement for part or all of the expenses during the disaster benefit period, only the net expense to the household is deductible. The necessary costs of producing self-employment income are excluded from gross sales and receipts including, but not limited to:

(1) Damage or destruction to self-employment business.

(2) Equipment and supplies.

(3) Disaster-damaged vehicle expenses.

(4) Business property protection.

(5) Storage.

(6) Clean-up.

(7) Costs paid by credit card are excluded unless the bill is also paid during the benefit period.

(8) Costs listed in (2) that are incurred during the disaster benefit period.

(F) The exclusions for items used for both business and personal purposes, such as automobiles and a residence, including utilities, are limited by the following subsections:

(1) In the ERDC, OSIP, OSIPM, and QMB programs, the portion of the expense that is for business use only is excluded.

(2) In the SNAP program, costs are excluded for a separate office or shop located on the property used as a home, if the costs are billed separately from the residence. Costs for other items used for both business and personal use are excluded.

(G) If no member of the financial group (see OAR 461-110-0530) has been self-employed for a sufficiently long period to ascertain the costs of self-employment, the costs may be estimated.

For HSD medical programs, the expenses allowed to be excluded are outlined in IRS Code. Staff are not expected to review IRS code. The expenses can be found on their tax return, including the schedules they include with their return. The total amount of allowable expenses will be coded as one combined amount on the MAGI Deductions screen in ONE. If the applicant doesn't file taxes and there is a question as to whether an expense is allowed, contact HSD medical policy.

Oregon Administrative Rule(s)

461-145-0600 — Work-Related Capital Assets, Equipment, and Inventory
461-145-0920 — Self-Employment; Costs That Are Excluded To Determine Countable Income
410-200-0015 (54) and (55) — General Definitions

Exclusions allowed from self-employment income

The following explains how exclusions are taken from self-employment gross income in the different programs. Gross income less exclusions leaves countable income. Costs of producing self-employment income, determined in accordance with costs excluded to determine countable income, are excludable according to the following guidelines:

The following is cited from Oregon Administrative Rule 461-145-0930 — Self-Employment; Determination of Countable Income:

(A) The Department initially determines gross sales and receipts, including mileage reimbursements, minus any returns and allowances (before excluding or deducting any costs).

(B) In the ERDC program, if an individual claims an excludable cost permitted under OAR 461-145-0920, at least 50 percent of gross self-employment income is excluded. The maximum exclusion is the total excludable cost under OAR 461-145-0920.

(C) In the OSIP, OSIPM, and QMB programs, all costs permitted under OAR 461-145-0920 are excluded.

(D) In the REF, REFM, and TANF programs, no costs are subtracted (excluded).

(E) In the SNAP program, if there are any costs permitted under OAR 461-145-0920, there is a deduction of 50 percent of gross self-employment income.

(F) In the DSNAP program, the Department allows all actual costs permitted under OAR 461-145-0920.

Oregon Administrative Rule(s)

461-145-0930 — Self-Employment; Determination of Countable Income
461-155-0225 — Income Standard; REFM

Additional exclusions for farming costs; SNAP

For SNAP: If gross self-employment income from farming is less than the costs calculated in accordance with OAR

461-145-0920, and the individual receives or anticipates receiving annual gross farm income of $1,000 or more, farming-related costs that exceed self-employment income from farming are allowed as an exclusion from non-farm self-employment income, other earned income and unearned income.

Oregon Administrative Rule(s)

461-145-0931 — Additional Exclusions for Farming Costs; SNAP

Chapter 2: Eligibility

Section 6: Non-financial eligibility

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Non-financial eligibility

Introduction

There are many non-financial eligibility requirements and they vary by program. Some requirements must be verified, and others do not require verification unless ODHS|OHA finds them questionable.

Caring for an incapacitated individual

This applies specifically to the SNAP and TANF programs.

Sometimes individuals may be unable to look for work, maintain employment or engage in other self-sufficiency activities due to caring for another individual.

SNAP Click here for SNAP employment services.

TANF A parent may be exempt from the JOBS program if they are providing care for a family member who has a disability and is living in the home. To be JOBS exempt, a statement from a medical provider is needed to indicate the parent is to remain in the home to care for the disabled family member. The DHS 7785, Documentation of Need to Care for Disabled Family Member, can be use.

ERDC This does not apply to the ERDC program.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Click here for examples: Caring for an incapacitated individual.

Oregon Administrative Rule(s)

461-130-0310 — Participation Classifications: Exempt, Mandatory, and Volunteer

Fleeing felons; probation and parole violators

A fleeing felon is an individual who is avoiding prosecution or custody (jail or prison) for a crime, or an attempt to commit a crime, classified by state law as a felony.

To be a fleeing felon, the individual must be aware of a warrant for their arrest and have fled or concealed himself or herself to avoid:

- Appearing in court regarding a crime considered a felony, or
- Going to jail or prison after conviction for a felony.

A parole, probation or post-prison supervision violator is an individual violating a condition of federal or state probation or parole, or post-prison supervision under Oregon law. Oregon uses the term "parole" if the crime occurred prior to Nov. 1, 1989, and the term "post-prison supervision" if the crime occurred on or after that date. Local, state or federal corrections agencies or the courts determine if an individual is in violation. OHDS|OHA does not make this determination. Each program has its own rules regarding fleeing felons, probation and parole violators.

On Aug. 22, 1996, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 became law. This law made fleeing felons and individuals in violation of conditions of parole and probation ineligible for the SNAP and TANF programs.

ODHS|OHA may learn a participant is a fleeing felon from the following sources:

- Social Security Administration
- HUD or Veterans Administration
- Law enforcement or local, county or state corrections offices
- Staff in SNAP or TANF offices from other states
- USDA Office of Inspector General or another federal agency (such as the US Marshals Service).

ODHS|OHA does not seek out this information but must act upon it when it is reported by the individual or by a law enforcement agency.

SNAP

Whenever ODHS|OHA receives a report from a local, state or federal corrections agency or the courts that an individual is in violation of conditions of parole, probation or post-prison supervision, the participant is ineligible for SNAP and TANF benefits. Their ineligibility continues until the local, state or federal corrections agency or the courts report the individual is cooperating with the conditions of their parole, probation or post-prison supervision.

The individual who is in violation of parole, probation or post-prison supervision is ineligible and is removed from the need group. Other individuals in the benefit group may remain eligible for benefits. The parole, probation or post-prison supervision violator's income and resources are still considered when determining eligibility.

The law of the state from which the individual is fleeing determines if the crime is considered a felony. In the case of New Jersey, a high misdemeanor under the law of New Jersey is treated as a felony. For example, if an individual committed a felony in California, they would be ineligible for benefits in Oregon (even if the crime is not considered a felony in Oregon).

For the purposes of the SNAP or TANF programs in Oregon, the existence of an outstanding felony warrant for an individual's arrest does not automatically establish the individual is fleeing. An individual wanted for a felony may not have fled their home or the local area. They may not have initiated actions to conceal themselves or to avoid arrest. An individual may have moved out of an area and not be aware of the arrest warrant. The police may know where the individual is but choose to not arrest them at this time.

Therefore, for the participant to remain eligible for benefits, ODHS|OHA must first determine if the

participant knows they are wanted for a felony and what actions have been taken to resolve the issue of being wanted for a felony.

A question on all applications for SNAP or TANF benefits asks participants if they, or anyone they want benefits for, have an outstanding arrest warrant. Whenever the household answers yes, ODHS|OHA must ask more questions to determine if the individual is a fleeing felon for SNAP and TANF purposes. The additional questions should include:

- Where was the arrest warrant issued? (city, county, state)
- When was the warrant issued?
- What is the reason for the warrant?
- Is it for a felony or a misdemeanor?
- When did the participant learn about the warrant?
- Did the participant move here after they learned the arrest warrant was issued?
- What steps has the participant taken to resolve the issue?
- If they have not taken steps to resolve the issue, why not?
- Does the participant have the mental or physical ability to resolve the issue?
- If they lack the financial ability to resolve the warrant, has the participant asked the district attorney or courts to pay for their return and was this request denied? (A copy of the letter will be requested.) Maybe the other state has decided not to extradite.

If the applicant is ineligible due to being a fleeing felon, ODHS|OHA will let them know what steps they need to take to make substantial effort to resolve the matter for future eligibility. The discussion, all responses and the decision should be carefully narrated.

TANF The participant is ineligible for SNAP and TANF benefits whenever ODHS|OHA receives a report from a local, state or federal corrections agency or the courts that an individual is in violation of conditions of parole, probation or post-prison supervision. Their ineligibility continues until the local, state or federal corrections agency or the courts report the individual is cooperating with the conditions of their parole, probation or post-prison supervision.

The individual who is in violation of parole, probation or post-prison supervision is ineligible and is removed from the benefit group. Other individuals in the benefit group may remain eligible for benefits. The parole, probation or post-prison supervision violator's income and resources are still considered when determining eligibility.

The law of the state from which the individual is fleeing determines if the crime is considered a felony. In the case of New Jersey, a high misdemeanor under the law of New Jersey is treated as a felony. For example, if an individual committed a felony in California, they would be ineligible for benefits in Oregon (even if the crime is not considered a felony in Oregon).

For the purposes of the SNAP or TANF programs in Oregon, the existence of an outstanding felony warrant for an individual's arrest does not automatically establish the individual is fleeing. An individual wanted for a felony may not have fled their home or the local area. They may not have initiated actions

to conceal themselves or to avoid arrest. An individual may have moved out of an area and not be aware of the arrest warrant. The police may know where the individual is but choose to not arrest them at this time.

Therefore, for the participant to remain eligible for benefits, ODHS|OHA must first determine if the participant knows they are wanted for a felony and what actions have been taken to resolve the issue of being wanted for a felony.

A question on all applications for SNAP or TANF benefits asks participants if they, or anyone they want benefits for, have an outstanding arrest warrant. Whenever the household answers yes, ODHS|OHA must ask more questions to determine if the individual is a fleeing felon for SNAP and TANF purposes. The additional questions should include:

- Where was the arrest warrant issued? (city, county, state)
- When was the warrant issued?
- What is the reason for the warrant?
- Is it for a felony or a misdemeanor?
- When did the participant learn about the warrant?
- Did the participant move here after they learned the arrest warrant was issued?
- What steps has the participant taken to resolve the issue?
- If they have not taken steps to resolve the issue, why not?
- Does the participant have the mental or physical ability to resolve the issue?
- If they lack the financial ability to resolve the warrant, has the participant asked the district attorney or courts to pay for their return and was this request denied? (A copy of the letter will be requested.) Maybe the other state has decided not to extradite.

If the applicant is ineligible due to being a fleeing felon, ODHS|OHA will let them know what steps they need to take to make substantial effort to resolve the matter for future eligibility. The discussion, all responses and the decision should be carefully narrated.

ERDC This does not apply to the ERDC program.

REF The participant is ineligible for SNAP and TANF benefits whenever ODHS|OHA receives a report from a local, state or federal corrections agency or the courts that an individual is in violation of conditions of parole, probation or post-prison supervision. Their ineligibility continues until the local, state or federal corrections agency or the courts report the individual is cooperating with the conditions of their parole, probation or post-prison supervision.

The individual who is in violation of parole, probation, or post-prison supervision is ineligible and is removed from the need group. Other individuals in the benefit group may remain eligible for benefits. The parole, probation, or post-prison supervision violator's income and resources are still considered when determining eligibility.

The law of the state from which the individual is fleeing determines if the crime is considered a felony.

In the case of New Jersey, a high misdemeanor under the law of New Jersey is treated as a felony. For example, if an individual committed a felony in California, they would be ineligible for benefits in Oregon (even if the crime is not considered a felony in Oregon).

For the purposes of the SNAP or TANF programs in Oregon, the existence of an outstanding felony warrant for an individual's arrest does not automatically establish the individual is fleeing. An individual wanted for a felony may not have fled their home or the local area. They may not have initiated actions to conceal themselves or to avoid arrest. An individual may have moved out of an area and not be aware of the arrest warrant. The police may know where the individual is but choose to not arrest them at this time.

Therefore, for the participant to remain eligible for benefits, ODHS|OHA must first determine if the participant knows they are wanted for a felony and what actions have been taken to resolve the issue of being wanted for a felony.

A question on all applications for SNAP or TANF benefits asks participants if they, or anyone they want benefits for, have an outstanding arrest warrant. Whenever the household answers yes, ODHS|OHA must ask more questions to determine if the individual is a fleeing felon for SNAP and TANF purposes. The additional questions should include:

- Where was the arrest warrant issued? (city, county, state)
- When was the warrant issued?
- What is the reason for the warrant?
- Is it for a felony or a misdemeanor?
- When did the participant learn about the warrant?
- Did the participant move here after they learned the arrest warrant was issued?
- What steps has the participant taken to resolve the issue?
- If they have not taken steps to resolve the issue, why not?
- Does the participant have the mental or physical ability to resolve the issue?
- If they lack the financial ability to resolve the warrant, has the participant asked the district attorney or courts to pay for their return and was this request denied? (A copy of the letter will be requested.) Maybe the other state has decided not to extradite.

If the applicant is ineligible due to being a fleeing felon, ODHS|OHA will let them know what steps they need to take to make substantial effort to resolve the matter for future eligibility. The discussion, all responses and the decision should be carefully narrated.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Click here for examples: Fleeing felons; probation and parole violators.

Oregon Administrative Rule(s)

461-135-0560 — Fleeing Felon and Violators of Parole, Probation, and Post-Prison Supervision; REF, REFM, SNAP, and TANF

Pursuit of assets

In some programs, applicants are required to actively pursue any income or resource to which they have a legal right or claim. This is called pursuit of assets. For programs that require pursuit of assets, benefits may not be opened until the individual has made a good faith effort to pursue the asset.

SNAP This does not apply to the SNAP program.

TANF Applicants and participants are to actively pursue any asset to which they have a legal right or claim. Helping families identify and pursue available assets connects them with additional resources that support family stability. Actively pursuing an asset means the participant is making a good faith effort to apply and/or satisfy all requirements to obtain the asset. This includes exploring legal remedies and securing legal counsel on a contingency fee basis if required and available. There is no requirement to pursue or apply for loans.

ODHS|OHA can accept an applicant's statement that they have applied for unemployment compensation (UC) or Social Security benefits (SSB), which meets the pursuit of UC and SSB assets. The outcome will be verified at a later date.

Penalties for not pursuing assets

- Initial application: Denial of the application
- Ongoing case: closure of the TANF case benefits with a timely decision notice.

Good cause for not pursuing assets

An individual may have good cause for not pursuing assets if the assets are not available to the applicant.

Click here for Availability of assets.

Specific assets

Unemployment compensation

ODHS|OHA can accept an applicant's statement that they have applied for unemployment compensation (UC). The outcome will be verified at a later date.

Participants who are considered exempt from the JOBS program are not required to pursue UC.

Social Security benefits

ODHS|OHA can accept an applicant's statement that they have applied for Social Security benefits (SSB). The outcome will be verified at a later date. Individuals are not required to apply for SSI.

Individual or vehicle injuries

- For vehicle injuries, applicants are to complete the Vehicle Related Personal Injury (MSC 0451) form if the participant has a pending claim against a third party that caused the injury.
- For non-vehicle accidents, the individual completes the Non-Vehicle Related Personal Injury (MSC 0451NV) form.

Click here for Personal Injury Lien website.
Click here for Tribal TANF.

ERDC This does not apply to the ERDC program.

REF REF follows TANF guidance, except that individuals are not required to pursue assets in their country of origin.

Benefits may not be opened until the individual has made a good faith effort to pursue the asset.

MSP To be eligible for benefits, the applicant must actively pursue any asset for which they have a legal right or claim, except as follows:

- Individuals applying for or receiving any program benefits from ODHS|OHA are not required to apply for other programs administered by ODHS|OHA (e.g., OSIPM recipients are not required to apply for SNAP).
- Individuals are not required to:
  - Pursue loans,
  - Pursue SSI,
  - Make an effort to obtain any asset if the individual can show good cause for not doing so,
    - Good cause means a circumstance beyond the ability of the individual to control.
    - Good cause does not include the fact that applying for SSB at 62 constitutes lower benefits than if pursued at full retirement age.
  - Convert pension/retirement plans to income to meet pursuit of assets requirements, or
  - Make an effort to obtain an asset if it will put the individual at further risk of current or future domestic violence.

To pursue available assets, the individual must do all the following:

- Apply for and satisfy all requirements to receive benefits from other programs, and
- Pursue legal remedies to obtain assets from any other source if they can secure legal counsel on a contingency fee basis.

Note: SSA provides receipts to all individuals who apply for Title II benefits. An individual can present this receipt as verification.

Note: Applicants are required to apply for early retirement benefits from the SSA.

The penalty for not pursuing assets is that the individual is ineligible, not the entire benefit group. End the

penalty when the individual provides evidence that they are willing to cooperate.

Assignment of third party liability (TPL) and support

Medical assignment

ODHS|OHA has the authority to collect reimbursement for medical expenses it paid for anyone receiving Medicaid that should have been paid by another party or resource. This is called assignment of medical benefits. ODHS|OHA has the authority to refuse to pay medical expenses for anyone receiving benefits when another party or resource should pay first.

The medical assignment process is a mandatory part of applying for and receiving medical benefits. By signing the application for assistance, individuals automatically agree to turn over any rights to health insurance or medical support to ODHS|OHA, as well as the rights of anyone for which they are legally responsible who is receiving Medicaid. ODHS|OHA does not need the individual's express consent. This should be explained to applicants at initial application.

The amount for which ODHS|OHA has the authority to collect reimbursement is equal to the full amount of medical services paid by ODHS|OHA on the individual's behalf. See rule below for a list of whom ODHS|OHA has the authority to collect medical reimbursements from. ODHS|OHA authority does not include collecting reimbursements from Medicare benefits.

Cooperation in identifying liable third parties and other information

The second piece to medical assignment, which requires more active participation, is cooperating with ODHS|OHA in identifying third parties that are liable or potentially liable to pay for costs paid by the medical assistance program for anyone receiving medical assistance from the State of Oregon. The actual requirement to cooperate, however, only applies to the legally responsible individual and not, for example, a child who is not legally able to assign their own rights. This means, if Dad applies for QMBP and his son is receiving MAGI, and he refuses to cooperate in identifying the auto insurance company that is potentially liable to pay for his son's hospital bills (that MAGI already covered), then Dad is ineligible for QMBP, but the child does not lose eligibility for MAGI. We cannot penalize someone who is not legally responsible for themselves. Legally responsible individuals must also provide any other information that ODHS|OHA, a CCO, or PMCH (prepaid managed care health service organization) needs in order to pursue payment from a liable third party.

Medical cooperation

Cooperation includes, but is not limited to, applying for, accepting and maintaining all available resources and identifying and providing information to assist ODHS|OHA in obtaining medical coverage.

To be eligible for MSP, legally responsible adult individuals must:

- Cooperate (unless good cause exists) in obtaining health care coverage and cash medical support for anyone for whom they are legally responsible who is receiving any type of medical assistance from the State of Oregon,
- Cooperate with ODHS|OHA and the Division of Child Support of the Department of Justice in

establishing the identity of the parents of any child for which the QMBP applicant is legally responsible who is receiving any type of medical assistance,

- Provide information for any third-party payments for medical care. This includes, but is not limited to:
  - Coverage under Medicare,
  - Coverage under Tri-Care, or
  - A claim for damages from personal injuries

The penalty for failure to cooperate with medical coverage is ineligibility for the legally responsible adult. A person can be penalized only if they have the legal right to obtain the health insurance. This means that individuals who cannot enroll in cost-effective employer-sponsored insurance for themselves are not disqualified. For example, if a spouse is unable to enroll on their own behalf, the spouse is not disqualified.

End the noncooperation penalty when the individual provides evidence that they are willing to cooperate.

Good cause for failing to pursue health care coverage and medical support

Good cause includes the following:

- Complying would result in emotional or physical harm to the individual or anyone on whose behalf that individual's cooperation is required.
- A child was conceived as a result of incest or rape and cooperating would cause harm to the individual, the child or the spouse.
- Legal proceedings are pending for an adoption of a child.
- A parent is being helped by a social service agency to help decide if a child should be released for adoption.
- The individual is pregnant.

OSIPM To be eligible for benefits, the applicant must actively pursue any asset for which they have a legal right or claim, except as follows:

- This requirement does not apply to non-applying or ineligible spouses or parents of applicants or recipients.
- Individuals applying for or receiving any program benefits from ODHS|OHA are not required to apply for other programs administered by ODHS|OHA (e.g., OSIPM recipients are not required to apply for SNAP).
- Individuals are not required to:
  - Pursue loans,
  - Pursue SSI,
  - Make an effort to obtain any asset if the individual can show good cause for not doing so,
    - » Good cause means a circumstance beyond the ability of the individual to control.

    - » Good cause does not include the fact that applying for SSB at 62 constitutes lower benefits than if pursued at full retirement age.
  - Convert pension/retirement plans to income to meet pursuit of assets requirements; however, for OSIPM, if they don't do so, the equity value of the pension/retirement plan will be counted as a resource,
  - Make an effort to obtain an asset if it will put the individual at further risk of current or future domestic violence.

To pursue available assets, the individual must do all the following:

- Apply for and satisfy all requirements to receive benefits from other programs, and
- Pursue legal remedies to obtain assets from any other source if they can secure legal counsel on a contingency fee basis.

Note: SSA provides receipts to all individuals who apply for Title II benefits. An individual can present this receipt as verification.

Note: Applicants are required to apply for early retirement benefits from the SSA.

A person is ineligible for benefits during the time they refuse to comply with the requirements of this policy.

Assignment of third party liability (TPL) and support

Medical assignment

ODHS|OHA has the authority to collect reimbursement for medical expenses it paid for anyone receiving Medicaid that should have been paid by another party or resource. This is called assignment of medical benefits. ODHS|OHA has the authority to refuse to pay medical expenses for anyone receiving benefits when another party or resource should pay first.

The medical assignment process is a mandatory part of applying for and receiving medical benefits. By signing the application for assistance, individuals automatically agree to turn over any rights they have to health insurance or medical support to ODHS|OHA, as well as the rights of anyone for which they are legally responsible who is receiving Medicaid. ODHS|OHA does not need the individual's express consent. This should be explained to applicants at initial application.

The amount the for which ODHS|OHA has the authority to collect reimbursement is equal to the full amount of medical services paid by ODHS|OHA on the individual's behalf. See rule at the end of this section for a list of whom ODHS|OHA has the authority to collect medical reimbursements from.

For those with long-term care insurance who are receiving or applying for services, there are additional steps needed to meet the medical assignment requirements. Refer to LTC.

Cooperation in identifying liable third parties and other information

The second piece to medical assignment, which requires more active participation, is cooperating with ODHS|OHA in identifying third parties that are liable or potentially liable to pay for costs paid by the

medical assistance program for anyone receiving medical assistance from the State of Oregon. The actual requirement to cooperate, however, only applies to the legally responsible individual and not, for example, a child who is not legally able to assign their own rights. This means, if Dad applies for OSIPM and his son is receiving MAGI, and he refuses to cooperate in identifying the auto insurance company that is potentially liable to pay for his son's hospital bills (that MAGI already covered), then Dad is ineligible for OSIPM, but the child does not lose eligibility for MAGI. We cannot penalize someone who is not legally responsible for themselves. Legally responsible individuals must also provide any other information ODHS|OHA needs to pursue payment from a liable third party.

Support rights: Any legally responsible individual applying for medical assistance must agree to assign to the state rights of any individual for whom the individual is legally responsible to receive any cash medical support that accrues while they receive assistance, not to exceed the total amount of assistance paid. This requirement is printed on the application, so signing the application constitutes the agreement to assign cash medical support. As with medical assignment, only the legally responsible adult who refuses to assign rights to support is ineligible for benefits, not the child for whom the cash medical support is intended.

Medical cooperation

Cooperation includes, but is not limited to, applying for, accepting and maintaining all available resources and identifying and providing information to assist ODHS|OHA in obtaining medical coverage.

To be eligible for OSIPM, legally responsible adult individuals must:

- Cooperate (unless good cause exists) in obtaining health care coverage and cash medical support for anyone for whom they are legally responsible who is receiving any type of medical assistance from the State of Oregon,
- Cooperate with ODHS|OHA and the Division of Child Support of the Department of Justice in establishing the identity of the parents of any child for which the OSIPM applicant is legally responsible who is receiving any type of medical assistance,
- Provide information for any third-party payments for medical care. This includes, but is not limited to:
  - Cost-effective, employer-sponsored health insurance. The individual is not expected to incur a cost, but they can be reimbursed by HIG. HIG will also determine whether or not the insurance is cost-effective.
  - Coverage under Medicare
  - Coverage under Tri-Care
  - A claim for damages from personal injuries

ODHS|OHA may not refer a case for medical support enforcement on a child based solely on health care services which they are eligible for or receiving through an Indian Health Program provided by the Indian Health Service.

Note: Medical-only individuals may not be disqualified for failure to pursue a cash child support order. They are required to cooperate with paternity and medical support only.

The penalty for failure to cooperate with medical coverage is ineligibility for the legally responsible adult. A person can be penalized only if they have the legal right to obtain the health insurance. This means that individuals who cannot enroll in cost-effective employer-sponsored insurance for themselves are not disqualified. For example, if a spouse is unable to enroll on their own behalf, the spouse is not disqualified.

End the noncooperation penalty when the individual provides evidence that they are willing to cooperate.

Good cause for failing to pursue health care coverage and medical support

Good cause includes the following:

- Complying would result in emotional or physical harm to the individual or anyone on whose behalf that individual's cooperation is required.
- A child was conceived as a result of incest or rape and cooperating would cause harm to the individual, the child or the spouse.
- Legal proceedings are pending for an adoption of a child.
- A parent is being helped by a social service agency to help decide if a child should be released for adoption.
- The individual is pregnant.

Reimbursement of cost effective, employer-sponsored Health Insurance Premium Payment (HIPP)

The HIPP program provides premium reimbursement to eligible policyholders who are paying for individuals also covered by Medicaid. Eligibility for the HIPP program is determined by a HIG premium reimbursement coordinator (PRC). Individuals wanting to apply for HIPP can apply in Step 4 of the online web form at https://apps.oregon.gov/dhs/opar.

Eligible policyholders can be reimbursed even if they don't live in the same household as the covered individual. HIPP can be applied for at any time as long as the Medicaid benefits and insurance are still active. If determined eligible, payments begin the month after they are approved. HIPP payments are not approved for periods prior to the request date.

For detailed information about the HIPP program including the eligibility criteria, referral process, instructions on how to complete the online form and the Medical Savings Chart (MSC), please see the OPAR website.

Refer to HIG HIPP QRG.

Individual or vehicle injuries

Individuals receiving medical assistance are required to report to Personal Injury Liens Unit (PIL) when injured by another person or business. Generally, the individual receiving benefits must make a claim

against the person, business or insurance that is liable for the injuries.

If an individual is applying for benefits and indicates they are currently being treated for an injury, the injury must be reported to PIL if the individual is approved for Medicaid. The individual or a worker can report the injury to PIL by going to www.reportinjury.org or they may complete and return the MSC 0451 (Vehicle) or MSC 0451NV (Non-Vehicle) form. If the claim was settled prior to applying for benefits, the individual does not have to report the injury.

Refer to Personal Injury Lien website.

HSD

Individuals are required to tell ODHSIOHA they agree to pursue the asset prior to an eligibility determination, but they are not required to actually pursue the asset until after their eligibility decision has been made (referred to as a post-eligibility pend). Agreement to pursue is obtained when an applicant signs the application and agrees to the Rights & Responsibilities (R&R). As a condition of ongoing eligibility, an applicant or beneficiary shall make a good faith effort to obtain an asset to which they have a legal right or claim.

For all HSD medical programs, pursuable assets include but are not limited to:

- Claims related to an injury,
  - If a participant has an unsettled or unopened claim for an accident or injury, the individual may comply with the requirement to pursue this asset by filing a claim and providing the details to OPAR/PIL Unit at www.reportinjury.org or on the MSC 0451 form.
- Disability benefits,
- Cost-effective healthcare coverage,
- Retirement benefits,
- Survivorship benefits (including inheritance, devise or elective share),
- Discretionary or mandatory distribution from a trust,
- Unemployment compensation, and
- Veteran's compensation and pensions.

Applicants and beneficiaries are not required to:

- Apply for Supplemental Security Income (SSI) from the Social Security Administration,
- Borrow money, or
- Pursue an asset if the individual can show good cause for not doing so.

For all HSD medical programs except MAGI CHIP and eligibility granted under Cover All Kids or during a period of hospital presumptive eligibility:

- Each caretaker in the EDG must agree to cooperate with the Division of Child Support (DCS) in identifying a child's non-custodial parent(s), establishing paternity and obtaining medical support and payments,
- Each applicant, including a parent for their child, shall make a good faith effort to obtain available coverage under Medicare, if it is available, and

- Beneficiaries, including a parent for their child, shall apply for, accept and maintain cost-effective employer-sponsored health insurance (ESI) unless they have good cause. The Health Insurance Group (HIG) determines if ESI meets the criteria to be cost effect. If it is determined to be cost effective and the individual pursues the insurance, HIG will authorize reimbursement of the individual's portion of the premium.

The requirement for an individual to pursue an asset does not apply when good cause exists. An individual is considered to have good cause if any of the following are true:

- Pursuit of the asset would result in emotional or physical harm to the dependent child or to the caretaker.
- For individuals with the authority to pursue child support on behalf of a child who is applying for or receiving Medicaid/CHIP benefits, the individual is considered to have good cause if:
  - Efforts to obtain support would be detrimental to the dependent child.
  - Legal proceedings are pending for adoption of the child
  - The parent is being helped by a public or licensed private social agency to decide whether to release the child for adoption.
  - The individual is pregnant.
  - Other good cause reasons exist for noncooperation.

An individual who fails to comply with the requirements to pursue an asset, unless good cause exists, is ineligible for benefits until the individual meets the requirements. Children are not penalized for non-pursuit of an available asset.

Click here for examples: Pursuit of assets.

Oregon Administrative Rule(s)

461-120-0330 — Requirement to Pursue Assets
461-120-0350 — Excused for Good Cause
461-120-0345 — Requirement to Obtain Health Insurance and Medical Support; MSP, OSIPM
461-155-0360 — Pursuit of Cost-Effective Employer Sponsored Health Insurance
461-120-0315 — Medical Assignment
461-120-0310 — Assignment of Support Rights; Not SNAP
461-145-0380 — Pension and Retirement Plans
461-135-0990 — Specific Requirements; Reimbursement of Cost-Effective, Private or Employer-Sponsored Health Insurance Premiums
410-200-0220 — Requirement to Pursue Assets

Other resources

Minimum Essential Coverage (MEC) *includes screenshots: Describes Minimum Essential Coverage (MEC) warning that appears when medical has not been requested for child(ren) and Third-Party Liability (TPL) has not been completed.

Health Insurance and ESI *includes screenshots: Reviews screens in the system that contain employment sponsored healthcare data. Provides steps to access these screens and proper process for data entry.

Cooperation with the Division of Child Support (DCS)

This specifically applies to eligibility for the TANF program.

Click here for Child Support Programs.

SNAP This does not apply to the SNAP program.

TANF Click here for Child support programs.

ERDC This does not apply to the ERDC program.

REF This does not apply to the REF program.

MSP Refer to pursuit of assets above.

OSIPM Refer to pursuit of assets above.

HSD Refer to pursuit of assets.

Click here for examples: Cooperation with the Division of Child Support (DCS).

Oregon Administrative Rule(s)

461-120-0350 — Clients Excused for Good Cause from Compliance with Requirements to Pursue Child Support, Heath Care Coverage, and Medical Support
461-120-0340 — Client Required to Help Department Obtain Support from Noncustodial Parent; TANF
461-120-0310 — Assignment of Support Rights; Not SNAP
461-115-0020 — Application Requirements

Other resources

Program Compliance Good Cause *includes screenshots: Overviews the Program Compliance Questions screen and how to navigate and enter data into it. Provides a list of noncompliance types and their respective Good Cause Reasons. Also reviews the Absent Parent Information screen and how to mark for cooperation with DCS for child support.

TANF Referrals to Division of Child Support Web Form *includes screenshots: Describes how to refer required Absent Parent information to Division of Child Support (DCS) manually until it can be automated.

Child Support QRG: How to enter child support income in ONE, verifying child support, and child support as it relates to each program.

Absent parent information

This applies specifically to the TANF program.

For guidance regarding household groups and/or individuals residing in multiple households.

Click here for Shared custody.

SNAP This does not apply to the SNAP program.

TANF Paternity must be legally established for a man to be a caretaker relative for TANF. Alleged fathers of children may not be the caretaker relative of children for TANF purposes. If a man wants to begin the process of establishing paternity, he may complete a Self-Alleged Father form, which is available from the Division of Child Support and must be submitted to DCS. Paternity must be legally established before the man is added to a TANF case as a caretaker relative.

A biological parent or other relative (as defined above) can be the caretaker relative to a TANF child, even if an adoption exists, when the adoptive parent has given up care, control and supervision of the child.

ERDC This does not apply to the ERDC program.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Click here for examples: Absent parent information.

Oregon Administrative Rule(s)

461-120-0340 — Client Required To Help Department Obtain Support from Noncustodial Parent; TANF
461-120-0310 — Assignment of Support Rights; Not SNAP
461-115-0020 — Application Requirements
461-145-0080 — Child Support and Cash Medical Support

Other resources

TANF Referrals to Division of Child Support Web Form *includes screenshots: Describes how to refer required Absent Parent information to Division of Child Support (DCS) manually until it can be automated.

Child requirement to live with a caretaker or caretaker relative

A caretaker is an individual who is responsible for the care, control and supervision of the child. Different programs have varying requirements regarding caretakers and caretaker relatives.

SNAP This does not apply to the SNAP program.

TANF To be eligible for TANF, a child must live with a caretaker relative. A caretaker relative is the individual, regardless of age, who is responsible for the care, control and supervision of the dependent child and who is related to the child in any of the following ways:

- A biological parent
- An individual who legally adopts the child and any individual related to the individual adopting the child, either naturally or through adoption in OAR 461-120-0630
- Any blood relative, including those of half-blood and including first cousins, nephews, nieces and individuals of preceding generations as denoted by prefixes of grand-, great- or great-great-
- Stepfathers, stepmothers, stepbrothers or stepsisters
- Is or was a spouse of anyone listed above.

A stepparent or stepsibling may be considered a caretaker relative even if the marriage to the biological or adoptive parent ended in death or divorce. When a caretaker relative of one child applies for another child in the same household, the groups must be combined. A dependent child can be in only one filing group at a time.

ERDC To be eligible for child care assistance, the child must live with a caretaker:

- The child does not have to be related to the caretaker;
- Caretaker status ends when the responsibility for care, control and supervision is given to another individual for 30 days or more, unless the caretaker is called to active duty — see below.

A parent is still considered the caretaker even though he/she is gone for 30 days or more if he/she is a U.S. military member and has been called to active duty away from the child's home.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM Refer to LTC for adult caretaker and caretaker relative.

HSD For HSD medical programs, to be eligible for the MAGI Parent or Caretaker Relative program, an individual must be a parent or caretaker relative who assumes primary responsibility for a dependent child and the individual must have a dependent child in the home. This is in addition to financial requirements.

Click here for examples: Requirement to live with a caretaker or caretaker relative.

Oregon Administrative Rule(s)

461-120-0630 — Requirement to Live with a Caretaker or Caretaker Relative
410-200-0420 — MAGI Parent or Caretaker Relative

Immunization requirements

This applies specifically to the ERDC program.

SNAP This does not apply to the SNAP program.

TANF This does not apply to the TANF program.

ERDC The intent of the requirement is to protect the health and safety of children. This requirement will ensure children in child care situations paid through ODHS|OHA are immunized or have started the immunization series according to a schedule approved by ODHS|OHA. The state requirement allows for exemptions due to a medical condition or non-medical reason.

Click here for an Immunization schedule and a list of county health departments.

The website address can also be found in the Child Care Provider Guide (DHS 7492).

If the caretaker marks on the application that the immunizations are not up to date, ODHS Child Care Policy allows the caretaker 45 days in a pend status to show they are moving forward in the immunization process. The caretaker will need to do the following:

- Show they have applied/obtained medical coverage (if they do not have medical coverage for their child(ren), or
- Show proof the immunization series has started, or
- Submit a completed copy of their medical or nonmedical exemption form with documentation from a health care practitioner or the vaccine educational module approved by the Oregon Health Authority.

At recertification, if the caretaker marks again on the application that the immunizations are not up to date, their application would be denied. The caretaker may apply again at any time and would be approved if all other criteria are met. To be eligible, the caretaker will provide the following:

- Proof the series of needed immunization has started, or
- A completed copy of their medical or nonmedical exemption form with documentation from a health care practitioner or the vaccine educational module approved by the Oregon Health Authority.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Click here for examples: Immunization requirements.

Oregon Administrative Rule(s)

461-135-0400 — Specific Requirements; ERDC

Employability screening tool and JOBS Program overview

This applies specifically to the TANF program.

SNAP This does not apply to the SNAP program.

TANF The employability screening and an overview of the JOBS program must be completed during the initial eligibility intake for TANF. Additionally, the Employability Screening (DHS 0415A) form must be completed at recertification If the applicant(s) are not in the office, the Employability Screening can be competed over the phone by asking the questions and filling out the form with their answers.

The Employability Screening (DHS 0415A) tool must be completed by all adults in the need group who are authorized to work in the United States when eligibility is being determined. This tool is used to assess initial employability and potential referrals or resources by asking about the individual's household, health, and accommodations needed to achieve self-sufficiency.

The Employability Screening questions do not reside in ONE, it must be downloaded from the forms server, completed, and uploaded into the electronic case file.

In single parent families: During the eligibility determination for TANF program benefits, the parent in the need group authorized to work in the United States must:

- Complete an employability screening, and
- Participate in an overview of the JOBS program.

In a two-parent family:

- Each parent in the need group authorized to work in the United States must complete an employability screening, and
- At least one parent in the need group must participate in the overview of the JOBS program.

ERDC This does not apply to the ERDC program.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Click here for examples: Employability screening tool and JOBS Program overview.

Oregon Administrative Rule(s)

461-135-0485 — Requirement to Complete an Employability Screening and Overview of the Job Opportunity and Basic Skills (JOBS) Program; Pre-TANF and TANF

Other resources

Hand-off to Family Coach: This process walks Support Staff/Transfer Clerks, Eligibility Workers, and Family Coaches through the hand-off processes for CASH.

Child care need

This specifically applies to the ERDC and TANF programs.

SNAP This does not apply to the SNAP program.

TANF Child care need is defined as the gap between the family's resources and what the family needs to maintain safe, dependable child care that supports children's development and family self-sufficiency. Child care need means the care is necessary to maintain employment or participate in self-sufficiency activities. Child care related to employment means the nature of the parent's work makes it necessary for someone else to provide care for the child during working hours. Ordinarily, there is no child care need if the caretaker works at home and can care for their own child without significantly affecting their work.

For example, resident apartment managers whose main duties consist of answering the phone and collecting rent would not generally require child care. Likewise, self-employed child care providers do not generally require child care for their own children.

Click here for Other parent available to provide care.
Click here for Identifying activities and support services.

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Click here for Other parent available to provide care.

Requirement to be employed or in self-sufficiency activities

The Employment-Related Day Care (ERDC) program can help pay child care expenses only for persons who are employed or participating in ODHS|OHA-approved self-sufficiency activities. Employment normally means work that results in earned income. For ERDC, self-sufficiency activities are limited to approved retention activities and student child care hours.

Employment: This includes paid work experience, paid practicum assignments, work study and self-employment. At least one caretaker must be receiving income from employment at the time of application in order to qualify for child care benefits.

Retention: Some types of employment require the employee to take ongoing classes or trainings to retain their current position, certification or license. A child care need is considered a retention activity if the employer does not pay the employee for class time. The caretaker is allowed to use authorized child care hours or have additional hours added to cover class time. If the employer pays the employee wages while they are attending classes and training, this is treated the same as regular employment hours.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Click here for examples: Child care need.

Oregon Administrative Rule(s)

461-160-0040 — Dependent Care Costs; Deduction and Coverage
461-135-0400 — Specific Requirements; ERDC

Child care hours

This specifically applies to the ERDC and TANF programs.

Some programs allow caretakers and caretaker relatives to receive a child care subsidy while they work, look for work, attend post-secondary education classes or engage in other self-sufficiency activities.

SNAP This does not apply to the SNAP program.

TANF ODHS|OHA will help pay for the number of child care hours necessary for caretaker relatives to engage in their plan activities. The computer system automatically adds 25 percent to the approved hours; the extra 25 percent covers the travel time to and from the child care site to the approved activity (work, school or JOBS program) and meal time. They can also be used for homework time if the parent was approved for student hours.

A two-parent household must have overlapping work or plan activity hours to be approved unless the second parent has provided documentation that they are physically or mentally unable to provide adequate care for the child(ren).

ERDC ODHS|OHA will help pay for the number of child care hours necessary for caretakers to perform their job duties or participate in approved self-sufficiency activities.

The nature of employment is important when looking at allowable child care hours. When the nature of the employment does not create a child care need, care cannot be covered. Some examples of this may include:

- Caretakers who work from their own home, or
- Caretakers who are child care providers in a home.

For more information, click here for Child care need.

ODHS|OHA will not help pay for child care hours when free care is available, such as during school hours for school age children who are able to attend school. ODHS|OHA cannot help pay for school tuition or care for a child in homeschool during the school hours of the local public school.

A two-parent household must have overlapping work hours to be approved unless the second parent has provided documentation that they are physically or mentally unable to provide adequate care for the child(ren).

The computer system automatically adds 25 percent to the approved hours; the extra 25 percent covers the travel time to and from the child care site to the approved activity (work, school or training) and meal time. They can also be used for homework time if the parent was approved for student hours.

Caretaker work/school schedule

For ERDC, it is a requirement that the caretaker's work schedule and school schedule be recorded in ONE in the Caretaker Schedule screens. The work schedule may be verbally communicated by the caretaker and verification is not required; however, when approving student hours, the caretaker must provide verification of their school schedule.

Determining child care work hours for one-parent families

Child care hours are authorized using the highest number of verified hours provided from the applicant's income verification, if the hours are reasonably anticipated to continue. Authorizing the highest number of verified hours helps assure the parent's child care need is covered and allows flexibility to work varying shifts or potential overtime without a child care disruption.

Determining child care work hours with split physical custody

Click here for Shared custody.

Determining child care work hours for two-parent families

When there are two adults in the filing group, child care hours are only allowed when both parents are working. This means ODHS|OHA needs to determine both parents' schedules and count only the work hours that overlap. Commute time is not included when looking at hours that overlap. Verification of work schedules is not required for two-parent families unless questionable.

Click here for Filing group.

Child care hours for self-employed individuals

The gross earnings of a self-employed individual are used before deductions when reviewing for ERDC eligibility. This means the total earnings are compared to the ERDC income limits, both initial and exit and ongoing limit, to determine whether the family is eligible for ERDC prior to exploring costs or deductions of the business. If the family is below the ERDC income limits using the gross earnings of their self-employment income, they meet ERDC income eligibility. Costs can be determined at this point.

Determining costs

There are various ways to treat self-employment income within ERDC:

- **No costs:**
  - If the applicant states they have no cost associated with running their business, the full gross amount is used.
- **50% cost:**
  - If the applicant states they have at least $1 in costs, they receive the 50 percent deduction. This does not need to be verified. Most businesses have at least $1 in costs.
- **Total allowable costs:**
  - If the applicant says they have more than 50 percent in costs, the full allowable cost can be used. The amount of the deduction is limited to costs that fit the definition of an allowable cost as described in Treatment of specific assets. Verification of costs is no longer required.

In the ERDC program, individuals may choose if they would like to deduct costs or not. Because countable income is directly tied to their copay amount, it is up to the family to make the best choice financially for their family, whether they need more child care hours or a lower copay.

ODHS|OHA should select which option the family has chosen in the ERDC Self Employment Deduction screen in ONE after running eligibility.

Child care hours and self-employment

A self-employed individual's child care hours are determined by taking their income after costs and dividing it by the local Oregon state minimum wage for the business location. If the applicant needs more

authorized child care hours, they can choose which cost option they would like to use. This will also affect their copay. For example, if a participant decides they need more child care hours with zero deductions, they will get more authorized hours; however, their copay will be higher as their income will be coded as a higher amount. The maximum authorized hours for self-employment cannot exceed 172 hours.

Calculating work hours when less than minimum wage is earned

When a caretaker earns less than state minimum wage, the countable income is calculated in ONE by dividing the current minimum wage in their area to determine the number of child care work hours allowed. The resulting figure is the maximum number of hours that can be authorized, not to exceed 172 hours. The minimum wage is determined by the business location.

For a caretaker in a start-up phase of employment that does not pay an hourly wage or salary, such as working on commission, the caretaker must supply verification of an anticipated amount of income. This may include the employer's statement of average wages for someone just starting out in a similar position.

Student hours

When a request for student hours is made, ODHS\OHA will need to review the case to ensure all the following criteria are met. Authorized student hours are limited as follows:

- The caretaker must be eligible due to employment before student hours can be determined.
- Coursework must lead to a certificate, degree or job-related knowledge and skills.
- Authorized student hours cannot exceed authorized work hours (at least 50 percent of all authorized hours must be from employment).
- Total authorized hours, from work and school, cannot exceed 172. (Authorizing extra hours is not allowed on working student child care cases).
- Coursework must be through a school or institution eligible for federal student aid.
  and
- The working student **must submit verification** of school registration and current class schedule before student hours can be approved.

The financial aid award letter is required at certification and recertification as verification of income. It should be requested along with proof of registration and class schedule if it has not already been provided.

ODHS\OHA must review the financial aid award letter to see if the child care need is covered by the caretaker's financial aid. If so, the caretaker is not eligible for student hours.

Any student receiving financial aid through the Office of Student Access and Completion (OSAC) is not eligible for ERDC benefits.

Requesting student hours during the certification period

If the caretaker is requesting student hours during the certification and report a change in their work

hours, ODHS|OHA will need to request verification of current work hours to determine how many student hours can be authorized.

If the student is not receiving financial aid, you can search for the school on the FAFSA website: https://fafsa.ed.gov/FAFSA/app/schoolSearch to determine if the school meets the federal student aid requirement. If unable to determine, ODHS|OHA sends a request for information (RFI) to the caretaker for verification.

Termination of schooling

If a caretaker reports they are no longer attending school or have completed their coursework, ODHS|OHA will need to enter that information into ONE by ending the student schedule record and selecting the enrollment end date in the Education screen. Authorized hours are not reduced during the certification period. The caretaker may use the authorized hours for employment or to maintain the child(ren)'s spot at a child care facility.

Loss of employment

If a caretaker has lost employment, student hours are not reduced during authorized work search (AWS), authorized medical leave (AML) or authorized military transition (AMT) periods. ERDC benefits for both employment and education will end at the end of these periods if new employment is not established.

Click here for Acting on reported changes.

Authorizing a higher limit for extra hours

When the child care need is greater than the standard calculation for approved hours plus travel time, ODHS|OHA can help pay for additional hours. Extra hours are not allowed for self-employment or student hours.

Authorizing extra hours are limited to the following situations:

- **Sleep hours:** The caretaker works an overnight shift and care is necessary for both work hours and sleep hours. This would ordinarily not apply during the school year for school age children. When authorizing extra hours for sleep time for individuals who work an overnight shift, sleep hours are not to exceed five (5) hours per work night. Sleep hours cannot be authorized for two-parent households. The need for extra hours must be determined by the worker. Authorized hours are typically based on the highest verified hours on a pay stub, but this does not always mean extra hours are required. Sleep hours should be entered in ONE using the caretaker schedule screen.
- **Split shift:** The caretaker works a split shift; it is not feasible to care for the child between shifts. Split shifts should be entered in ONE using the caretaker schedule screen.
- The travel time to and from work (and meal breaks) exceeds 25 percent of the authorized hours.
- The caretaker consistently works more than 40 hours a week.

For part-time employment: Additional hours for travel can be authorized up to the monthly maximum by entering commute time in the caretaker schedule in ONE.

For full-time employment: When a caretaker requires more than 215 hours of care per month, ODHSIOHA can authorize an additional amount above the monthly maximum limit. This is capped at 50 percent above the monthly maximum and will be automatically calculated by the ONE system.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Click here for examples: Child care hours.

Oregon Administrative Rule(s)

461-190-0211 — Case Plan Activities and Standards for Support Service Payments; JOBS, Pre-TANF, REF, REP, SFPSS, TA-DVS, TANF
461-135-0400 — Specific Requirements; ERDC
461-160-0040 — Dependent Care Costs; Deduction and Coverage

Other resources

ERDC Schedule *includes screenshots: Provides steps for how to enter a caretaker schedule and add additional caretaker schedules.

Child care copays

This applies specifically to the ERDC program.

In the ERDC program, caretakers are required to pay a portion of their child care costs before ODHSIOHA can assist with payment. This cost is called the copay. The parent's copay is listed every month on their Child Care Billing (CCB) form.

The copay is calculated based on EDG size and countable income. The copay is not increased during the 12-month certification period but may increase at re-certification due to increased income or a change in the household.

SNAP This does not apply to the SNAP program.

For deductions of dependent care expenses, click here for Expenses and deductions.

TANF For JOBS plan activities, there is no copay for child care assistance.

ERDC Requirement for caretaker to pay ERDC copay

Parents are required to pay their ERDC copay to their child care provider. When copays are not paid or another satisfactory arrangement is not made, a family will lose their eligibility for the ERDC program and their case will be closed.

Satisfactory arrangements may include bartering or income in-kind. For example, a parent may provide child care for a provider's children instead of paying the copay. Parents and providers should be encouraged to put any agreement in writing. It is most beneficial for a parent to request a receipt when the copay arrangements are made, whether the payment is bartered or in cash.

In situations where there are multiple providers caring for the child(ren), a primary provider is designated. The primary provider is the one who provides the most care. Copays are usually paid to the primary provider but may be split between the primary provider and secondary provider in some cases.

If the copay exceeds the billed amount or the maximum allowed by ODHS|OHA, the copay amount owed by the parent may be less than the copay. DPU will determine the total amount owed. DPU may change the primary provider designation or split the copay on future billing forms among all the providers who bill for care.

If a provider indicates on the Child Care Billing (CCB) form a parent did not pay the required copay or make satisfactory arrangements to pay it, the Direct Pay Unit (DPU) will end benefits and send a closing notice as soon as timely notice requirements allow. DPU also enters the copay not met information in ONE using the Program Compliance Screens in Household Information. If the parent later requests ERDC, they cannot qualify until past copays are paid or satisfactory arrangements are made with the provider.

The period of ineligibility ends in either of the following circumstances:

- On the first day of the month in which the caretaker makes the copayment or makes satisfactory arrangements with the provider, or
- On the first day of the month after three years have lapsed from the date the caretaker failed to make payment.

The provider has up to 60 days after the CCB is processed to notify ODHS|OHA the copay or satisfactory arrangements have not been made. If not reported within 60 days, ODHS|OHA will consider the copay requirement met.

If an ERDC case has been closed because of an unpaid copay, it can be reopened under any of the following circumstances:

- The provider agrees the copay has been met or satisfactory arrangements have been made.
- The parent submits evidence of making the payment, such as a receipt or canceled check.
- The parent verifies the debt was discharged by a bankruptcy filing.
- The parent has attempted to pay the provider, but the provider refuses payment. This can occur when the copay is part of a larger bill that includes charges above the maximum rates. The case can be reopened if the parent presents evidence of an attempt to pay the entire copay.
- The parent attempts to pay the provider, but the provider cannot be located.

The effective date for reopening the case is the first of the month in which the copay requirement was met.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Click here for examples: Child care copays.

Oregon Administrative Rule(s)

461-160-0040 — Dependent Care Costs; Deduction and Coverage
461-155-0150 — Child Care Eligibility Standard, Payment Rates, and Copayments

Child care provider requirements

This specifically applies to the ERDC and TANF child care programs. This does not apply to the SNAP and REF programs.

Child care providers paid by the state for care provided while caretakers engage in work or self-sufficiency activities must also meet additional requirements to be paid.

Click here for the Child Care Provider Guide (DHS 7492).

Child care provider eligibility requirements

The intent of the listing process is to ensure providers meet the following criteria to be eligible for payment:

- All Early Learning Division Office of Child Care (OCC) licensing requirements
- All Oregon Department of Human Services (ODHS) pre-service program requirements and health and safety standards, and
- Pass a background check.

This is important for child safety. The requirements apply to all child care providers paid by ODHS. The process is designed to encourage compliance with the requirements before providers are approved for payment. The listing form includes an agreement that all providers must sign indicating they meet the program requirements.

The provider must submit a completed Child Care Provider Listing Form (DHS 7494) to ODHS|OHA within 30 calendar days from the date ODHS|OHA issues the listing form to the caretaker. The listing form includes an agreement that all providers and persons subject to records checks must sign indicating that they meet the program requirements. The provider and persons subject to records checks must fully disclose all requested information as part of the records check.

Program requirements

To be eligible for child care payment from ODHS|OHA, all child care providers must submit a completed listing form to DPU, pass a background check and comply with the following program requirements:

- Agree not to charge ODHS|OHA participants a higher rate than they charge other families in care.

- Keep daily attendance records for at least 12 months that show when children are in care, and billing records for each child receiving ODHS|OHA child care benefits
- Give ODHS|OHA their correct SSN or IRS identification number
- Be the person who actually provides the child care (the provider may only use someone else to supervise a child on a temporary basis if the person was included on the most current listing form and the provider notifies DPU)
- Be an eligible provider (This means the provider must be at least 18 years old and cannot be a parent or stepparent of the child, a parent of the child's sibling (including unborn children) if all live in the same household, a sibling who lives with the child or in the same filing group as the child in care/)
- Not bill an ODHS|OHA participant for an amount collected by ODHS|OHA to recover an overpayment or an amount paid by ODHS|OHA to a creditor of the provider because of a lien, garnishment or other legal process
- Develop and communicate expulsion and suspension policies to parents/caretakers
- Provide evidence of compliance with the rules, including an inspection when ODHS|OHA determines an inspection is necessary
- Complete and submit a new listing form every two years or sooner at the request of ODHS|OHA, so ODHS|OHA may review the provider's eligibility and
- Licensed providers must meet the regulatory requirements of the Office of Child Care (OCC) or, if exempt from licensing, attend a child care orientation class given by ODHS|OHA or a local Child Care Resource and Referral (CCR&R) agency

  License-exempt providers who are a nonrelative to at least one child in care must:

  - Complete required pre-service trainings (Introduction to Child Care Health and Safety, Recognizing and Reporting Child Abuse and Neglect (RRCAN), Infant and Toddler CPR/First aid)
  - Submit to and pass a health and safety review of the child care site by an Early Learning Division, Office of Child Care licensing specialist, and
  - Meet OCC rules (OARs 414-175-0005 through 414-175-0100).

    Definition of a relative provider: great-grandparent, grandparent, aunt, uncle and sibling not living in the home of the child needing care.
- License exempt providers who are a relative to the child in care must complete the pre-service Introduction to Child Care Health and Safety.
- All providers who are exempt from licensing must attend ODHS|OHA Child Care Orientation class given by a local Child Care Resource and Referral (CCR&R) agency.
- Must provide care at a location within the state.

Care that does not require licensing in Oregon:

- The provider cares for three or fewer children in addition to the provider's own children.
- The provider cares for any number of children from the same family.
- The care is provided in the home of the child.
- The care is provided by the child's parent or guardian or a relative.

- The care is provided on an occasional basis by someone who does not usually provide child care.
- The facility provides a preschool program that operates for four hours or less per day and provides education to children from age 3, up to school age.
- The facility provides training on a specific subject such as dancing, drama, music, etc.
- The facility is an organized club or hobby group providing short athletic or social activities, such as soccer or scouts.
- The facility is operated by a governmental agency.

Only one exemption may apply at any one time; they cannot be combined.

Registered providers: The Office of Child Care (OCC) requires providers who give care in their own home for more than three children (not including the provider's own children) to be registered. This means the provider completes a Family Child Care Overview session, meets training requirements, passes criminal and child protective services records checks, agrees to meet health and safety standards and passes a health and safety review by OCC.

Certification by OCC requires some training in childhood care and education, passing a background check, and regular inspections by an OCC certifier. Certification applies to both child care family homes and child care centers. (Family home care is provided in a dwelling, but it meets a higher standard than care provided in most family child care homes). Most, but not all, child care centers are required to be certified. Center care may be exempt from OCC requirements if it is provided by a school district or recreation program.

Suspension and expulsion in child care settings

ODHS|OHA recognizes the importance of children's social, emotional and behavioral health. High-quality early childhood environments and positive experiences nurture social, emotional and behavioral health. Exclusionary practices, such as expulsion and suspension, are negative experiences that hinder children's development and learning. Providers should develop and clearly communicate preventive guidance, discipline practices, expulsion and suspension policies. Strong partnerships between parents and providers are good for children. By increasing the level of communication between providers and families, we have the opportunity to reduce or prevent expulsion and help children become strong.

Home and facility health and safety requirements

Providers must ensure the home or facility where care is provided meets the following standards:

- All floor levels used by children have two usable exits to the outdoors (a sliding door or window that can be used to evacuate children can be considered a usable exit). If a second floor is used for child care, the provider has a written plan for evacuating occupants in an emergency.
- The home or facility has water that is safe to drink.
- The home or facility has a working smoke detector on each floor level and in any area where children nap.
- Fireplaces, space heaters, electrical outlets, wood stoves, stairways, pools, ponds and other hazards have barriers to protect children.
- The building, grounds, toys, equipment and furniture are maintained in a clean, sanitary and hazard-free condition.

- Firearms, ammunition and other dangerous items such as medicine, drugs, cleaning supplies, paints, plastic bags, and poisonous and toxic materials are kept in a secure place out of children's reach.
- The home or facility has a working telephone.
- No one smokes or uses smokeless tobacco in the home or facility during the hours the child care business is conducted. No one smokes or uses smokeless tobacco in motor vehicles while child care children are passengers.
- No one consumes or is under the influence of alcohol or nonprescription controlled substances while child care children are present.
- Child care is not conducted in a halfway house, hotel, motel, shelter or other temporary housing such as a tent, trailer or motor home. (This does not apply to licensed care approved in a hotel, motel or shelter.)
- Child care is not conducted in a structure designed to be transportable and not attached to the ground, another structure or any utilities on the same premises.

Required training for child care providers

Providers legally exempt (license exempt) from certification or registration with the Office of Child Care of the Department of Education (DOE) must complete an orientation provided by ODHS|OHA or a Child Care Resource and Referral agency within 90 days of being approved by ODHS|OHA if the provider:

- Receives payment from ODHS|OHA on behalf of a subsidy family, and
- Begins providing child care services after June 30, 2010, or
- Resumes providing services after a break of a year or more after June 30, 2010.

A provider who is in "Failed" status because they did not attend an orientation will not be paid for child care provided while in failed status – except for any billing forms already issued to the provider. Billing forms will stop being sent to the provider until the month in which the orientation is completed. Past billing forms during the time the provider was failed will not be issued.

Basic Child Care Health and Safety training and Introduction to Child Care Health and Safety

License exempt providers and registered family child care providers registered with the OCC must complete the Basic Child Care Health and Safety online training or have taken the Oregon Kids Healthy and Safe (OKHS) three-hour training. This training must be completed before the child care provider can be approved and listed as a provider with ODHS|OHA. More information about this training can be found at www.oregon.gov/dhs/children/pages/childcare/providers.aspx.

Providers who are already approved and listed with ODHS|OHA as of April 1, 2014 and are licensed exempt or registered with OCC must take the training at their next reevaluation. Providers who have taken the OKHS anytime in the past are considered to have met this requirement.

All providers who were required to take the Basic Child Care Health and Safety training or Oregon Kids Healthy and Safe (OKHS) must take the Introduction to Child Care Health and Safety training. This is due to new federal requirements. Introduction to Child Care Health and Safety is available online. All providers becoming approved starting November will be required to take the training before sending in their Child Care Provider Listing Form

(DHS 7494) Instructions. All license-exempt and registered child care providers already approved by ODHS|OHA must take this training by July 31, 2017. There are no exemptions for this training and OKHS does not replace taking the new training. More information can be found at www.oregon.gov/DHS/children/pages/childcare/providers.aspx.

Child care provider health and safety requirements

Providers must meet the following caregiver requirements:

- Obtain written approval from their certifier or certifier's supervisor if the provider is also certified as a foster parent.
- Be 18 years of age or older and in such physical and mental health as will not adversely affect a child in care (ODHS|OHA may request documentation to verify this).
- Report to the DPU within five days of occurrence:
  - Any arrest or convictions of persons subject to background checks
  - Any involvement of persons subject to background checks with CPS or any other agency providing child protective services
  - Any change to the provider's name or address including any location where care is provided
  - The addition of any persons subject to background checks.
- Report suspected child abuse of any child in their care to CPS or a law enforcement agency.
- Supervise children in care at all times.
- Prevent persons who behave in a manner that may harm children from having access to children in care.
- Allow custodial parents of children in care to have immediate access to their children at all times.
- Inform parents of the need to obtain immunizations for their children.
- Comply with state and federal laws related to child safety systems and seat belts in vehicles, bicycle safety and crib standards under 16 CFR 1219 and 1220.
- Place infants to sleep on their backs.
- Take steps to protect children from the spread of infectious diseases.

Licensed child care providers must follow any additional health and safety requirements as specified by OCC.

Child care provider background check

Intent

The intent is to ensure all providers paid by ODHS|OHA have a current background check completed through OCC or, if exempt from registration or licensing by OCC, through ODHS|OHA. Even though a provider may be registered or certified with OCC, ODHS|OHA may deny eligibility for payment if a current background check indicates substantial risk to the health and safety of children.

Fingerprinting is required as part of a Federal Bureau of Investigation (FBI) national criminal history check. Background checks will include the following components:

- An FBI fingerprint check using the Integrated Automated Fingerprint Identification System
- A search of the state criminal and sex offender registry or repository in the state where the individual resides, and each state where the individual resided during the preceding five years
- A search of the National Crime Information Center
- A search of the National Sex Offender Registry established under the Adam Walsh Child Protection and Safety Act of 2006 (42 U.S.C. 16901 et seq.).

A background check may include information from the Driver and Motor Vehicle Services Division, Department of Corrections, Juvenile Justice system and local, state and federal courts. Information from other criminal justice, corrections and law-enforcement agencies and other state and local government agencies may also be used. This may include information related to abuse or neglect of vulnerable persons.

Persons subject to records checks

OCC regulations specify who is subject to a background check for providers who are registered or licensed by OCC. Providers who are exempt from OCC regulation must complete background checks on the following persons:

- The provider and whomever they use to supervise children in their absence
- Other persons 16 years of age or older who live in the home where care is provided (This includes the parent of the child in care when the parent and child care provider live in the same household.)
- Persons who visit the home of a provider during the hours child care is provided and may have unsupervised access to children in care
- Site directors of child care centers and programs specifically exempted by law from certification by OCC and their employees or volunteers who may have unsupervised access to children.

Mandatory exclusions

Federal law lists a number of convictions that make anyone subject to a background check as a child care provider ineligible for the position.

If anyone subject to a background check for providing child care has any of the following convictions or conditions, the background check request will result in a decision of “mandatory exclusion,” and the provider will not be able to provide care:

- Refusal to complete the background check
- Knowingly making a materially false statement in connection with your criminal history of arrests, charges or convictions/adjudications
- Listing on or requirement to be listed on a sex offender registry,
- Felony conviction consisting of:
  - Murder
  - Child abuse or neglect
  - A crime against children, including child pornography
  - Spousal abuse

- Rape or sexual assault
- Kidnapping
- Arson
- Physical assault or battery.

- Conviction of a violent misdemeanor as an adult against a child, including but not limited to:
  - Child abuse
  - Child endangerment
  - Sexual assault.
- Conviction of misdemeanor child pornography
- A drug-related offense if within five years from the date ODHS|OHA makes a decision about an applicant's background check and if ODHS|OHA determines after reviewing all information in the background check that they pose a risk to children in care.

Disqualifying criminal history

Crimes considered

A conviction of any of the following crimes or offenses is potentially disqualifying, unless otherwise provided by law: all felonies, all misdemeanors, any U.S. military crime or international crime.

The authorized agency or district shall evaluate a crime or offense on the basis of the law of the jurisdiction in which the crime or offense occurred.

ODHS|OHA may also deny eligibility for payment when the criminal history of the provider or other person subject to these rules, indicates behavior that may jeopardize the safety of children or have a detrimental effect on children in care. This includes, but is not limited to:

- Arrests for drug-related, sexual or violent crimes listed in the permanent review crime list
- Arrests for any crime listed, or warrants for arrest, where final disposition has not been reached
- Convictions for two or more crimes listed during any time period
- Convictions for two or more crimes, which relate to the person's qualification or duties as a child care provider, whether or not listed in this rule, including a conviction for violation of probation
- Multiple arrests (two or more) for a listed crime within the past five years, or three or more arrests for a listed crime during any time period
- Providing misleading, false or incomplete information regarding pending charges or criminal history on any application or report provided to ODHS|OHA,
- An outstanding warrant,
- A deferred sentence, conditional discharge or participating in a diversion program,
- Current probation, parole or post-prison supervision
- An unresolved arrest
- Arrest as a fugitive from another state, and

- An adjudication in juvenile court finding the individual responsible for a potentially disqualifying crime.

Disqualifying protective services history

BCU completes a child protective services (CPS) records check on the provider and other persons subject to background checks. CPS records are maintained by ODHS|OHA. If the check results in one or more reports implicating the person in child abuse, neglect or failure to protect a child, the person will have a potential disqualification that will require a weigh test.

BCU also completes an adult protective services (APS) records check on the provider and other persons subject to background checks. APS records are maintained by ODHS|OHA. If the check results in one or more reports finding the person responsible for serious sexual abuse, physical abuse or financial abuse, the person will have a potential disqualification that will require a weigh test.

ODHS|OHA Background Check Unit (BCU) weigh test

If the provider or anyone subject to a background check has any potentially disqualifying criminal history, potentially disqualifying protective service history or other potentially disqualifying conditions, BCU shall conduct a weighing test. The weigh test will include, but is not limited to, an assessment of:

- The nature of the crime
- The facts supporting the conviction, arrest or warrant
- Intervening circumstances since the incident
- Likelihood of repetition of behaviors leading to potentially disqualifying convictions or conditions including, but not limited to, patterns of criminal activity or behavior
- Information provided as requested by ODHS|OHA
- The content of the abuse reports, the time elapsed since the reports and the number of reports and referrals indicating repeated behavior is unlikely
- The information provided indicates the person has successfully participated in rehabilitation, training or counseling to address the behavior
- The information provided indicates abuse of drugs or alcohol is unlikely.

After review, ODHS|OHA may approve and pay for the services of a child care provider with a disqualifying criminal history, only if determined that repeated criminal behavior is unlikely, and the provider does not present a danger to children in care.

Denial notifications

If BCU determines a provider is not eligible for payment based on a criminal history or a protective service records check, they will send the provider a denial notice. The notice to the provider will include the following information:

- The provider is entitled to a review of the circumstances related to their denial. To request a review, the provider must send the information to the BCU.
- The provider has the right to a hearing if the request is made, in writing, within 45 days of the notification date. Before the hearing, the provider will be contacted by a Hearing Representative to schedule an informal conference.

- The provider remains ineligible for payment pending the hearing, unless the decision to deny eligibility was based on a mistake in identifying the person with the CH or CPS record.
- The provider is not eligible to reapply for listing until 180 days after the denial date.

When the denial is recorded on the computer record, a notice will be sent to the parent telling them the provider has been denied based on a records check. The notice tells the parent to talk to the provider if they want more detailed information.

Child care provider hearings

Providers have a right to a contested case hearing only to dispute:

- A denial of eligibility for payment, or
- An allegation of an overpayment of child care payments.

Payment issues such as the number of authorized hours or ODHS maximum rates are not hearable issues.

Hearings on provider overpayments

When ODHS|OHA has determined a provider overpayment has occurred, a notice of the overpayment and of the right to a hearing will be sent to the provider. To have a hearing on the overpayment, the provider must request it within 45 days of the date of the notice. To delay repayment on an overpayment until a decision is reached, the hearing request must be made in writing within 15 days of the notice date.

Hearings on denial of provider eligibility

When BCU determines the provider is not eligible for payment based on a records check, the notice described above will be sent. To be granted a hearing, the provider must request it within 45 days of the notice. The provider is not eligible for payment pending the hearing decision.

An informal conference will be scheduled in which ODHS|OHA and the provider discuss the specific information needed to restore the provider's eligibility. If the issue is not resolved at the informal conference, a hearing will be held in accordance with the policy in the hearings section of the Program Integrity section of this manual.

The provider is not eligible to reapply for listing until 180 days after the denial date.

Click here for examples: Child care provider requirements.

Oregon Administrative Rule(s)

461-135-0400 — Specific Requirements; ERDC
461-165-0180 — Eligibility of Child Care Providers
461-155-0150 — Child Care Eligibility Standard, Payment Rates, and Copayments
461-160-0040 — Dependent Care Costs; Deduction and Coverage
461-165-0430 — Child Care Provider Hearings
461-025-0310 — Hearing Requests
461-165-0410 — Provider Listing; Disqualifying Criminal History
461-165-0160 — Direct Provider Payments; General Information

Child care payment process

This applies specifically to the ERDC and TANF child care programs.

ODHS|OHA child care provider rates

The limits established in the rate tables are intended to reflect the rates charged by most providers in the community. ODHS|OHA uses a market price survey based on the rates providers report throughout the state. Parents receiving ODHS|OHA child care assistance should have access to the same types and quality of care available to the majority of other parents in the community who use child care. The rate structure is intended to facilitate this access.

ODHS|OHA provider rates are also structured to improve the quality of care available to ODHS|OHA participants by offering an incentive to providers to obtain additional training. Providers who meet established training requirements can be paid at a higher rate and have access to billing options that more accurately reflect the market practices of the professional provider community.

Standard, enhanced and licensed care

There are three levels of rate limits: standard rate, enhanced rate and licensed rate. Providers qualify for the standard rate if they are not registered or certified by the Office of Child Care (OCC) or do not meet the qualifications for the enhanced rate. Providers can qualify for the enhanced rate by meeting established training requirements. Providers can qualify for the licensed rate by becoming registered or certified by the OCC. The differences between the three rate limits are:

- The enhanced and licensed rate definition of full-time care is 136 hours or more in the month. There is also an additional billing option of a part-time monthly rate.
- The standard rate definition of full-time care is 158 hours or more in the month. The part-time monthly billing option is not available for providers who qualify for the standard rate.

Qualifying for the enhanced rate

OCC-certified centers, registered and certified families automatically qualify for the licensed rate because registration and certification training requirements meet or exceed the ODHS|OHA enhanced rate requirements.

Family and in-home providers and staff of centers exempt from certification rules will qualify for the enhanced rate by working with the Oregon Registry. This program is part of the Oregon Center for Career Development in Childhood Care and Education located at Portland State University. To qualify, the provider or staff person must:

- Have completed at least two hours of training on child abuse and neglect issues
- Be currently certified in first aid
- Be currently certified in infant and child CPR
- Have a current food handlers permit, and
- Agree to complete a minimum of eight hours of additional training related to child care every two years.

For family providers to be paid up to the enhanced rate, the Central Coordination of Child Care Resource and Referral network notifies the Oregon Registry office when the trainings have been completed. The Oregon Registry

office notifies ODHS|OHA when the provider qualifies, and future billing forms are coded to allow the enhanced rate.

Family providers who apply for OCC registration do not need to make a separate application to the Oregon Registry office. Once registration is approved, OCC notifies the Oregon Registry office and ODHS|OHA.

Exempt centers must have at least one staff member who meets these standards for every 20 children in care to receive the enhanced rate.

Hourly, part-time and full-time monthly rates

Providers eligible only for the standard rate will be paid at either the hourly or full-time monthly rate:

- The hourly rate limit applies when children are in care less than 158 hours per month or when a provider is not designated as the primary provider for the case.
- The full-time monthly rate limit applies when children are in care 158 hours or more per month and the provider is designated as the primary provider for the case.

Providers eligible for the enhanced or licensed rate will be paid at the hourly, part-time monthly or full-time monthly rates.

- The hourly rate applies when children are in care less than 136 hours per month, unless the provider has an established part-time monthly rate, charges all families part-time rate for part-time care and is designated as the primary provider for the case.
- The part-time monthly rate applies if:
  - The provider has an established part-time monthly rate
  - The children are in care between 63 and 135 hours per month, and
  - The provider is designated as the primary provider for the case.

  For these providers, the hourly rate applies when children are in care less than 63 hours a month.
- The full-time monthly rate applies when children are in care 136 or more hours per month and when the provider is designated as the primary provider for the case.

Age and special needs categories

The maximum allowable rate is determined in part by age or special needs of the children in care. The age categories on the provider rates charts are as follows:

- Infant: A child who is:
  - Newborn to 1 year (12 months) for non-licensed care, or
  - Newborn to 2 years (24 months) for licensed care, registered or certified.
- Toddler: A child who is:
  - 1 year (12 months) to 3 years old for non-licensed care, or
  - 2 years to 3 years old for licensed care, registered or certified.
- Preschool: A child 3 years to 6 years old
- School-age: A child 6 years old and older

- Special needs: A child who requires a higher level of care than usually required for their age due to a physical, behavioral or mental disability.

Special needs rate (SNR)

A parent/caretaker who is applying for child care assistance may have a child who requires higher than normal levels of care for their age due to a physical, behavioral or mental disability. The child provider caring for a child who requires and qualifies as a higher level of care, newborn through age 17, may be reimbursed at a special needs rate. This rate offers families more options for child care services in their area. For the special needs rate (SNR) to be authorized, the provider's rates for all of their families need to be more than the ODHS maximum rate for their area.

To authorize the special needs rate, the parent/caretaker will need to provide proof of the child's physical, mental or behavioral disability. Verification can be from:

- A physician, osteopath, nurse practitioner, physician assistant, psychiatrist, licensed or certified psychologist, optometrist, ophthalmologist or clinical social worker,
- Eligibility for early intervention and early childhood special education programs or school-age special education programs
- Eligibility for SSI.

The Special Need Child Care Request (DHS 7486) form is given to the caretaker as a tool listing the verification needed. It is important to note that this form is not required to establish SNR eligibility, but it can help families understand verification requirements. The form provides the Americans with Disabilities Act (ADA) information. The ADA states child care providers may not charge parents of children who have disabilities more than other families are charged to cover any increased costs the program incurs in making the making the reasonable accommodations necessary to comply with ADA.

A case note is needed indicating the SNR is authorized and the necessary documentation is on file.

If the SNR is requested at initial application or at recertification, the effective date of the SNR will be the same as the ERDC approval date.

At recertification, SNR must be reviewed to determine if there is a continued need of a higher level of care. A conversation is needed with the caretaker to make a determination. The continuous SNR rate must be removed when the child no longer needs a higher level of care. Make a case note explaining your conversation and action.

If the SNR is requested during the certification period, allow ONE to pend for verification. The effective date will be the month after the documentation has been submitted.

Supplementing for very high needs

In some cases, the special needs rate does not adequately cover the cost of caring for children who have very high needs and require a much higher level of care than other children of the same age. This includes, but is not limited to, children diagnosed as having extreme developmental delays, very high medical needs, severe physical limitations or significant mental health issues.

For these children, ODHS|OHA can pay an additional amount above the special needs rate. The amount of this high

needs rate payment is determined by how much additional care the child requires in the child care setting and is different for each child.

To qualify, the child must be eligible for the special needs rate as described in subsection (B) above. In addition, the child must be enrolled or in the process of being enrolled, with early intervention, early childhood special education, special education programs or mental health services. The amount that can be approved is up to a maximum of $5 additional per hour. The maximum amount per month is $840.

The determination that it may cost an additional amount to care for a child with very high needs is made by one or more designated high needs specialists in each district. When staff become aware of children with high needs in their caseloads, they should contact the specialist in their area. The district office will have the contact information for the high needs specialist. If appropriate, the high needs specialist will refer the case to the Oregon Council on Developmental Disabilities' Inclusive Child Care Program (ICCP). Staff from ICCP will complete an assessment with the parent and the child care provider to determine the need for a higher payment level. This assessment must be supported by additional documentation. ICCP staff will coordinate this documentation.

Some parents may not recognize their child may be eligible for high needs payments. Workers should be aware of this and inform families about the Inclusive Partners program. Some situations to watch for include:

- A child has experienced repeated loss of child care placements
- Any child care placement has been lost due to medical, developmental or behavioral issues
- A provider reports needing a specialist to provide medical care for a child, or
- Children older than 12 at certification or recertification that still need a significant level of supervision and care due to a disability.

The high needs payments are issued by the Direct Pay Unit (DPU) using the special pay process. The Inclusive Child Care Program calculates the supplemental payment. This calculation is sent to DPU for processing.

For questions, contact Child Care Policy.

Types of child care providers

Allowable rates vary depending on the type of child care provided. The following describes the types of care listed in the child care rates charts:

- The standard family rate applies to child care provided in the provider's own home or in the home of the child when the provider does not qualify for the enhanced or licensed rate described in this section.
- The standard center rate applies to child care provided in a facility that is not located in a residential dwelling, is exempt from OCC certification rules and whose staff do not meet the requirements for the enhanced rate.
- The enhanced family rate applies to child care provided in the provider's own home or in the home of the child, and the provider qualifies for the enhanced rate.
- The enhanced center rate applies to child care provided in an exempt center whose staff meets the enhanced rate training requirements at a ratio of one staff person per 20 children in care.
- The licensed registered family rate applies to child care provided in a residential dwelling registered by the OCC as a registered family provider. The facility must be inspected, and both provider and facility are required to meet certain standards.

- The licensed certified family rate applies to child care provided in a residential dwelling certified by the OCC as a certified family home. To earn this designation, the facility must be inspected, and both provider and facility are required to meet certain standards not required of a registered family provider.
- The licensed certified center rate applies to child care provided in a facility certified by the OCC as a certified child care center. To earn this designation, the facility must be inspected, and both staff and facility are required to meet certain standards not required of other provider types.

Child care rate charts

The following are the child care rate charts. Because the market price survey found rates providers charged were higher in some areas of the state than in others, the state was divided into three areas, with a separate chart for each area. The ZIP code of the provider determines which chart to use. (Out-of-state providers use Group Area C.)

Click here for the most recent ODHS Child Care Maximum Rates.

Child care provider Spark incentive payments

Effective April 1, 2016, child care providers who have been awarded a Spark star rating may be eligible to receive a payment in addition to ODHS|OHA maximum rate. The additional monthly amount the provider could receive is based on the provider's QRIS star rating.

Star rating	Incentive amount
3 Star	$54
4 Star	$72
5 Star	$90

In order to qualify for the incentive payment, the provider must meet the following requirements:

- Be an ODHS|OHA approved provider
- Achieved and maintained a 3, 4 or 5 star Spark rating
- Have been paid for full-time care (136 hours or more) for an ERDC child
- Not be a contracted child care provider.

Provider incentive payments can be made for each full-time ERDC child per month. Changes in the provider's star rating are effective the following month and may affect the incentive amount the provider receives. Providers can choose not to receive the incentive amount.

Eligible providers will only receive incentive payments for children currently on ERDC. Providers caring for children on JOBS and TANF subsidy will not receive incentive payments for those children.

Billing for absent days

ODHS|OHA can pay for days when a child is absent from care under the following circumstances:

- The provider bills for the time the child was scheduled to be in care on the absent day.
- It is the provider's policy to bill all families for absent days.

Effective July 1, 2021, all providers may bill for up to 31 absent days in a month if the child has attended at least

one day.

The provider will need to indicate the absent days on their attendance logs.

SNAP This does not apply to the SNAP program.

TANF No additional program-specific information.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Payment process

General payment provisions are as follows:

- A payment is made only after the provider has met the listing requirements and is in approved status.
- Child care payments are made directly to the provider.
- Child care payments made to a provider are made on behalf of the family and do not constitute a contractual obligation or place ODHS|OHA in an employer relationship with the provider.
- Child care payments cover only child care already provided.
- No provider payments will be authorized unless an approved primary provider has been designated. The primary provider is usually the one who provides most of the care. For ERDC, the primary provider is responsible for collecting the copay.
- Payments are limited to the rates listed in this section of chapter 2.

For license-exempt providers (FAM, QFM, NQC and QEC), payment will only be made for an eligible child for child care provided on or after the date the provider is in approved listing status.

For licensed providers (RFM, CFM and CNT), child care payments can be backdated because the licensed provider has already completed a background check. Back pay cannot be allowed for licensed providers who did not meet ODHS|OHA requirements (failed, suspended, denied or collection status).

A provider caring for an eligible child in the TANF or ERDC programs may submit their billing form at the beginning of the month. Providers may bill in advance for hours the child is scheduled to be in their care for the month.

A parent signature is not required on child care billing forms. However, the provider may ask a parent to sign to confirm the number of hours and amount being billed.

Registration fees

ODHS|OHA may cover the cost of registration fees for families receiving ERDC in the following scenarios:

- The fee is required to obtain or maintain care,
- The provider is approved with ODHS|OHA and licensed with the Office of Child Care, and

- The fees are also required of the general public (private paying families).

Any registration fee over $150 per child must be staffed with Child Care Policy by emailing ChildCare.Policy@dhsoha.state.or.us.

Registration fees are paid to the provider, not the parent. They are paid using the Authorization of Cash Payment form (MSC 0437) with pay code 89 as special cash pay to be administered by the branch financial clerk. ODHS|OHA may cover registration fees for families who have already paid a registration fee if the request is made the month following when the payment was made. Similarly, ODHS|OHA may pay registration fees for care in the current month or next month. Payments are not allowed for the cost of tuition, to hold a spot in a child care facility or for insurance costs.

Other resources

ERDC Special Cash Payments in Legacy *includes screenshots: Covers special cash payments made in Legacy, what they are and how to use them.

ERDC child care billings (CCBs)

Payments for ERDC child care are paid directly to the provider using billing forms issued by the Provider Pay (PP) and Service Authorization (SA) system.

The following is a brief summary:

- **Eligibility:** The branch worker updates ONE with ERDC or TANF eligibility information, such as authorized hours, caretaker schedule(s), income, household information, etc.
- **Provider connection:** The provider is connected to the family's case on the situation screen (WCCS,SC,case#). DPU makes the connection between the provider and case through the electronic connection or listing process. The situation screen shows the link between the case and all current and past providers (press F9 to scroll to the next situation).
- **Billing forms:** A child care billing (CCB) is issued to the approved provider. From the situation screen, type BU (billing update) in the Fast Path and hit enter to view the CCB information. To view previous months, change the date in the "Ben mo" (benefit month) field. For ongoing cases, the CCB for the following month is issued at end of month cutoff. End of month cutoff is the fourth business day before the end of the month.
- **Provider payment:** The provider must wait until after all of the care is provided for the month before they complete the CCB and send it to DPU. The CCBs are sent directly to data entry for imaging and payment. Some CCBs will be pulled out for manual review. These include billings with a reported change, copay not met, missing signatures or other errors. When the payment is issued, it is recorded on the provider pay (PPS) system and notices are sent to the parent and the provider.

TANF/JOBS child care billings (JCCBs)

The JOBS child care billing (JCCB) is generated through WSIT by the Direct Pay Unit (DPU) once a provider connection form is received from service delivery staff. The process to establish a connection and request a billing form is similar to the CCB process for ERDC participants.

The following is a brief summary of the JCCB process:

- **Case plan:** The family coach and participant mutually develop an employment or self-sufficiency plan. The plan needs to be added in TRACS and have a step that allows for child care through JOBS support services.
  - The provider must be listed and approved for ODHS payments or be given a listing form to become approved. JCCBs cannot be issued until the provider passes the background check and is approved by the Background Check Unit (BCU). The effective date for payment cannot be earlier than the date the provider met the listing requirements and is in approved status.
  - If you are unsure of when a provider became eligible for child care payments, contact DPU for assistance.
- **Billing forms:** : The family coach sends DPU a provider connection form requesting to set up WSIT and issue a JOBS child care billing to the approved provider. The WSIT screen pulls information from three different computer systems — the ONE system, the provider pay (PP) system and TRACS— to determine eligibility for child care and the amount or authorized hours on the billing form.
  - Once the child care situation is established on WSIT, the system sends the billing form to the provide To ensure billings are sent timely, family coaches need to continue to update attendance in TRACS timely. The JCCB is issued at end of month cutoff for the following month. See Payment Program and Supports QRG for details on how to request JCCB.
- **Provider payment:** After the care is provided, the provider completes the billing form and sends it to DPU.
  - The JCCBs are batched and sent to data entry for imaging and payment. The payment is issued and recorded on the provider pay (PP) system. Notices are sent to the participant and the provider.

Branch-authorized child care payments

Payments to providers typically should never be issued out of the branch office. There are a limited number of situations where a child care payment can be made by a branch-authorized check instead of by JCCB; however, these situations are handled directly by DPU.

A special pay check can be written as follows:

- **DPU issued:** To the approved provider for an interim check to meet the provider's emergency. A provider's emergency is normally defined as a 72-hour eviction notice, shut-off notice or unexpected expenses due to a domestic violence situation. The emergent situation must be caused by circumstances outside of the provider's control, especially when there has been an ODHS delay in issuing the billing form, the case has not been updated or the participant did not turn in paperwork on time for continued eligibility, etc. Providers with an emergent need should be directed to contact DPU for assistance. DPU will discuss the provider's options to help the provider determine how ODHS|OHA can best help to meet their needs. Emergent provider payments should only be issued by DPU and not out of the branch office.
- **DPU issued:** To the participant and the approved provider (as a dual-payee check), when the computer system support is not available to make full payment. This is used to issue special high needs payments for children approved through the Inclusive Child Care Program.

Child care payments should never be issued directly to the parent. This practice is not allowed. Payments for child care can only be made directly to a provider who has been listed and approved with ODHS|OHA. This assures the provider and anyone with access to the children have had appropriate background and Child Protective Service history checks and the care is being provided at a site that has met all basic health and safety requirements.

Billing form time limits

CCBs and JCCBs both expire 90 days from the issue date. If they are received after that time, DPU must determine if the provider had good cause for returning the form late, before any replacement billing form is issued.

Canceling and reissuing CCBs

In most circumstances, CCBs are not canceled and reissued once they have been sent to the provider. A billing form should never be canceled and reissued if this results in a decrease in the authorized hours or an increase in the copay amount. However, there are limited situations where a billing form can be canceled and reissued to increase the authorized hours or decrease the copay amount. These situations include:

- **Administrative error:** The original billing form was incorrect because of an administrative error.
- **Job loss or reduction of income:** The caretaker reported a good cause job loss or an ongoing reduction in timely pay, and the caretaker does not have enough income in that month to pay the copay. The change must make a difference of at least $25 in the copay amount.
- **Increased work hours:** The caretaker reported and verified an increase in work hours in the current month, and the caretaker does not have enough income in that month to pay the additional cost of child care caused by the increased hours.
- **Reported after CMS cutoff:** The caretaker reported a change during compute deadline and the CCB has already been issued for the next month.
- **Timely report in the beginning of the next month:** A change that will benefit the family occurs toward the end of a month. It is effective the month after the change occurs when it is reported in a timely manner (within 10 days).

To cancel and reissue a CCB:

- Reduce income or increase hours on CMS for all situations except AWS or AMT.
- Email DPU.Childcare@dhsoha.state.or.us (for all situations).
- DPU will need to know the case number, provider, month and new copay amount or new number of authorized hours. Include information about any special coding like AWS or AMT when the case cannot be updated.
  - Use the electronic form Child Care Billing Change/Issue Request, provided by DPU.

Canceling and reissuing JCCBs

Exact duplicates of the original JCCB can be re-sent by DPU from the WJSS screen, the family coach would send an email to DPU requesting a replacement billing form. The provider can also contact DPU directly to request the replacement. This can be done to replace a lost billing form.

JCCBs can also be canceled and replaced by DPU as long as the replacement JCCB is for an equal or larger number of child care hours. This can be done when the child care hours have increased and new billing form reflecting the corrected hours is needed.

Click here for examples: Child care payment process.

Oregon Administrative Rule(s)

461-190-0211 — Case Plan Activities and Standards for Support Service Payments; JOBS, Pre-TANF, REF, REP, SFPSS, TA-DVS, TANF
461-165-0160 — Direct Provider Payments; General Information
461-155-0150 — Child Care Eligibility Standard, Payment Rates, and Copayments
461-160-0040 — Dependent Care Costs; Deduction and Coverage
461-165-0180 — Eligibility of Child Care Providers
461-165-0410 — Provider Listing; Disqualifying Criminal History
461-165-0430 — Child Care Provider Hearings
461-025-0310 — Hearing Requests

Child care contracts

This specifically applies to the ERDC program.

The majority of families on the Employment-Related Day Care (ERDC) program are served under the standard voucher payment process. Contracted child care is another option for families who meet ERDC eligibility along with some additional requirements. Contracted child care is not available in all areas.

Families need to meet minimum working requirements, and they need to be evaluated to ensure the family is a good fit for a contracted slot. This includes looking at the parent's or caretaker's work hours to see if they are in line with the child care facility's business hours.

Contracted child care is offered through different types of providers. The goals of contracted child care are to help parents, children and providers succeed.

This is done by increasing:

- Stability of child care to help the parent remain employed,
- Continuity of high-quality care to help the child prepare for kindergarten, and
- Stability of funding for the provider to allow them to serve subsidy families without the risk of fluctuating payments or a sudden end to the child care subsidy.

SNAP This does not apply to the SNAP program.

TANF This does not apply to the TANF program.

ERDC No additional program-specific information.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Other resources

Contracted Child Care Case: Process for assigning to FC/FCs that carry Contracted Child Care Cases

Partnerships with 211Info and Child Care Resource and Referral (CCR&R) agencies

ODHS|OHA contracts with 211Info, which plays an important role providing services to ODHS|OHA participants. The services they provide include:

- Providing information about ODHS|OHA programs to parents who may be eligible
- Offering one point of contact for child care referrals along with other community resources
- Educating participants about quality child care and helping them find it.

ODHS|OHA contracts with CCR&R agencies to assist in services and training to ODHS|OHA child care providers. The services they provide include:

- Offering training and professional development to providers to help increase and maintain quality
- Assisting providers by giving them information about ODHS|OHA payment processes and helping them troubleshoot payment problems
- Helping recruit and retain providers who provide care for participants receiving ODHS|OHA child care assistance
- Assessing the supply of child care and working with local ODHS|OHA staff to meet the need for an adequate supply of quality child care.

CCR&R agencies are a vital link with child care providers and child care programs in the local community.

Note: It is important that ODHS staff never give out a list of recommended providers and instead refers families to 211info. Creating lists of providers, even with the best intentions, can result in instances of perceived favoritism or discrimination. Please contact Child Care Policy with any questions.

Unions and training funds

There are two unions that represent child care providers. The first union is for family care providers licensed with the Oregon Department of Education Office of Child Care of the Early Learning Division. This union is the American Federation of State, County and Municipal Employees, Council 75 (AFSCME). The second union is for family care providers exempt from licensing. They are represented by the Service Employees International Union Local 503 (SEIU). License-exempt home-based providers are also referred to as family, friend and neighbor (FFN) care.

Training funds are available to ODHS|OHA-approved FFN providers caring for children of families enrolled in ERDC and TANF. The training funds are offered to encourage providers to attend an orientation class and meet the requirements to receive the enhanced rate.

To qualify for the enhanced rate, a provider must:

- Have completed two hours of Recognizing and Reporting Child Abuse and Neglect training
- Be certified in Infant and Child CPR and First Aid

- Have a current food handler's permit, and
- Agreed to complete a minimum of eight hours additional training related to child care issues within the next two years.

Child care orientation classes are being offered by the local Child Care Resource and Referral agencies. The orientation covers ODHS|OHA listing and billing process, and the Child and Adult Care Food Program. It encourages providers to get additional training. The Child Care Resource and Referral agencies partner with SEIU representatives to coordinate and schedule orientations.

Stipends and scholarships will be available for FFN providers attending the orientation as well as for completing other classes that will help them meet and maintain the ODHS|OHA enhanced rate requirements.

Head Start contracted slots

Head Start contracts providing child care services for ODHS|OHA participants are developed and administered by Central Office with feedback and assistance from the local district. Not all Head Start programs have contracted slots. Only sites able to offer full-day, full-year care and meet other minimum requirements are eligible to contract with the ODHS|OHA.

Head Start contracted slots begin Sept. 1 or Oct. 1 (depending on the program) and end Aug. 31 of the following year. A child can enter a contracted slot anytime throughout the year and children in a contracted slot will have the potential to renew the contracted slot the next year as long as they meet ERDC and Head Start eligibility requirements.

Head Start programs recruit existing or new ERDC-eligible children, ages 0 through 5, to participate in the contracted slots. ODHS|OHA workers may also refer families to Head Start.

To meet initial Head Start eligibility a family must be eligible for ERDC, and:

- Meet Head Start income standards (these are lower than ERDC income standards)
- The parent or caretaker must be working at least 25 hours per week
- The parent or caretaker must agree to have the child attend the Head Start at least 136 hours per month.

Children in a Head Start contracted slot will have protected eligibility and can only be removed from a Head Start slot prior to the certification end date if:

- There is an unmet copayment
- The child's attendance hours at the program are less than full time (136) and efforts to increase attendance have failed
- The Head Start Program decides to remove the child from a slot
- The family chooses to leave the Head Start Program
- The parent or caretaker does not continue to actively seek employment or is not available to work during the hours the Head Start program is operating
- The parent or caretaker of the child voluntarily quits their job or causes their own dismissal, and they do not have good cause

  - They no longer meet ERDC eligibility requirements
  - They are approved for TANF
- The parent or caretaker enrolls in school instead of continuing to seek employment or remain available to work during the hours the Head Start program is operating

Children served by a Head Start contract are not eligible for ODHS|OHA to make direct payments to other providers. A billing form cannot be sent to a secondary provider for backup care. Head Start programs can offer subcontracted payments to ODHS|OHA-approved providers who are registered or certified through the Office of Child Care.

These subcontracted providers help cover care when the Head Start facility or EHS-CCP provider is closed for holidays, in-service, vacation or other approved clo-sures. These payments are monitored and tracked through Central Office.

A child should not be removed from a contracted slot and the parent should not be told to stop using child care when they have lost a job. The child remains in the contracted slot as long as the child's participation remains above 108 hours unless determined otherwise by the local contracted child care point person and the Head Start program.

Early Head Start contracted slots

In order for a provider to be eligible for an Early Head Start (EHS) contract, they must be working with one of four EHS grantees. The grantees work with providers to bring their sites up to Head Start standards including curriculum and staffing requirements. The grantees have agreed to ensure the providers they work with will serve families on child care subsidy programs.

Entering Ccontracting coding information in ONE

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Click here for examples: Child care contracts.

Oregon Administrative Rule(s)

461-135-0405 — Children in the Head Start Program; ERDC and TANF
461-155-0150 — Child Care Eligibility Standard, Payment Rates, and Copayments

SNAP employment services

This applies specifically to the SNAP program.

SNAP Work registration

Work registrant definition:

An individual aged 18 and not yet 60, or ages 16 and 17 if they are the head of household and there is a signed SNAP application.

Work registrant exemptions:

The following reasons exempt a SNAP participant from work registration. An exempt work registrant will not be disqualified from SNAP benefits.

- Being responsible for the care of a dependent child under age 6 in the filing group. In two-parent families, establish with the participant who is the primary caretaker of each of the children. (Code 1)
- Being a student enrolled at least half-time (as defined by the school). School for this purpose includes high school or an equivalent program (GED), training programs, a refugee enrolled in training with a federal refugee resettlement or the Immigrant and Refugee Community Organization (IRCO), and higher education (college or university). If a participant is a higher education student, they must first meet SNAP student eligibility. (Code 2)
- Having a physical, mental or behavioral health condition that prevents performance of work or the ability to obtain or maintain employment. (Code 3) including:
  - Pregnancy qualifies as a work registration exemption if there is a complication that limits their ability to maintain employment.
  - Receiving disability benefits.
  - Receiving “wraparound services” focused on physical or mental health. “Wraparound services” are a range of services provided by a community-based organization (CBO) addressing a participant’s needs and include medical or health conditions preventing a participant from obtaining or maintaining employment.
  - An individual with a medical condition preventing them from obtaining or maintaining employment , at least 20 hours a week.
- Regularly attending alcoholic or drug addiction treatment and rehabilitation program (not including NA or AA). (Code 6)
- Regularly caring for an individual that is incapacitated and providing the care prevents the participant from obtaining or maintaining employment. The individual receiving the care need not live in the participant’s household. (Code 8)

Mandatory work registrants:

Participants who do not meet one of the above exemptions are called “mandatory” work registrants. This includes people that meet the following situations:

- Working a minimum of 30 hours a week for money or earning money from employment equal to or greater than the federal minimum wage ($7.25 as of April 2019) x 30 hours a week x 4.3 weeks.

(Code 4)

- Self-employment and earning money (after considering 50% if there are costs) equal to or greater than the federal minimum wage ($7.25 as of April 2019) x 30 hours a week x 4.3 weeks. (Code 5)
- Migrant and seasonal farmworkers if they have a contract or agreement to begin work within 30 days.
- TANF recipients that are actively participating in a JOBS Plan. (Code 7) when TANF is funded under Title IV of the Social Security Act.
- Participants who have applied for or are receiving unemployment compensation (UC). The individual must be completing the unemployment compensation requirements. (Code 9). The individual may also be participating in a program for displaced workers under the Trade Act. These include:
- The Training Unemployment Insurance (TUI) program
- The Self-Employment Assistance (SEA) program
- The Apprenticeship Program (APT)

Mandatory work registrant activities

SNAP applicants and participants who are considered mandatory work registrants must do the following or be subject to SNAP benefit disqualifications (see Mandatory work registrant noncooperation and disqualification):

- Register for the SNAP Employment and Training Program. (When an application for SNAP benefits is signed, all current and future adults under age 60 receiving SNAP agree to be registered for the SNAP Employment and Training Program.)
- Cooperate in determining their work registration status (mandatory or exempt).
- Accept a bona fide offer of employment, as long as the position is not vacant due to strike or lockout, and it pays the applicable minimum wage.
- Not quit or voluntarily reduce hours at a productive job without good cause. A productive job is defined as working 30 or more hours per week or weekly earnings equaling or greater than 30 hours each week at federal minimum wage. This includes:
  - An individual who quit a productive job in the 30 days preceding the SNAP filing date.
- Comply with the OED reporting and work-search activities if receiving UC.
- TANF individuals are asked to cooperate with their JOBS plan for the work-related activities.

Duties of local offices

ODHS|OHA follows local procedures when referring participants to the STEP contractor.

Duties of local offices:

- Determine and narrate if the participant is work registration exempt or mandatory.
- Explain to work registration mandatory participants what their responsibilities are (see Mandatory work registrants) as a work registrant,

- Review the DHS 7280F form with each household and complete the form, Give a copy of the signed form to the household and retain a copy of at least page one (signed page) in the case file.
- Explain the type of training and work-related opportunities available in the local area and provide referrals to the appropriate step provider.

Mandatory work registrant noncooperation, good cause and disqualification

Mandatory work registrant noncooperation

Mandatory work registrants must cooperate with the work registration activities identified above. If they fail to do so, this is considered noncooperation and results in a disqualification penalty if the participant does not have good cause.

Exploring good cause for noncooperation

Mandatory work registrants must explain their reasons for not meeting the work registration activities. When ODHS|OHA determines good cause existed, there is no disqualification imposed on the SNAP participant or applicant. Good cause may be established based on the following criteria:

- The task has an adverse effect on their physical or mental health.
- Left a worksite that violates health and safety standards.
- Had no means of transportation, such as: they lack the funds, have no vehicle, not near a bus route or have no one to take them to their employment. The individual must have made a good-faith effort to secure the needed transportation.
- Was not being paid at least minimum wage.
- Left because the work hours:
  - Are not customary to the occupation
  - Interfere with religious observances or beliefs of the participant.
- Do not have child care arrangements, those arrangements have broken down or they cannot pay for the child care.
- Job is vacant due to strike, lockout or other labor dispute.
- Do not want to join a union due to religious objections.
- Belong to a union and a potential job goes against the conditions of that union. Good cause does not exist if the employment is not governed by the rules of the union to which the participant belongs.
- Are offered a job within the first 30 days of participation, and the job is not in the participant's field of expertise.
- Have a job referral or employer that is discriminatory on the basis of age, sex, race, religious or political belief, marital status, disability, sexual orientation or ethnic origin.
- Failed to cooperate due to circumstances beyond their control, such as a medical condition, court appearance, breakdown in transportation, inclement weather, family issues or a misunderstanding in the cooperation requirement.

- Were subject to job quit provisions, but they quit their job to stay with another filing group member who moved for employment or school.
- Quit employment when they were under age 60, but the employer considers them retired.
- Left a job to follow a type of employment that moves, such as migrant labor.
- Accepted a new job that failed to materialize or resulted in fewer hours, if it was beyond the participant's control.
- Have unreasonable employment, such as not being paid on schedule or at all.

Disqualification penalties

Are imposed only after ODHS|OHA reviews if the individual meets an exemption and none is found, and there is no good cause for not cooperating.

There is no penalty when an individual who is exempt from work registration fails to accept a bona fide offer of employment, quits a job, or reduces work hours to less than 30 hours per week.

Applicants who withdraw their application before benefits are approved or denied are not disqualified. Applicants who are exempt from work registration or who have good cause are not disqualified.

Disqualification periods are progressive and are in full calendar months. Disqualification periods have minimum, but no maximum, durations. They last until the participant demonstrates cooperation or notifies ODHS|OHA of a change that makes them exempt. The disqualified participant remains in the SNAP filing group. Their income and resources count when determining eligibility for the group.

- The first disqualification is at least one calendar month. (Coded as LV1 on FSMIS.)
- The second disqualification is at least three calendar months. (Coded as LV2 on FSMIS.)
- Every time thereafter, the disqualification is at least six calendar months. (Coded as LV3 on FSMIS.)

ODHS|OHA sends notice of disqualification before imposing the penalty, even if the certification period is ending. Notice Writer FSC1FJQ is used to close benefits and FSC2FJQ to reduce benefits. APD/AAA staff may also use the Notification of Planned Action form (APD 0540). The notice must state:

- The action that resulted in disqualification
- The length of the minimum disqualification period
- The reduced benefit amount, and
- How they can end the disqualification (what task will meet the requirement) after the minimum period.

Note:

- If an applicant had a disqualifying job quit, they are ineligible from the filing date. The appropriate disqualification penalty, level 1–3, is applied for full months only. If the filing date was not the first of the month, the disqualification period is the first of the month following the filing date. No 10- day notice is required for applicants.
- For ongoing participants, follow the same steps as for any other disqualification.
- The disqualification penalties are listed in E&T noncooperation; disqualification penalties

Showing cooperation and ending disqualification

Local offices and districts have operational flexibility to decide what disqualified participants must do to demonstrate cooperation. They will create a minimum standard in their area.

- Districts and branches may establish tasks for the participant to complete that demonstrate cooperation. The local office must track completion of the task. For example: Local branch requires demonstration of two weeks of job search activity. Participant is required to turn in a job search log showing a minimum of six job contacts over two weeks.

Cooperation tasks should be:

- Something the participant can complete during their minimum disqualification period;
- Reasonable, considering local labor market conditions. For example, a branch or area could decide all disqualified participants must complete two weeks of job search or seek job search assistance with OED.
- For job quits, cooperation is considered met if the participant does any of the following:

  The participant:

  - Gets another job of similar wage or hours to the one they quit.
  - Gets work hours restored to more than 30 hours per week if they reduced their work hours
  - Complies with the task determined by the local branch.

Ending disqualifications:

- For ongoing cases, the participant is added back to the case the first of the month after they complete their minimum disqualification period and demonstrate cooperation.
- For cases that were closed because the certification period ended or due to the disqualification, the participant must show cooperation and serve the penalty period before becoming eligible for SNAP. Open the case on the filing date, the date the participant shows cooperation or the end of the disqualification period, whichever is later.
- The disqualification follows the individual if they change households. It should be added to their new case. If the individual leaves the filing group, the disqualification is removed from the case with the person.
- If a disqualified participant becomes exempt from work registration:
  - On an ongoing case, remove the disqualification. Leave the LV coding for history purposes. Add

the individual back to the case the first of the month after the change becomes known.

- On a closed case, the participant must reapply and can be SNAP eligible from the filing date.

Work registration status evaluation and status changes

An individual's work registration status (mandatory or exempt) is fully reviewed and determined at the following times:

- Certification
- Recertification
- Whenever a change is reported that changes the work registration status

  When an individual's work registration changes, ODHS|OHA updates the code in the Work Reg field of FSUP, sends any necessary forms and narrates the information.
- Change to mandatory work registrant: If an individual reports something during the certification period that makes them no longer exempt from work registration, ODHS|OHA informs them of their SNAP Employment and Training Program requirements by completing and providing form DHS 7280F within 10 days of receiving the information. ODHS|OHA also shares information about volunteering for STEP.
- Change to exempt work registrant: If an individual reports something that makes them exempt from work registration, SSP shares information about volunteering for STEP.

SNAP Employment and Training (E&T) programs

Oregon provides SNAP Employment and Training programs.

- STEP
- ABAWD

For more information, see below.

STEP (SNAP Training and Employment Program) (nationally called the SNAP 50/50 program)

The intent of the STEP program is for approved STEP providers to offer comprehensive E&T services to eligible SNAP participants to assist them in obtaining and maintaining living-wage employment.

Oregon currently has at least one STEP provider in every area offering a robust set of services and individualized support to SNAP participants who are interested in seeking additional education and employment training. Some STEP providers serve a targeted population such as homeless teens, veterans, individuals transitioning from dependency programs and individuals who are homeless or formally homeless.

In the STEP program, the providers will receive 50 percent federal cost reimbursement for approved employment-related services provided to SNAP recipients. In other words, for every dollar in allowable costs, the provider would receive .50 cents reimbursed. The most common funding sources are private donations, fundraising and private source grants that are not used for other state or federal program

funding purposes.

Because this is a SNAP E&T program, Oregon Department of Human Services (ODHS) retains oversight of this program to ensure services provided, budget/funding and program administration meet federal SNAP E&T guidelines. These contracts are currently managed by the Self-Sufficiency Program Central Office E&T team in coordination with the local ODHS districts. The E&T team also provides technical assistance and consulting to both provider agencies interested in SNAP E&T programs and current providers.

Who may participate in STEP activities?

Adult SNAP recipients 18 or older (16 and 17 years old if they are head of household) may participate in SNAP funded E&T activities. SNAP recipients currently receiving TANF funds are not eligible. In addition, in-patient drug treatment participants are ineligible.

What E&T services are available within STEP?

- Supervised job search training
- Supported job search
- Unpaid supported work experience (please note, SNAP cannot reimburse wages for participants but can for the managers/supervisors)
- Short-term vocational and educational training
- Job retention (for up to 90 days following SNAP case closure. Another E&T service is required to be received within 90-days prior to participating in Job retention).
- GED preparation (please note, over age 21 only. State and local school districts provide GED related services for students age 21 and under)
- Internship
- On-the-job training
- Pre-apprenticeship/apprenticeship programs
- Self-employment training
- English language acquisition (ELA) formerly known as ESL
- Integrated Education and Training/Bridge Program
- Work readiness training

To be considered a SNAP E&T participant, an individual must knowingly volunteer for the SNAP E&T program, and receive an orientation, assessment and a case plan by the provider. In addition, they must be placed in an approved and appropriate SNAP E&T component that the provider administers or purchases. Because the SNAP E&T participant is voluntarily in the STEP program, they cannot be disqualified for failing to complete the activities in their case plan.

Support service payments

Support service payments may be authorized by the STEP provider to cover the costs of the participant's transportation for program participation. This includes bus tickets, passes for other public transportation

or gas vouchers. Other costs directly related to participating in the STEP program or when obtaining or maintaining employment are also allowed. These things may include training fees, books, clothing, tools, etc.

Other resources

FFY20 STEP Provider Network: Provides matrix of STEP provider organizations, services offered, counties served, target audience, and website.

SNAP E&T Navigator Contact List: Contains list of Navigator contacts for SNAP E&T.

OFSET (Oregon Food Stamp Employment and Training) Program

The OFSET Program ended in all areas of Oregon on Sept. 30, 2019.

Referral process

Each ODHS|OHA area follows local procedures to refer participants to their local STEP providers.

Duties of local offices

- Determine and narrate if the participant is work registration exempt or mandatory.
- Explain to work registration mandatory participants what their responsibilities are (see Mandatory work registration) as a work registrant.
- Explain to participants their opportunity to obtain help through various STEP providers available in their area. The participant has the option to participate or not.
- Complete, review and give a copy of the SNAP Employment and Training Programs Rights and Responsibilities (DHS 7280F).
- Refer all participants who wish to volunteer to STEP.

Duties of the contractors

- Assess the participant, which includes a review of work history.
- Write a case plan.
- Refer the participant to in-house or outside work-related activities or appropriate community work-related training or seminar opportunities.
- Refer to possible job openings.
- Identify the need for support services and pay as agreed with the district.
- Provide ongoing case management services to the participant.
- Track participant participation and report to ODHS|OHA as agreed in the contract.

ABAWDs

ABAWD definition:

An able-bodied adult without dependents (ABAWD) is an individual who is age 18 through 49 and there

are no persons under age 18 in the SNAP filing group. ABAWDs can be work registrant exempt or work registrant mandatory depending on their circumstance. Individuals that are not ABAWDs include:

- Those age 50 and older
- Those age 17 and younger, and
- Those on a SNAP case with any child in the filing group (age 17 or younger).

SNAP time limit three-year clock

Federal law requires ABAWDs to fulfill special work-related activities. They are given three months during this three-year period when they do not need to perform certain work-related activities at 80 hours a month. The exception to this is if they meet one of the following:

- Live in a waived area
- Are pregnant, or
- Meet one of the mandatory or exempt work registration items listed below.

Areas in Oregon that are not waived are called "time limit" areas.

Note: The current list of waived areas can be found by going to the SNAP web page or reviewing OAR 461-135-0520.

Oregon's three-year SNAP time clock:

- Jan. 1, 2019, to Dec. 31, 2021.

Exemptions from the SNAP time limit

An individual that is an ABAWD is considered "exempt" from the SNAP time limit if one of the following circumstances applies to them:

- Lives in a waived area
- Pregnant (including pregnancy with no health complications) (Use Code 3)
- Meets one of the work registration exemptions identified above.
- Working a minimum of 30 hours a week for money or earning money from employment equal to or greater than the federal minimum wage ($7.25 as of July 2019 [7/24/2009]) x 30 hours a week x 4.3 weeks. (Code 4)
- Self-employment and earning money (after considering 50% if there are costs) equal to or greater than the federal minimum wage ($7.25 as of July 2019 [7/24/2009]) x 30 hours a week x 4.3 weeks. (Code 5)
- TANF recipients that are participating in a JOBS Plan. (Code 7)
- Participants who have applied for or are receiving unemployment compensation (UC) . (Code 9)

ABAWD work-related activities

All ABAWDs who do not meet one of the SNAP time limit exemptions stated above are given a choice to do one of the following:

- Choose to not fulfill the monthly ABAWD work-related activities and receive three months of SNAP benefits during the three-year SNAP time clock, or
- Choose to fulfill the monthly ABAWD work-related activities and be eligible to receive more than three months of SNAP during the three-year SNAP time clock.

The ABAWD is asked to participate in one or more of the following work components (these work components can be combined) to meet 80 hours a month averaged to 20 hours a week. The 80 hours must be completed in a calendar month for monthly work-related activities to be considered met.

- Paid or unpaid work (including employment, bartering or volunteering),
- Self-employed work, which is determined by gross income rather than hours worked (80 hours is equal to gross of $580 or more if no costs (SEN) and gross of $1160 or more with costs (SEC)), or
- Completing their assigned work-related activities contained within their case plan through Oregon Employment Department (OED).

OED also offers some ABAWDs the opportunity to gain work experience under the Workfare program. Workfare hours cannot be combined with the other work-related activities listed above. The hours under workfare are limited to the FLSA figure. ABAWDs who are placed in Workfare will be participating less than 80 hours a month. See Workfare below.

Verifying and tracking of the work-related activities is performed by both ODHS|OHA and OED. They each have separate and unique roles.

- ODHS|OHA offices verify and track work hours when an ABAWD reports working in paid or unpaid employment. ODHS|OHA offices verify the work hours in the same manner they verify earned income. Except during the middle of a certification period, it is recommended to use the DHS 7450 form because this form requests proof of work hours and does not request proof of income. Once reported and verified, the individual only needs to provide proof of work hours at certification, recertification or interim change report. They are asked to report a change in work hours in between only when the work hours drop below 20 hours a week. This report needs to be made within 10 days of occurrence to be timely.
- OED tracks the weekly non-work activities according to the case plan. They note these reported and verified hours on non-JOBS TRACS. ODHS|OHA uses non-JOBS TRACs to determine if each ABAWD who is not exempt from the SNAP time limit is meeting the required hours or if they earned a counting month.
- OED also provides support services to ABAWDs who are participating in the activities in their case plan.

Failure to meet the work requirements

When an ABAWD is not exempt from the SNAP time limit and chooses not to complete their 80 hours of work-related activities during a calendar month, they will earn one of their three counting months.

SNAP time limit good cause

The good cause criteria for the SNAP time limit is a little different from the good cause used for work

registration. Good cause may be granted when an ABAWD is attempting to complete the work-related activities in a month but cannot due to circumstances beyond their control. These circumstances are:

- Inclement weather
- Transportation difficulties
- Illness affecting the ability to work
- Tragic loss.

It is important to note that ABAWDs are a sub-group of the work registration group above. ABAWDs are asked to do all of the work registration activities in addition to the application of the SNAP time limit rules. This means an ABAWD who quit a job without good cause could receive an LV disqualification. However, they will not receive an LV disqualification and a counting month in the same calendar month.

ABAWD procedures

ODHS|OHA offices follow local procedures when referring participants to the ABAWD contractor.

Duties of local offices:

- Determine and narrate if the participant is work registration exempt or mandatory.
- Determine and narrate if the participant meets any exemptions from the SNAP time limit.
- Explain to work registration mandatory ABAWD participants what their responsibilities are (see Mandatory work registrants) as a work registrant.
- Explain to ABAWDs not exempt from the SNAP time limit that they have the choice of receiving SNAP without fulfilling the special ABAWD work-related activities for three months, or that they may choose to do the special work-related activities and not be limited to three months of SNAP during the three-year time clock.
- Complete, review and give a copy of the Simplify Reporting Systems for Able-Bodied Adults Without Dependents (ABAWD) (DHS 0854) and the SNAP Employment and Training Programs Rights and Responsibilities (DHS 7280F).
- Refer all ABAWDs living in a time limit area to OED if they are not exempt from the SNAP time limit and not completing the 80 hours by working in a paid or unpaid job. This is a formal referral; ODHS|OHA creates an appointment in iMatchSkills Scheduling tool and provides the participant with an appointment notice (date, time, address of appointment).
- Creates a non-JOBS TRACS plan
- Determine and narrate if the participant is work registration exempt or mandatory.
- Determine and narrate if the participant meets any exemptions from the SNAP time limit.
- Explain to work registration mandatory ABAWD participants what their responsibilities are (see Mandatory work registrants) as a work registrant.
- Explain to ABAWDs not exempt from the SNAP time limit that they have the choice of receiving SNAP without fulfilling the special ABAWD work-related activities for three months, or that they may choose to do the special work-related activities and not be limited to three months of SNAP during the three-year time clock.

- Complete, review and give a copy of the Simplify Reporting Systems for Able-Bodied Adults Without Dependents (ABAWD) (DHS 0854) and the SNAP Employment and Training Programs Rights and Responsibilities (DHS 7280F).
- Refer all ABAWDs living in a time limit area to OED if they are not exempt from the SNAP time limit and not completing the 80 hours by working in a paid or unpaid job. This is a formal referral; ODHS|OHA creates an appointment in iMatchSkills Scheduling tool and provides the participant with an appointment notice (date, time, address of appointment).
- Creates a non-JOBS TRACS plan
  - PE step if meeting no activity hours on their own
  - BF step if working in a paid or unpaid job 80 hours a month (no referral to contractor)
  - PE and BF step if working but less than 80 hours a month and still need a referral to contractor to fulfill the monthly requirement.
- Review the non-JOBS TRACS plan monthly of all ABAWDs not exempt from the SNAP time limit to determine if the individual is performing the assigned work-related activities. The names of these ABAWDs will appear on the monthly ABAWD list in the BI Center (SNAP 2059).
- Also, review each month the list of persons turning 18 next month (SNAP 2060). All persons in these SNAP households are becoming ABAWDs in a month. Determine if they are exempt from the SNAP time limit and, if not, refer to Oregon Employment Department so they may begin to participate in the work-related activities.
- Apply and lift countable months, as appropriate, and send proper notice.
- Duties of the contractors:
  - Assess the participant, which includes a review of work history.
  - Write an ABAWD non-JOBS case plan.
  - Refer the ABAWD to in-house or outside work-related activities.
  - Refer to appropriate community work-related training or seminar opportunities.
  - Refer to possible job openings.
  - Identify the need for support services and pay as agreed with the district.
  - Provide ongoing case management services to the ABAWD.
  - Track participant participation and report to ODHS|OHA each month.

Countable months and regaining eligibility

A countable month is earned when an ABAWD receives a full month of SNAP benefits while not performing the work-related activities identified on their case plan for the month. Federal law limits ABAWDs to no more than three months of SNAP in a three-year period, except when the ABAWD is exempt from the SNAP time limit or if the ABAWD is performing the approved work-related activities.

A counting month is never assigned when, during any part of the month, any of the following were true:

- The SNAP allotment was prorated.

- The SNAP allotment was $0.
- The participant resided in a waived area.
- A child (under age 18) joined the SNAP filing group.
- The participant turned 50 years of age.
- The participant was exempt from the SNAP time limit (see Exemptions from the SNAP time limit)

The participant's TRACS non-JOBS case plan is checked monthly by ODHS|OHA to see if the participant is fulfilling the required number of hours in their work activities. If they are not, their SNAP case is coded with a countable (CT) month. When a counting month (CT) is given, the ABAWD has 90 days following the last day of the CT month to show they met the work-related activities for that month, to explain why they believe they were exempt from the SNAP time limit, or believe they meet the circumstances for ABAWD good cause.

Countable months cross state lines. This means a countable month may be assigned in another state and count in Oregon as long as the counting month was earned in the other state during the current Oregon three-year time clock. States choose how their three-year clock falls, and they are often different from one another.

The first set of counting months

The first three counting months (CT1, CT2, CT3) in the three-year time clock are known as the first set of countable months. The first set of countable months do not need to be consecutive.

- The first countable month is coded as CT1 on FSMIS and the SNAP Time Limit screen found on the participant information (FIND) screen. Send NOTM FSWCT1i.
- The second countable month is coded by replacing CT1 with CT2 on FSMIS and entering it in the SNAP time limit screen found on the participant information (FIND) screen. Send NOTM FSWCT1i.
- The third countable month is coded by replacing CT2 with CT3 on FSMIS and entering it in the SNAP time limit screen found on the participant information (FIND) screen. Send NOTM FSWCT1i.

Following receipt of CT3, the SNAP case is usually closed or reduced. To continue benefits after CT3, the ABAWD needs to be meeting the required number of work-related activities or have a circumstance that makes them exempt from the SNAP time limit. If they do not meet any of these situations, they are disqualified for exceeding the SNAP time limit. The notice for exceeding the SNAP time limit at the CT3 level is FSWCT3C (to close) or FSWCT3R (to reduce).

Regaining SNAP eligibility and the second set of counting months

After becoming ineligible for food benefits due to exceeding the SNAP time limit, an ABAWD can regain eligibility during the 36-month time period. There is no limit to the number of times an ABAWD can regain eligibility. Regaining can occur anytime the ABAWD exhausts the first set of the three-month counting months (CT1, CT2, CT3) or the second set of counting months (CT4, CT5, CT6).

An ABAWD who has received counting month 3, their benefits ended and they regained eligibility may qualify for another set of three counting months (a bonus). Under no circumstances can the second set of countable months immediately follow the CT3 month. An ABAWD must first lose eligibility and then regain

eligibility.

Regaining can occur only after an ABAWD becomes ineligible due to the SNAP time limit and their benefits end. They cannot regain eligibility while their benefits remain open. They may regain eligibility anytime they become exempt from the SNAP time limit, or by performing one of the required work-related activities:

- Working 80 hours in a 30-consecutive day period after their SNAP benefits ended, or
- Completed the work-related activities required in the case plan with OED over a 30-day period after the SNAP filing date. Generally, this is 80 hours of work-related activities but could also be workfare participation.

The second set is identified as CT4, CT5 and CT6. These counting months must be consecutive. Months CT5 and CT6 follow CT4 even if the ABAWD becomes ineligible for another reason, and their benefits end for another reason. In other words, the clock ticks for the months of CT5 and CT6 even if the ABAWD receives no SNAP benefits, was working or met an exemption from the SNAP time limit. CT5 and CT6 can only be lifted or removed if CT4 is lifted. As with CT1, CT2 and CT3, there are special notices in NOTM to inform the ABAWD they are receiving CT4, CT5 and CT6. This is NOTM FSWCT4i. At the end of CT6, they should receive a timely notice announcing the closure or reduction of their benefits due to the SNAP time limit (FSWCT4C to close and FSWCT4R to reduce).

In some instances, an ABAWD may reapply after they have exhausted their countable months, and they do not complete the regain activities in a 30-consecutive day period. The Notice Writer FSW0ABD should be used to issue the denial regarding having exceeded the SNAP time limit.

ABAWD status evaluation and status changes

Small changes in an individual's life can create large changes in their ABAWD status or SNAP time limit requirements.

During certification and recertification time, ODHS|OHA conducts a full review of the applicant's ABAWD status and SNAP time limit exemptions. When processing the Interim Change Report and during ongoing months, ODHS|OHA only acts on information that is volunteered or found during its required course of business (e.g., when checking IEVS screens during the processing of an ICR).

Minor moving into the filing group

When a minor moves into the SNAP filing group, there are no longer any ABAWDs in the SNAP filing group.

- ODHS|OHA leaves any CTs coded for the current SNAP time clock. They must remain until the new time clock begins.
- If any ABAWDs are not receiving SNAP on the case due to a SNAP time limit disqualification, ODHS|OHA asks if they would like SNAP for that individual and restores them to the case effective the first of the following month.

Moving to a waived area

When a filing group containing ABAWDs moves to a waived area, there are no longer SNAP time limits for that group based on fulfilling work-related activities.

- ODHS|OHA leaves any CTs coded for the current SNAP time clock. They must remain until the new time clock begins.
- If any ABAWDs are not receiving SNAP on the case due to a SNAP time limit disqualification, ODHS|OHA asks if they would like SNAP for that individual and restores them to the case effective the first of the following month.

Reporting exemptions from the SNAP time limit

When an ABAWD reports a change in circumstance that qualifies as an exemption from the SNAP time limit, there is no longer a need for that individual to fulfill the work-related activities for the SNAP time limit.

- ODHS|OHA reminds the individual they may continue to work with a STEP in pursuing their training or career goals.
- ODHS|OHA leaves any CTs coded for the current SNAP time clock. They must remain until the new time clock begins.
- ODHS|OHA updates any coding, especially work registrant coding, to match the new circumstance.
- If that individual ABAWD is not receiving SNAP on the case due to a SNAP time limit disqualification, ODHS|OHA asks if they would like SNAP and restores them to the case effective the first of the following month.

Moving into a SNAP time limit area, youngest child turns 18, SNAP TL exemption ends, all minors move out of the filing group

When an individual has no exemption from the SNAP time limit due to a change, ODHS|OHA uses the following evaluation process:

Make a courtesy contact to screen individuals for exemption from the SNAP time limit.

- If exemption is found, Work Reg code is updated and narrated.
  - Any retroactive CT months remain coded on this person on the FSUP and SNAP TL screens.
- If exemption is not found (including not being able to reach the individual), based on the information known and reported to ODHS:
  - Step 1: If reached the ABAWD, discuss the SNAP time limit, its exemptions and, if not exempt, the choice to use three counting months or to do the work-related activities.
  - Step 2: Work Reg code updated to a C.
  - Step 3: Code any retroactive CT months on FSUP and SNAP TL screens and NOTM FSWCT1I is sent (if applies).
  - Step 4: Create the appropriate non-JOBS case plan in TRACS.
  - Step 5: The OED referral is completed in iMatchSkills Scheduling tool (with workfare hours per FLSA).

- Step 6: Mail the forms 7280F, 0854, and OED appointment notice with the ODHS 0210ABW informing the ABAWD you have attempted to reach them.
- Step 7: The above is narrated.

Verifying countable ABAWD months

If the individual indicates they received SNAP benefits in another state Jan. 1, 2019, or later, ask them questions regarding their status in that state. Include questions on whether or not they were an ABAWD in that state; were they told about the SNAP time limit; were they required to do work-related activities of 20 hours a week; did they receive any counting months for not doing those activities and, if yes, what months? You must make at least two attempts to contact the other state and verify if the individual received any countable months after Jan. 1, 2016, or later. Please narrate each of the attempts and the results of the call. It is important to note this activity for ABAWDs is required statewide in both waived counties and time limit counties.

- If the ABAWD resides in an area applying the time limits (SNAP-e.19), inform them of the need for verification if they used counting months in that state on the pending notice (DHS 0210). Do this in addition to making the two attempts to verify the information.
- If the individual tells you they tried and could not obtain the information and you could not obtain the verification after two attempts, make a reasonable determination based on their answers to the questions about ABAWD in the other state.
- If the individual does not respond with the needed information or does not tell you they attempted to obtain the information but could not get it and you were unsuccessful after two attempts, deny the application at the end of the application process for failure to provide the requested information.
- If the ABAWD resides in any of the other counties in Oregon, inform them of the need for verification if they used counting months in that state on the pending notice, Notice of information or verification needed for an Able-Bodied Adult Without Dependents (DHS 0210ABW). The DHS 0210ABW is a special pending notice that does not end in denial or case closure if the individual fails to provide the requested information. Do this, in addition to your making the two attempts to verify the information. Whether or not the individual tells you they tried and could not obtain the information, and you could not obtain the verification after two attempts, make a reasonable determination based on their answers to the questions about ABAWD in the other state.
- Enter any of the out-of-state ABAWD countable months on to the SNAP FSUP screen, TRACS and the SNAP time limit screen found on the individual information (FIND) screen (CT1, CT2, CT3, CT4, CT5 or CT6). Narrate whom you contacted and the month in which the ABAWD earned the countable month. Counting months received in another state count toward the three-year clock in Oregon if received during Oregon's current time clock.

Helpful tips

In the rare circumstance when you are unable to verify ABAWD countable months from the other state after you have made two attempts to validate countable months:

ABAWD interview questions:

- Were you an ABAWD in your previous state?
- Did you have to do any work-related activities as part of receiving food benefits?
- Did you ever lose food benefits due to not complying with a work program or activity?
- If no to the questions above, accept the individual's statement, narrate your contact attempts, and certify the case if they are otherwise eligible.
- If yes to any of the above questions, a pending notice can be issued to the applicant (after you have attempted to validate the countable months yourself) in order to have them provide something showing what countable months they may have earned from the other state. For expedited cases only, follow the verification requirements for expedited service. (Under expedited service, individual statements and limited verification are used to determine eligibility for SNAP for a short period of time. All verification except identity may be postponed until later.)
- When an ABAWD reapplies for benefits, ODHS|OHA will need to determine if the individual is still an ABAWD and, if so, if the ABAWD meet one of the exemptions:
- If not, determine if the participant worked at all since they last received food benefits.
- If yes, was it for 80 hours in a 30-day period? If so, request verification from the individual of the work hours using a Notice of Pending Status (DHS 0210).
- If the mandatory ABAWD has not worked 80 hours in a 30-day period since last receiving SNAP benefits, refer the ABAWD to the contractor. They must complete 80 hours of work-related activities in a 30-day period to regain eligibility. ODHS|OHA may need to extend the application processing period beyond 30 days if there is not enough time remaining in the application process to allow for the ABAWD to complete the 80 hours.
- If requested verification is not received within 30 days or the individual does not meet an exemption or has not worked 80 hours in a 30-day period, the SNAP request is denied.
- If the requested verification is received and the ABAWD has proven to be eligible for program participation within the pending period, benefits must be prorated back to the filing date.
- For ongoing cases, add the ABAWD to the case effective the first of the following month.
- An ABAWD individual who regains eligibility but is no longer fulfilling the work-related activities can receive three additional months of benefits during the 36-month time period. The additional three-month period is called the "second set" and must be consecutive. This second set is coded as CT4, CT5 and CT6, and ABAWDs can only take advantage of this provision once during the 36-month period. Once the second set of countable months have been used, an ABAWD will need to meet the ABAWD work-related activities or an ABAWD exemption to receive food benefits for any of the remaining 36 months.

Click here for Work registrant, STEP Program, and ABAWD.

TANF This does not apply to the TANF program.

ERDC This does not apply to the ERDC program.

REF This does not apply to the REF or REFM programs.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Oregon Administrative Rule(s)

461-130-0305 — General Provisions; Employment Programs
461-130-0310 — Participation Classifications; Exempt, Mandatory, and Volunteer
461-130-0315 — Requirements for Mandatory Employment Program Individuals; Pre-TANF, REF, SNAP, TANF
461-130-0327 — Good Cause
461-130-0330 — Disqualifications; Pre-TANF, REF, SNAP TANF
461-130-0335 — Removing Disqualifications and Effect on Benefits
461-135-0520 — Time Limit and Special Requirements for ABAWD; SNAP
461-135-0521 — Job Quit by Applicants; SNAP

Other resources

Able-Bodied Adults Without Dependents (ABAWD) Process: This process walks Eligibility Workers, and Leadership through ABAWD referrals and working monthly lists.

ABAWD Adding a Month *includes screenshots: ABAWD Month Tracker overview for tracking countable months in which the individual received a full month of benefits while not fulfilling the ABAWD work requirements

Work Registration and ABAWD Exemptions in ONE: Gives comprehensive breakdown of Work Registration and ABAWD Exemptions in ONE, including pregnancy, unemployment, and addiction treatment.

Changing ABAWD Month Status *includes screenshots: Updating past ABAWD month entry from non-exempt to exempt status based on new information (e.g. pregnancy beginning in January reported in month of March--countable months in January and February changed from non-exempt to exempt status)

TANF time limits

This specifically applies to the TANF program.

SNAP This does not apply to the SNAP program.

TANF What is the Oregon TANF time limit?

Under federal and state law, most adults and minor parent heads-of-households can receive TANF cash assistance for a total of 60 months (five years). TANF cash assistance is intended to be a temporary means of support while families work toward self-sufficiency.

In Oregon, the 60-month time limit began on July 1, 2003, and is applied based on state law.

Participants who meet one of the hardship extension criteria but have used their 60 months may be eligible for additional months. If the participant does not meet one of the hardship extension criteria but is in the JOBS Plus program or has an extreme need in their 60th month, they may be granted a temporary continuation of benefits.

Reminder:

- Eligibility decisions for ongoing or recertifying TANF in Oregon are only based on time that counts against the Oregon time limit.
- Eligibility decisions for participants who are applying in Oregon after receiving TANF in another state are based on federally accrued months, federal time clock.

To whom do time limits apply?

The following people are subject to TANF time limits:

- A minor parent head of household
- Adult single parents
- Both adults in a two-parent family
- Needy caretaker relatives
- Participants who reached the 60-month TANF time limit in another state and do not currently qualify for an Oregon hardship extension.

Some states count months when there is a child-only case. Oregon does not and information about child-only cases should not be shared with another state or added to our system.

Time limits do not apply to:

- Children
- Non-needy caretaker relatives
- SSI parents
- Ineligible non-citizens

Dates	Did time count for those receiving Oregon TANF?	If yes, who receiving Oregon TANF did it count for?	Does out of-state or tribal TANF count from that time toward the Oregon time limit?
08/01/96—06/30/03	No		No
07/01/03—09/30/07	Yes	Only participants serving a JOBS disqualification	Yes, unless they lived in Indian Country

10/01/07—06/30/08	Yes	All adults and minor parent head-of-households receiving TANF except those who: • Qualified for an exemption • Lived in Indian Country • Were part of a two-parent family where deprivation was based off unemployment or underemployment, or • Participated in JOBS Plus, Pre-TANF, Post-TANF, SFPSS, Degree Completion Initiative	Yes, unless they lived in Indian Country
07/01/08—04/30/12	No		Yes, unless they lived in Indian Country
05/01/12—03/31/16	Yes	All adults and minor parent head-of-households except those who: • Qualified for an exemption	Yes, unless they lived in Indian Country
04/01/16—Present	Yes	All adults and minor parent head-of-households except those who: • Live in Indian Country; • Receive *Employment Payments*; or • Participate in JOBS Plus (PL), Pre-TANF, SFPSS (SS) or Parents as Scholars (PS).	Yes, unless they lived in Indian Country

What is Indian Country?

"Indian Country" is a federally defined term that pertains to either specific communities defined by 18 USC 1151 or counties defined by the state and specific to tribal membership.

To be exempt from time limits due to Indian Country, the participant must:

- Live on an Indian reservation, live in a dependent Indian community or live on a tribal allotment, or

- Be an enrolled, verified member of one of Oregon's nine federally recognized tribes.

Oregon's nine federally recognized tribes are:

- Burns Paiute Tribe
- Confederated Tribes of the Coos, Lower Umpqua and Siuslaw Indians
- Confederated Tribes of the Grand Ronde Community of Oregon
- Confederated Tribes of the Siletz Indians
- Confederated Tribes of the Umatilla Indian Reservation
- Confederated Tribes of Warm Springs
- Coquille Indian Tribe
- Cow Creek Band of the Umpqua Tribe of Indians, and
- Klamath Tribes.

ODHS|OHA receives population and employment data from the Oregon Employment Department in late spring of each year and uses this to determine the economic criteria for the Indian Country designation for the following federal fiscal years of Oct. 1 to Sept. 30.

When a participant lives in a county deemed Indian Country and is a verified member of one of Oregon's nine federally recognized tribes, no months will count, even if the participant's case was coded with a TLY.

What counties are designated as Indian Country?

Year	County or counties
FFY 2017 (October—September)	Coos, Crook, Curry, Douglas, Josephine, Lincoln
FFY 2016 (October—September)	Coos, Crook, Curry, Douglas, Josephine, Klamath, Lincoln
FFY 2015 (October—September)	Coos, Crook, Curry, Douglas, Josephine, Klamath, Lincoln
2014 (January—September)	Coos, Crook, Curry, Douglas, Josephine, Klamath, Lincoln
2013 (January—December)	Coos, Crook, Curry, Douglas, Harney, Jefferson, Josephine, Klamath
2012 (January—December)	Coos, Crook, Curry, Douglas, Josephine
2011 (January—December)	Coos, Crook, Curry, Douglas, Jefferson, Josephine
2010 (January—December)	Coos, Crook, Curry, Douglas, Harney, Jefferson, Josephine
2009 (January—December)	Coos, Crook, Curry, Douglas, Harney, Jefferson, Josephine
2008 (January—December)	Crook, Curry, Josephine
2007 (January—December)	Crook, Josephine
2006 (January—December)	Crook, Josephine

2005 (January—December)	Crook, Curry, Josephine
2004 (January—December)	Curry, Josephine
2003 (January—December)	Coos, Curry, Josephine

Beginning in federal fiscal year (FFY) 2015, Indian Country designations are determined in the summer of each year and are effective for the following federal fiscal year of Oct. 1 to Sept. 30: for example, in June 2016, the 2015 data will be received and will be used to determine the designation for FFY 2017 Oct. 1, 2016, through Sept. 30, 2017. Prior years were determined retrospectively and for a calendar year.

What is an exemption?

Exemptions are reasons that allow a month of TANF to be excluded from the time limit clock.

Prior to April 1, 2016, for a participant to be granted an exemption, they must have been unable to obtain or maintain employment for one of the following reasons:

- (TLA) Has a verified alcohol and drug treatment plan**
- (TLB) Is subjected to battery or extreme cruelty
- (TLC) Has a child with a disability, which prevents the parent from obtaining or keeping employment**
- (TLD) Is a victim of domestic violence (see OAR 461-001-0000)
- (TLE) Is participating in the Parents as Scholars (PAS) activity (see OAR 461-001-0025)
- (TLL) Has a certified learning disability**
- (TLM) Has a mental health condition**
- (TLN) Is caring for a family member who has a disability, is in the home and is not attending school full-time**
- (TLS) Has a disability (see OAR 461-001-0000)** or
- (TLX) Is deprived of needed medical care.

Note: Exemptions coded with ** must have been verified by a licensed or certified professional qualified to determine the condition or circumstances. An exemption was not able to be coded until verification is received.

Hardship extension criteria coded with a (*) must be staffed with a TANF policy analyst; hardship extension criteria coded with (**) must be verified by a licensed or certified professional qualified to determine the condition or circumstances. A hardship extension cannot be coded until verification is received.

Occasionally, there are times when an exemption has been coded in error. When this occurs, workers should:

- Email the TANF Policy box with the recipient's name, Social Security number and reason the exemption coding should be changed,
- Narrate the correct time limit exemption coding, including when the time limit was in place and, if

required, how the exemption was verified, and

- Determine eligibility decisions off the correct time limit.

What is a time limit hardship criteria extension?

Hardship extension criteria are situations that allow an adult or teen parent head-of- household to receive additional months once they have already accrued 60 months. The hardship extension may be granted at any point after 60 months, even if the participant has already been removed from the grant.

For the participant to be granted a hardship extension, they must be unable to obtain or maintain employment that provides earnings in excess of TANF income limits for one of the following reasons::

- (TLA) Has a verified alcohol and drug treatment plan**
- (TLB) Is subjected to battery or extreme cruelty*
- (TLC) Has a child with a disability, which prevents the parent from obtaining or keeping employment**
- (TLD) Is a victim of domestic violence (see OAR 461-001-0000)
- (TLL) Has a certified learning disability**
- (TLM) Has a mental health condition**
- (TLS) Has a disability (see OAR 461-001-0000)** or
- (TLX) Is deprived of needed medical care.*

Note:

Hardship extension criteria coded with a (*) must be staffed with a TANF policy analyst. Hardship extension criteria coded with (**) must be verified by a licensed or certified professional qualified to determine the condition or circumstances. Documentation must include a diagnosis and prognosis. A hardship extension cannot be coded until verification is received.

Although JOBS participation exemptions are different than time-limit hardship extensions, many participants who are exempt from JOBS participation may also meet a hardship extension criterion. Cases that are JOBS exempt for possible time limit hardship extensions should be reviewed.

Temporary continuation of benefits

If, during the 60th month, the participant is either actively engaged in a JOBS Plus activity or experiences an extreme need, the participant may be considered for a temporary continuation of their benefits. This is different from meeting hardship extension criteria because it may only be considered in the 60th month, where a hardship extension can be granted at any point past the 60th month.

These temporary continuations of benefits must be staffed with a TANF policy analyst and the TLF can only be coded by someone in Central Office.

The temporary continuation of benefit need/resource codes are:

- (TLF) Family crisis

- (TLP) JOBS Plus completion.

The TLF code is appropriate for participants who experience a crisis outside of their control during the 60th month. These situations include but are not limited to a death in the immediate family, natural disaster affecting the family or medical catastrophe affecting the family.

The TLP code is appropriate for participants who are actively engaged in a JOBS Plus activity, already having been placed on a JOBS Plus site and have an active agreement. The participant must be a TANF recipient to be in a JOBS Plus activity and the intent with this temporary continuation was to ensure that, if a participant enters a JOBS Plus agreement, they are allowed to complete the subsidized work experience.

48-month notice and assessment

TANF participants will receive an auto-generated notice. "Time Limit Update – 12 months remaining," when an adult or minor parent head of household on a TANF case reaches 48 months on the state time limit. It will not be sent to participants at 48 months who live in Indian Country because they are not currently accruing additional months.

This notice, the CM07G, will be a mid-month notice that informs the participant:

- DHS wants to partner with them to engage them in services leading to employment or other self-reliant alternatives prior to them using the remainder of their 60-month lifetime limit.
- If they reach 60 months and are not eligible for hardship extension, their TANF grant will be lowered or closed.
- Children of adults who reach 60 months on TANF may still be eligible for TANF.
- They should expect contact from their worker.

48-month time limit assessment

Participants who receive the CM07G should be scheduled for a 48-month time limit assessment that will specifically address their remaining time on TANF.

A specific appointment notice, 12 Months Remaining on Temporary Assistance for Needy Families (TANF) Appointment (DHS 7827), has been created for these appointments. It is available on the Forms Server.

When the participant comes in for their assessment, ODHS|OHA will address and narrate:

- Strengths and goals to help the family move off TANF
- Available supports from family, friends and the community
- Any necessary screenings
- Potential referrals to both internal and external programs including the State Family Pre-SSI/SSDI (SFPSS) Program and Family Support and Connections (FS&C).

When creating a JOBS plan, ODHS|OHA prioritizes these participants for available JOBS program activities.

JOBS participation after reaching 60 months

When a participant reaches 60 months on TANF, the minor parent head of household or adults must cooperate with their case plan (if not otherwise JOBS-exempt), regardless of whether they are included on the TANF grant.

Participants who have been granted a hardship extension should have a plan to reflect the hardship criteria. Participants who have been removed from the grant but remain JOBS-eligible should be given the opportunity to develop a plan that will encourage their progress and move them toward stability.

Participants who meet the JOBS exemption criteria are not eligible to participate in case plan activities.

Participants who are not cooperating with the requirements of their case plan are subject to disqualification only after the participant has had an opportunity to participate in the re-engagement process that includes a determination by ODHS|OHA of whether good cause exists.

Any disqualifications remain in place that have accrued for the benefit group members prior to the 60-month limit.

Coding requirements for participants who have reached 60 months

If any adult or minor parent head of household is no longer eligible to receive TANF due to having reached 60 months of time and meets no hardship extension criteria, the following coding changes are to be made:

- Add a TRJ C/D
- Change the in-grant code to 'NO.'

If any adult or minor parent head of household has reached 60-months but continues to be eligible because they meet a hardship extension criterion, the following coding changes are to be made:

- Add a TRH case descriptor.
- A TL hardship extension N/R code is required with an end date to match either the provided documentation or review date, whichever is sooner.
- A TLY N/R code is also required with an end date to match the review date

  and
- Keep the in-grant code as an "AD."

Verifying TANF months

When a participant indicates on the application, they received TANF benefits in another state(s) or from a tribal program, ODHS|OHA must verify how many months the participant received TANF in the other state(s) or program.

If verification is needed, ODHS|OHA will do the following things:

- Pend the adult's benefits for 30 days and open a case for the children if all other TANF eligibility requirements are met, and

- Attempt to verify the out-of-state or tribal time by contacting the other state or tribe.

If verification of time on TANF from another state is not received within the 30-day- application period, the adult's application will be denied for failure to complete the application process; they will be coded as a "NO," and the case will remain open for the children, so long as they remain otherwise eligible. Even when the adult is a "NO," the JOBS status and case plan still need to be considered.

When verification is received within the 45-day application time frame:

- If the adult has less than 60 months on TANF: TANF will be supplemented back to the filing date.
- If over 60 months: The adult's needs would not be added to the grant unless the participant meets a hardship extension criterion. The children would continue to receive benefits as long as all other TANF eligibility requirements were met.

Out-of-state months, once verified, must be added to the "Out-of-State Time Limits" screen.

If verification from the other state identifies months in Indian Country or months a program was not federally funded, those months do not count toward the federal or Oregon time limit.

ERDC This does not apply to the ERDC program.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Click here for examples: TANF time limits.

Oregon Administrative Rule(s)

461-135-0071 — TANF Time Limit; General Provisions
461-135-0073 — TANF Time Limit; Extension Criteria
461-135-0075 — TANF Time Limit; Exemptions

Other resources

TANF Hardship *includes screenshots: Describes the TANF Hardship Request process and policy for different hardship types. Provides steps for how to create the request.

TANF Time Limit QRG: Managing TANF Time Clock. Explains that most adults and minor parent head of households cannot receive more than 60 months of TANF benefits, unless a hardship exists. There is a federal time clock and a state time clock.

Out-of-state benefits

Programs can receive all or part of their funding from the federal government. However, each state can choose

different options that shape how they administer programs. This flexibility allows states to decide how to best meet the needs of their residents. Eligibility and benefits don't cross or transfer when someone moves to another state and they must reapply in the state where they are residing. When an applicant reports moving from another state, it is important to ask if they have an open case or have received benefits in a state other than Oregon. The following can be indicators that additional information or an in-depth conversation is needed:

- ID or driver's license is presented from another state
- IEVS screens, including The Work Number, display work history for an out-of-state employer
- The application reports that benefits were received in another state.
- A child in the household was born in another state.

Click here for Out-of-state verification.

SNAP When determining eligibility for SNAP benefits for an applicant who has moved to Oregon or has provided out-of-state ID, ODHS|OHA will ask the following questions to determine eligibility:

- What brought you to Oregon?
- How long have you lived in Oregon?
- Can you tell me about any assistance you received in other states you have lived?
- SNAP benefits are not transferred between states. Is there another state I can contact to help you close an open case?
- Were you required to participate in a work search program or work 20 hours per week in another state? If so, did you have any countable months? Did you receive SNAP in another state since Jan. 1, 2019?

Pending for verification

- ODHS|OHA is required to make two attempts to contact the other state to verify benefits. Click here for a complete list of the states with preferred contact method. One of the attempts must be made using the preferred method chosen by the state.
- The case is not pended until after all attempts have been unsuccessful and the applicant has reported open benefits in another state. In this situation, a pending notice would be issued to the applicant to provide proof the case has been closed. If the individual reports no open benefits in another state, ODHS|OHA will narrate the two attempts and continue with the eligibility determination.

Situation/ circumstance	Expedited application	Non-expedited application
Out-of-state verification	• Certify case for following expedited processing policy; case is certified longer once verification is received.	• Follow policy for approving application.

Out-of-state ID	• Ask when they moved to Oregon. • If open in another state, must have verification before opening. • If no open benefits, please follow verification policy.	• If open in another state, must verify case has closed in other state. • If reporting no open benefits in another state, make two attempts to confirm before opening. Narrate both attempts!
Moved in last six months	• Ask when they moved to Oregon.	• If not open out of state, make two attempts to verify they closed before opening and add case note. • If an open case out of state, verify it has closed before opening.
Living in Oregon longer than six months and previously received benefits in another state	• Do not verify out-of-state benefits.	• Do not verify out-of-state benefits.

California SSI recipients

As of June 1, 2019, California is no longer including SNAP benefits in SSI payments. Individuals can now apply for SNAP and potentially be eligible for benefits.

In California, each county is responsible for administering the SNAP program. Because Social Security is no longer automatically including SNAP benefits as part of SSI payments, ODHS|OHA will need to verify with the local county SNAP office that there are no open SNAP benefits.

When an applicant reports either open or closed benefits in California:

- Ask clarifying questions about what California county they received benefits in.
- Contact the California county office to verify SNAP benefits have closed before approving in Oregon.
- Narrate who was contacted and how closure was verified (phone, email, etc.).

When an applicant reports no open benefits:

- Make two valid attempts to contact California. Do not forget to narrate each attempt.
- After two valid attempts are completed and narrated, continue with eligibility determination.

Verifying countable out-of-state ABAWD months

The SNAP time limits are applied across state lines. If the ABAWD presents an out-of-state ID or indicates they moved to Oregon Jan. 1, 2019, or later, ODHS|OHA must contact the other state to verify ABAWD

countable months. As of Jan. 1, 2019, all SNAP offices statewide (including time-limit-exempt areas) must check for countable months received in another state whenever an ABAWD applies for SNAP in their office. If countable months were received in the other state, the latest CT received must be coded on FCAS and all the CTs received must be coded in the WEBM FIND SNAP Time Limits screen.

Oregon is on a fixed clock and will not count months used in another state prior to Jan. 1, 2019.

TANF

Verifying out-of-state benefits is only a requirement if ODHS|OHA has reason to believe an individual currently has open benefits outside of Oregon. Reasons it may be appropriate to verify out-of-state benefits include, but are not limited to:

- Applicant presents an out-of-state ID or license, or
- Applicant marks on the application for benefits that they received benefits or resided previously in another state.

Time limits must be verified if an applicant indicates on the application or during the interview, or it is discovered through a review of the case file that they have received benefits in another state.

Verifying time on TANF from another state

When an individual indicates on the application that they received TANF benefits in another state(s) or from a tribal program, ODHS|OHA must verify how many months the individual received TANF in the other state(s) or program.

If verification is needed, ODHS|OHA will do the following things.

- Pend the adult's benefits for 30 days and open the case for the children, if all other TANF eligibility requirements have been met, and
- Attempt to verify the out-of-state time by contacting the other state. If the other state does not respond or provide this information, the individual is responsible for verifying they have not received out-of-state benefits.

If verification for TANF time from another state or tribe is not received within the 30-day application period, the application is denied for the adult for failure to complete the application process. The case will remain open for the children.

When verification is received within the 30-day application time frame:

- If the adult has **less than 60 months** on TANF, the adult is added and TANF is supplemented back to the filing date.
- If the adult has **more than 60 months**, the adult's needs would not be added to the grant unless the individual meets one of the hardship extension criteria. The children can continue to receive benefits as long as all other TANF eligibility requirements were met.
- If the adult has more than 60 months and meets one of the hardship extension criteria, the adult is added and TANF is supplemented back to the filing date.

Once out-of-state months have been received, they must be added to the Out-of-State Time Limits screen.

ERDC A family can receive child care benefits in Oregon even though they may have an open case in another state. This is because ERDC benefits are paid to the provider based on the date they started caring for the child here in Oregon.

REF This does not apply to the REF program.

MSP Benefits received from another state are considered concurrent benefits and are addressed in Concurrent and other benefits.

Payment of benefits out of state

Send benefits out of state if individuals are absent from Oregon and they establish their intent to return within 60 days. If individuals are detained out of state beyond 60 days for medical reasons, determine continued eligibility and require the individual to provide documentation of the need to remain in the other state.

Out-of-state medical expenditures must have prior authorization. Refer out-of-state medical providers to DMAP for approval and copies of Oregon's fee schedule so they can accurately bill for medical services provided to the individual.

Advise people receiving medical assistance who are temporarily leaving Oregon that they will receive only emergency medical coverage while they are out of state. If the participant needs specific information, contact the "out-of-state" coordinator at DMAP.

OSIPM Benefits received from another state are considered concurrent benefits and are addressed in Concurrent and other benefits.

Payment of benefits out of state

Send benefits out of state if individuals are absent from Oregon and they establish their intent to return within 60 days. If individuals are detained out of state beyond 60 days for medical reasons, determine continued eligibility and require the individual to provide documentation of the need to remain in the other state.

Out-of-state medical expenditures must have prior authorization. Refer out-of-state medical providers to DMAP for approval and copies of Oregon's fee schedule so they can accurately bill for medical services provided to the individual.

Advise people receiving medical assistance who are temporarily leaving Oregon that they will receive only emergency medical coverage while they are out of state. If the participant needs specific information, contact the "out-of-state" coordinator at DMAP.

Individuals who are enrolled with a CCO should contact their respective plan offices for information and/or authorization for out-of-state medical coverage.

HSD An individual is not eligible for Medicaid or CHIP in Oregon if they are receiving these benefits in another state. Their benefits will need to be closed in that state prior to being opened in Oregon. Individuals who have an urgent need and whose provider has refused to bill the other state may have their benefits

opened in Oregon prior to closure in the other state. Be sure to enter a case note about why medical is being opened in Oregon prior to the close date in the other state.

Click here for examples: Out-of-state benefits.

Oregon Administrative Rule(s)

461-165-0130 — Payment of Benefit Out of State; MSP, OSIPM
461-115-0610 — Verification; General
461-115-0651 — Required Verification and When to Verify; SNAP

SSI discontinuance

This applies specifically to OSIPM.

OSIPM: Individuals who no longer receive SSI payments may be eligible for certain medical programs under a protected status.

Refer to special considerations for OSIPM.

Pending or appeal of SSI benefits

This applies specifically to OSIPM.

OSIPM: If an OSIPM recipient has an SSA denial they have not timely appealed and/or a denial from the Appeals Council, and a MAGI determination is NOT favorable, forward the case to the Presumptive Medicaid Disability Determination Team (PMDDT) for review.

Refer to PMDDT.

Concurrent and other benefits

In most circumstances, an individual cannot receive benefits for the same program within the same month. There may be times when eligibility may remain for one member of the household even if other members are ineligible.

SNAP SNAP benefits for survivors of domestic violence relocating to domestic violence shelter or safe homes

An individual experiencing domestic violence may be part of two filing groups in the same month when they recently left a household with the person who abused them, and enter one of the following living situations:

- A domestic violence shelter, or
- A safe house for survivors of domestic violence.

TANF Concurrent TANF/ERDC benefit group membership

Participants can be members in both a TANF and an ERDC benefit group only in the following

circumstances:

- Adults receiving TANF for themselves and their children may also receive ERDC for children who are in the household but cannot be included in the TANF benefit group.
- Children who are in an ERDC benefit group can also be a TANF benefit group member when living with a non-needy caretaker relative who is not included in the TANF benefit group.
- Children who are in an ERDC benefit group can also be in a TANF benefit group when living with a needy caretaker receiving SSI.
- A TANF applicant is receiving ERDC and applies for TANF in the same month.

A TANF filing group may not receive TANF benefits during the same month an individual in that group was enrolled in or received assistance from the Office of Refugee Resettlement Matching Grant Program.

ERDC

Concurrent TANF/ERDC benefit group membership

Participants can be members in both a TANF and an ERDC benefit group only in the following circumstances:

- Adults receiving TANF for themselves and their children may also receive ERDC for children who are in the household but cannot be included in the TANF Benefit group.
- Children who are in an ERDC benefit group can also be a TANF benefit group member when living with a non-needy caretaker relative who is not included in the TANF benefit group.
- Children who are in an ERDC benefit group can also be in a TANF benefit group when living with a needy caretaker receiving SSI.

A child who lives with different caretakers during the month may be considered a member of both householders. For example, in joint custody situations, both parents could have their own ERDC case if they are eligible. The shared custody child is listed on each case. Click here for Household.

REF

A REF or TANF filing group may not receive REF or TANF benefits during the same month an individual in that group was enrolled in or received assistance from the Office of Refugee Resettlement Matching Grant Program.

MSP

An individual cannot receive benefits from ODHS|OHA of the same type for the same period as a member of two different benefit groups or from two separate programs, except as follows: An MSP recipient may also receive medical benefits from OSIPM.

Individuals cannot receive benefits of the same type for the same period from both Oregon and another state, except as follows:

- Medical benefits may be authorized for an eligible individual if the individual's provider refuses to submit a bill to the Medicaid agency of another state and the individual would not otherwise receive medical care. Accept the individual's statement as verification that a provider will not bill another state for needed medical services.
- Do not supplement benefits for a person receiving benefits under the same program from another state who moves into Oregon, even if the benefit standards in Oregon are higher than those in the

other state.

Use the following procedure to determine if the applicant received benefits from another state while receiving benefits in Oregon:

- Contact the other state to see if benefits were issued to the applicant. Click here for a list of contacts for statewide verification of assistance. California is county based; give the person the county you want and they will give you the contact number. If the individual has a different phone number for a specific worker in another state or territory, use that number. Please notify the policy unit of any changes to the numbers on this list.
- If benefits were issued, but then returned and canceled, that is proof that the individual did not receive benefits from the other state
- If benefits were issued but not returned and canceled, have the individual sign a statement that they did not receive benefits from the other state. If the other state says the benefit check was cashed, ask them to send a copy of the check to Oregon. Use the replacement check procedures to determine if the signature on the other state's check is the applicants. If it is, the participant is responsible for the overpayment.

When you contact a state where the individual had been receiving benefits, request that those benefits be closed. If the other state refuses to close the benefits or requests a copy of the signed application or some other form of documentation proving the individual is an Oregon resident, tell them we now consider the individual to be a resident of Oregon. Add a case note with the following: "This individual has established residency in Oregon. We have notified the individual's previous state of Oregon residency. Per 42 CFR 435.403 (j)(3) and (m), Oregon has determined that the individual is a resident for the purposes of Medicaid. This individual's provider is unwilling to bill another state and the individual will not otherwise receive medical care."

OSIPM Individuals cannot receive benefits from ODHS|OHA of the same type for the same period as a member of two different benefit groups or from two separate programs, except as follows: An OSIPM recipient may also receive medical benefits from MSP.

Individuals cannot receive benefits of the same type for the same period from both Oregon and another state, except as follows:

- Medical benefits may be authorized for an eligible individual if the individual's provider refuses to submit a bill to the Medicaid agency of another state and the individual would not otherwise receive medical care. Accept the individual's statement as verification that a provider will not bill another state for needed medical services.
- Do not supplement benefits for a person receiving benefits under the same program from another state who moves into Oregon, even if the benefit standards in Oregon are higher than those in the other state.

Use the following procedure to determine if the applicant received benefits from another state while receiving benefits in Oregon:

- Contact the other state to see if benefits were issued to the applicant. Click here for a list of

contacts for statewide verification of assistance. California is county based; give the person the county you want and they will give you the contact number. If the individual has a different phone number for a specific worker in another state or territory, use that number. Please notify the policy unit of any changes to the numbers on this list.

- If benefits were issued, but then returned and canceled, that is proof that the individual did not receive benefits from the other state
- If benefits were issued but not returned and canceled, have the individual sign a statement that they did not receive benefits from the other state. If the other state says the benefit check was cashed, ask them to send a copy of the check to Oregon. Use the replacement check procedures to determine if the signature on the other state's check is the applicants. If it is, the participant is responsible for the overpayment.

When you contact a state where the individual had been receiving benefits, request that those benefits be closed. If the other state refuses to close the benefits or requests a copy of the signed application or some other form of documentation proving the individual is an Oregon resident, tell them we now consider the individual to be a resident of Oregon. Narrate the following: "This individual has established residency in Oregon. We have notified the individual's previous state of Oregon residency. Per 42 CFR 435.403 (j)(3) and (m), Oregon has determined that the individual is a resident for the purposes of Medicaid. This individual's provider is unwilling to bill another state and the individual will not otherwise receive medical care."

HSD An individual receiving HSD medical program benefits may not receive the following medical benefits at the same time:

- Any other HSD medical program,
- Office of Child Welfare Medical,
- Oregon Youth Authority Medical,
- Oregon Supplemental Income Program-Medical (OSIPM); or
- Refugee Medical Assistance (REFM)

An individual may not receive HSD medical program benefits and medical benefits from another state unless the individual's provider refuses to submit a bill to the Medicaid/CHIP agency of the other state and the individual would not otherwise receive medical care. You must enter a case note if you are opening benefits in Oregon under these circumstances.

Click here for examples: Concurrent and other benefits.

Oregon Administrative Rule(s)

461-001-0000 — Definitions for Chapter 461
461-165-0030 — Concurrent and Duplicate Program Benefits
461-110-0210 — Household Group
410-200-0205 — Concurrent and Duplicate Program Benefits

Other parent available to provide care

This is relevant to the TANF and ERDC programs only.

SNAP This does not apply to the SNAP program.

TANF In a two-parent household, the second parent or spouse is ordinarily considered available to provide child care, unless both parents are at work or participating in ODHS\OHA-approved activities. Both parents' schedules must overlap in order for the hours to be approved.

There may be a child care need if the second parent is physically or mentally unable to provide adequate care. The inability of the second parent to provide adequate care must be documented.

Child care can also be approved if Child Welfare has confirmed the unemployed caretaker or spouse cannot be left unsupervised with the child.

ERDC In a two-parent household, the second parent or spouse is ordinarily considered available to provide child care, unless both parents are at work or participating in ODHS\OHA-approved activities. Both parents' schedules must overlap in order for the hours to be approved.

There may be a child care need if the second parent is physically or mentally unable to provide adequate care. The inability of the second parent to provide adequate care must be documented.

Child care can also be approved if the Child Welfare program has confirmed the unemployed caretaker or spouse cannot be left unsupervised with the child.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Click here for examples: Other parent available to provide care.

Newborn JOBS exemption

This is specifically relevant to the TANF program.

SNAP This does not apply to the SNAP program.

TANF A parent may be considered JOBS-exempt from participation and disqualification when they have a child less than 6 months of age. They have the option of volunteering for the JOBS program and may request support services, based on local budget. As JOBS volunteers, these individuals would not be subject to disqualification.

ERDC This does not apply to the ERDC program.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Oregon Administrative Rule(s)

461-130-0310 — Participation Classifications: Exempt, Mandatory, and Volunteer
461-130-0315 — Requirements for Mandatory Employment Program Individuals; Pre-TANF, REF, SNAP, TANF
461-130-0327 — Good Cause

Service eligibility

This applies to medical programs only.

To be eligible for LTC (Long Term Care) or I/DD (Intellectual/Development Disabilities) services, an individual must take an assessment to determine level of care needed. Once completed, the number result will be viewed on SELG and put into ONE to determine eligibility for services.

State and federal funding for TANF

This is specifically relevant to the TANF program.

SNAP This does not apply to the SNAP program.

TANF In 1935, the Social Security Act was passed. Its passage made it possible for states to use federal money to assist the aged, the blind and children who were deprived of parental support. There are 21 titles in the act, many of which have been repealed over the years. Title IV-A is the specific provision that gives grants to states for aid and services to needy families with dependent children. These grants are better known as federal matching funds to participating states.

To receive matching funds from the federal government, states must follow federal laws and regulations. Congress introduces changes and passes laws. The Administration for Children and Families (ACF), a federal agency, sets regulations and monitors the Temporary Assistance for Needy Families (TANF) program for states that receive federal funds for its administration. Besides federal laws and regulations, the program also follows the respective state's statutes on policies not specifically addressed by their federal counterparts.

The TANF program has undergone numerous changes since it officially began in 1937. The changes are usually made as a result of the economic, political and social changes in our country. They often reflect the various attitudes and thoughts on poverty and welfare dependency. These attitudes and thoughts have affected laws and brought forth further changes to the program, not only in Oregon but also in other states.

Under TANF, states are given the flexibility to design their welfare programs according to their own needs. However, there are a few prohibitions. For example:

- A needy family must still include a minor child under age 18 and a caretaker relative.
- There is no assistance for families not assigning certain support rights to the state.
- There is no assistance for minor parents not living in adult-supervised settings.

With previously approved waivers from the federal government, Oregon has been making changes to its welfare programs for the last few years. TANF was a welcome change. It allowed us to continue with the changes we requested under the Oregon Option waiver and make other changes we think necessary to help participants reach their goal of self-sufficiency. Oregon is on track with its goals and mission with welfare reform. Not only are we able to help our participants find jobs, we are able to help our participants keep their jobs or find better employment.

ERDC This does not apply to the ERDC program.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Job separation and voluntary reduction of hours

Applicants and participants who have quit or been fired from a productive job could be ineligible for benefits unless they have a good reason/cause. Good cause is determined by ODHS|OHA.

Job loss covers voluntary quit of a job, voluntary reduction of hours and termination of a job.

Job loss chart by program

Program	Last 30 days and 30 hours per week (worked or scheduled to work)	Last 120 days and worked or scheduled to work 100 hours per month	Good cause	No good cause
SNAP	✓	n/a	Issue benefits	No benefits/full month progressive disqualification
TANF	n/a	✓	Issue benefits	No benefits/120-day penalty period
ERDC	✓	n/a	AWS coding for 90 days	Close ERDC case and send notice (no child care need)
REF	n/a	✓	Issue benefits	No benefits/120-day penalty period

SNAP Job quit and reducing work effort is a separate, non-financial eligibility requirement for SNAP. For SNAP,

individuals are not to have quit a productive job unless they have a good reason. A productive job is paid work that averages at least 30 hours per week or pays at least 30 hours per week times the federal minimum wage. Applicants must not have quit these jobs within 30 days before applying for SNAP or while receiving SNAP. Reducing hours of work below the productive job standard is also considered job quit.

Mandatory individuals, both ABAWD and non-ABAWD, are not eligible for SNAP if they voluntarily quit a productive job without good cause during their certification period or in the 30 days before applying for SNAP.

- If an applicant had a disqualifying job quit, they are ineligible from the filing date. The appropriate disqualification penalty, level 1–3, is applied for full months only. If the filing date was not the first of the month, the effective date of the disqualification is the first of the month following the filing date. Although not disqualified in the month of application, the person is not eligible. No 10-day notice is required for applicants.
- For ongoing participants, follow the same steps as for any other disqualification.

There is no job quit penalty when the individual is fired, laid off or has hours cut at the employer's discretion. There is also no job quit penalty if there was good cause for a job quit.

If the individual does not meet one of the work requirement exemptions, they can be disqualified for quitting a productive job or reducing work hours without good cause.

TANF Employment separation rule applies to both new applicants and ongoing TANF participants.

In order for the need group to be eligible for TANF, a caretaker relative (which includes all adults in the need group) must not be separated from their employment for any of the following reasons:

- Discharged or fired, without good cause for:
  - Misconduct, or
  - Felony or theft.
- Labor dispute, or
- Voluntary quit or work hour reduction:
  - In anticipation of discharge, or
  - Without good cause.

What employment is reviewed?

Past employment is the last job the caretaker relative had that meets the two "tests" below:

- The job was within the past 120 days (from the filing date for TANF applicants).
- The applicant or participant was hired to work 100 hours or more per month, worked or scheduled to work at least 100 hours in the final full calendar month on the job.

If the last job does not meet the 100 hours per month, ODHS|OHA will look to the previous job that meets the criteria.

When determining the calculation of hours, use actual hours for work done in the past; for future or scheduled weekly hours, use actual days or weeks.

What is the penalty for leaving a job without good cause?

When it is determined a caretaker relative left their employment without good cause, the need group would be ineligible for TANF program benefits. The period of ineligibility lasts for 120 days from the date the caretaker relative left their employment.

What would be the date the caretaker relative left their employment?

There are several possibilities of which date ODHS\OHA will use a caretaker relative left their last job. They include:

- The date the caretaker relative was fired
- The last day the caretaker relative worked before they quit a job
- The first day in which a caretaker relative was hired to work but did not show for the job or quit before the job began
- The date a caretaker relative on FMLA, maternity leave, administrative leave or other type of authorized leave of absence from work informs their employer they will not be returning to the job.

How would a case be coded?

A needs resource (NR) and case descriptor (CD) code is added to the caretaker relative who left their last employment without good cause. The NR and CD code is "ESD." The CD is used as an historical marker indicating the participant was at one time denied or lost TANF due to the employment separation rule. The NR code is used to prevent the system from allowing the case to be coded a Program 2 or 82 until the code is removed or falls off the case. The NR code requires an end date. The end date can only be a month and year; therefore, it will be important to include a case note indicating the exact day, month and year the 120th day falls.

There are individuals who are not affected by employment separation rule

The following individuals are not affected by the employment separation rule when applying for TANF program benefits. They include:

- A Parents as Scholars (PAS) participant who temporarily becomes ineligible for TANF program benefits for four months or less due to income from a paid work experience
- A teen parent returning to high school or equivalent
- An individual fleeing from or at risk of domestic violence
- An individual who is pregnant and has reached the calendar month prior to the month in which the due date falls or is experiencing a medical complication due to the pregnancy that is documented by a qualified and appropriate medical professional
- An individual unable to work due to a disability or medical condition documented by a qualified and

appropriate professional, which is expected to last 30 days or more from the filing date for TANF program benefits

- An individual who is separated from their last employment for a reason ODHS|OHA determines is good cause
- An individual who has experienced a layoff from employment.

Are there certain types of jobs that would not be considered under the employment separation rule?

Yes, there are certain jobs that would not be considered. They include the following:

- JOBS Plus (PL) assignment related to a JOBS case plan
- Work experience (WE) related to a JOBS case plan
- Supported work (SW) related to a JOBS case plan
- On-the-job training (OJT) related to a JOBS case plan;
- Volunteer or unpaid employment
- Temporary or limited duration employment to include but not limited to WIA summer jobs, jobs connected to federal or state stimulus funding, day labor or on-call jobs, etc.
- Short-term placements under 90 days through a temporary employment agency.

An individual who is on Family Medical Leave Act (FMLA) or administrative, maternity or other form of a leave of absence from their current job is considered to still be working. Therefore, the employment separation would not be a factor because they have not been separated from their job.

Guidance for determining good cause

ODHS|OHA will look at a list of reasons that would not be good cause. They include, but are not limited to:

- Leaving suitable work to seek other work
- Leaving work rather than paying union membership dues
- Refusing to join a bona fide labor organization when membership therein was a condition of employment
- Leaving work to attend school, unless required by law
- Parents as Scholars participants who may not be affected by leaving work to attend school
- Resignation to avoid what would otherwise be a discharge for misconduct or potential discharge for misconduct
- Willful or wanton negligent violation of the standards of behavior that an employer has the right to expect of an employee is misconduct. An act or series of actions that amount to a willful or wantonly negligent disregard of an employer's interest is misconduct.

Not misconduct

The following are not considered "misconduct":

- Isolated instances of poor judgment
- Good faith errors
- Unavoidable accidents
- Absences due to illness or other physical or mental disability
- Mere inefficiency resulting from lack of job skills or experience.
- Compelling family reasons, when the individual has made the attempt to maintain the employer-employee relationship.

An individual can leave work to accept an offer of other work and it would be considered good cause, but only when:

- The offer was definite
- Work was to begin in the shortest length of time as can be deemed reasonable under the individual circumstances
- The offered work must have been reasonably expected to continue, and
- The work would have paid an amount greater than the work the caretaker relative left.

"Good cause" means a reasonable person of normal sensitivity, exercising ordinary common sense, would leave work. For an individual with a permanent or long-term physical or mental impairment (as defined at 29 CFR 1630.2(h)), good cause for voluntarily leaving work is such that a reasonable person with the characteristics and qualities of such individual would leave work. Good cause for leaving work can include the following:

- Accommodation or accommodations provided were not adequate enough to overcome a physical or mental impairment.
- The person accepted another job at a higher wage but less than 100 hours a month.
- Circumstances were beyond the control of the applicant such as but not limited to:
  - Layoff
  - Employer went out of business
  - Natural disaster preventing the individual from going to work.
- A court order existed.
- Employer was unable or unwilling to provide a needed accommodation.
- Employer engages in employment practices that are illegally discriminatory on the basis of age, sex, race, religious or political belief, marital status, disability, sexual orientation or ethnic origin.
- The person entered, or will be entering within the next 30 days, a residential treatment facility.
- Child Welfare or another agency recommended leaving.
  - An applicant may be working with other agencies such as Parole and Probation, Vocational Rehabilitation or Veterans Affairs. Each situation will be looked at individually.
- The individual was unable to obtain or maintain appropriate child care.
  - Good cause is not limited to special needs care but also includes regular child care. The

situation may be that the applicant had their hours reduced but still worked more than 100 hours. However, the reduction caused the applicant to no longer be able to afford child care. This would also be good cause.

- An unsafe workplace caused risk to an individual's health and wellbeing

Self-employment job

What if the applicant was self-employed?

Individuals who are self-employed, regardless of where they were self-employed, are also affected by the employment separation. You will need to determine how much money the individual made in the last full calendar month they were self-employed; determine how many hours they worked and find out the reason why the self-employment ended.

If the caretaker relative's self-employment job was within the past 120 days, we will use their income from the last full calendar month of self-employment to accurately determine the number of hours they worked. Use their last full calendar month's gross income and dividing by Oregon minimum wage to determine if it was 100 hours or greater.

ERDC There must be earnings from employment or self-employment at the time of certification and re-certification for ERDC. If the applicant is not working or self-employed at application, they are not eligible for ERDC.

For job separation during the certification period, click here for Acting on reported changes.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Click here for examples: Job separation and voluntary reduction of hours.

Two-week cooperation requirement

This applies specifically to the TANF program.

SNAP This does not apply to the SNAP program.

TANF When a TANF grant closes within three months prior to the new filing date and at least one adult in the HH is actively disqualified at the time of case closure, the disqualified adult must complete a two-week cooperation period before TANF is opened unless one of the following is true:

- The disqualified person is now JOBS-exempt.
- ODHS|OHA determines good cause for not requiring the two-week cooperation period.

Difference between DQ1 and DQR

TANF closes on April 30 with an active DQ1 – DQ4. The two-week cooperation period would be required when applying for TANF in May, June and July.

TANF closes on April 30 and moves into DQR status. The DQR is active in May and June, in which the individual and their family would be ineligible for TANF. Because of this two-month ineligibility, the three-month period wouldn't begin until the DQR ends. In this situation, the DQR would end on June 30. The two-week cooperation period would be required in July, August and September.

What are the elements of the "two-week cooperation period"?

- Appropriate activities based on the individual's circumstances
- No minimum required number of hours.

A Notice of Pending Status (DHS 0210) is provided to the applicant, as cooperation for two consecutive weeks is a condition of eligibility.

Once the applicant has cooperated two consecutive weeks, they have satisfied this eligibility requirement and the TANF grant is opened back to the filing date.

If the applicant does not cooperate, two consecutive weeks prior to the 30th day from the filing date, the TANF application is denied and a basic decision notice is sent.

ERDC This does not apply to the ERDC program.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Click here for examples: Two-week cooperation requirement.

Chapter 2: Eligibility

Section 7: Temporary Assistance for Domestic Violence Survivors (TA-DVS) overview

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Temporary Assistance for Domestic Violence (TA-DVS) overview

Although survivors requesting Temporary Assistance for Domestic Violence (TA-DVS) program benefits often request other benefits, their TA-DVS eligibility must be determined as a stand-alone program. This is for survivor confidentiality and safety. Many of the eligibility factors for TA-DVS follow those for the TANF program, but separate determinations must be made, and separate cases must be used for documenting the case and issuing benefits.

For more information, click on Temporary Assistance for Domestic Violence (TA-DVS) Program.

Chapter 2:
Eligibility

Section 8: Disaster (Emergency) Supplemental Nutrition Assistance Program (DSNAP)

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Disaster (Emergency) Supplemental Nutrition Assistance Program (DSNAP)

Following a natural disaster, people may be unable to supply their everyday needs for food, clothing, and shelter. Services and facilities may be available to victims from volunteer agencies on either an individual basis or through emergency group shelters or feeding stations.

In Oregon, in cases of natural disaster, local governments and volunteer agencies provide the immediate response. State resources are not committed until, or unless, the Governor declares a state of emergency. At the state's request, and the President's concurrence that a major disaster exists, the federal government will also participate and provide additional services. Where more than one agency or level of government provide similar assistance, close communication will be maintained to avoid duplication and to assure the best level of assistance to the victims.

Background

The Stafford Disaster Relief and Emergency Assistance Act of 1988 allows distribution of emergency SNAP benefits to victims of a Presidentially-declared major disaster. In areas affected by a Presidential declaration, the only two requirements that must be met are that commercial channels of food distribution are available so that SNAP benefits can be used, and that the ongoing SNAP program is unable to handle the increased number of households needing assistance.

Under the Food and Nutrition Act of 2008, the Secretary of Agriculture can authorize emergency food assistance to areas not declared a major disaster by the President if a disaster has caused the disruption and subsequent restoration of commercial channels of food distribution. A disruption in the commercial channels of food distribution will include conditions that limit households' access to food outlets as well as the closing and reopening of retail and wholesale food outlets.

Evidence of disrupted food distribution would include significantly curtailed business hours; impassable roads; significantly hampered delivery of commodities to food outlets; unusually heavy demand on food outlets to the extent that the normal opportunity to purchase food is significantly hampered due to households replacing food supplies damaged or destroyed by the disaster; or power failure which significantly restricts the operation of food outlets.

Commercial channels of food distribution will be considered restored when conditions or operations have improved to the extent that households in the disaster area have reasonable access to food outlets. The three conditions which must be met before disaster SNAP assistance can be authorized are (1) that commercial channels of food distribution have been disrupted; (2) that commercial channels of food distribution have been restored; and (3) that the normal, ongoing SNAP program is unable to expeditiously handle the number of households affected by the disaster who are in need of emergency SNAP assistance.

The FNS Regional Disaster Task Force will serve as the primary coordinator for SNAP disaster activities, gathering data, evaluating the need for emergency food assistance, and providing information and/or recommendations to the FNS National Disaster Task Force.

Eligibility criteria

To be eligible for emergency SNAP assistance during a disaster, a household must file an *Application for Emergency Food Stamp Assistance (DHS 0349) (paper only)*, and be interviewed, determined to meet all the following criteria and provide the required verification.

- At the time the disaster struck, the household must have resided or worked within the geographical area authorized for disaster procedures. The household may be certified for emergency SNAP assistance even if at the time of application it is occupying temporary accommodations outside the disaster area. However, the household's representative would need to come to the disaster certification site to be certified for disaster SNAP assistance;
- The household must plan on purchasing food during the disaster period. A household residing in a temporary shelter but not expected to remain there for the entire benefit period is eligible for DSNAP benefits;
- The household must have experienced at least one of the following adverse effects due to the disaster:
  - **Loss or inaccessibility of income involving a reduction or termination of income or a significant delay in receipt of income**. This could occur if the disaster has caused a place of employment to close or reduce its work days, if pay checks or other payments are lost or destroyed, or if there is a significant delay in the issuance of pay checks or other payments. It could also occur if the work location is inaccessible due to the disaster;
  - **Inaccessibility of liquid resources**. The household is unable to reach its cash resources and is not expected to be able to access its liquid resources for most of the disaster benefit period. This may occur because the financial institutions where the household has its resources are closed due to the disaster;
  - **Loss of food**;
  - **Real property damage**. Damage to or destruction of the household's home or self-employment business.

Determining the availability of income

To be eligible for disaster SNAP assistance, the household's take-home pay for the disaster benefits period, plus its cash resources (cash on hand and accessible funds in checking and savings accounts), less disaster-related expenses, must be less than or equal to the SNAP maximum income level for the household size of DSNAP.

Take-home pay includes:

- The wages a household actually receives after taxes and other payroll withholding is taken out; and
- The assistance payment or other unearned income a household received; and
- Self-employment income earned after personal income and social security taxes as well as costs of producing the self-employment income are subtracted. Allowable costs of producing the self-employment income are described in OAR 461-145-0930.

Note: The household must meet the income limit for emergency SNAP assistance. Because this standard requires that cash resources be added to income, large numbers of households in disaster areas will be screened out of the program unless the cash is inaccessible. Inaccessible resources are disregarded if they are expected to be inaccessible for most of the disaster benefit period.

Disaster-related expenses include expenses the household has paid or is expected to pay during the disaster benefit period for one of the following expenses and full reimbursement is not expected during the disaster benefit period. Expenses are only limited to the following:

- Expenses to repair damages to the household's home or other property essential to the employment or self-employment of a household member;
- Expenses for temporary shelter if the household's home is not livable or if the household cannot reach its home;
- Expenses for moving out of an area evacuated due to the disaster;
- Expenses related to protecting property from disaster damage including for paying for storage for such items;
- Food destroyed in the disaster;
- Dependent care needed during the disaster; and
- Medical expenses for disaster-related injury to a person who was a household member at the time of the disaster (including funeral and burial expenses in the event of death)'
- Expenses to clean up the home or business following the disaster;
- Expenses related to replacing necessary personal and household items, such as clothing, appliances, tools and educational materials;
- Expenses to repair a vehicle damaged in the disaster;
- Pet boarding fees when a pet must be placed in boarding due to a disaster.

Calculating benefits

Income would be counted if it had already been received in the disaster benefit period or if it is reasonably certain to be received during the benefit period.

For any expense to be deductible, the household has to have paid, or expect to pay for the expense during the one-month or half-month disaster benefit period. If the household will not pay for the expense until after the disaster benefits period, it is not a deductible expense. Likewise, if the household has received or reasonably anticipates receiving a reimbursement for part or all of the expense during the disaster benefit period, only the net expense to the household would be deductible. If reimbursement is not anticipated until after the benefit period ends, the full amount of the expense paid or expected to be paid would be deductible.

If the disaster benefit period is one month, income over that full month period and all accessible resources shall be counted, disaster-related expenses that are paid, or are expected to be paid over that full month period, shall be deducted and the maximum income limit shall be for a one-month period.

If the disaster benefit period is for one-half month, income over the half-month period shall be counted, disaster-related expenses paid or expected to be paid over this period shall be deducted, and the disaster eligibility limit shall be one half of the monthly SNAP maximum limit. However, the full amount of accessible cash resources shall be counted, regardless of the length of the disaster benefit period.

Oregon Administrative Rule(s)

461-135-0491 — Disaster Supplemental Nutrition Assistance Program (DSNAP)

Application

A household must submit a completed ODHS 349 application form at a certification site in person or through an authorized representative. If the household designates a non-household member as authorized representative, a *Designation of Authorized Representative or Alternate Payee* form (MSC 231) must be completed and filed with the case record.

The application must be filed during the period designated by FNS for acceptance of applications for disaster SNAP assistance.

The application must be signed by a responsible member of the household or by an authorized representative designated by the household.

No emergency SNAP benefits shall be authorized after the expiration of the period for which the state is authorized by FNS to process and approve applications for emergency SNAP assistance.

The household or its authorized representative must be interviewed and must provide the required verification.

The length of the benefit period, which is the length of time corresponding to the allotment to be provided, either one-half or one full month, will be based on an estimate of how long it will take households to return to their normal means of support.

Oregon Administrative Rule(s)

461-135-0492 — Application, Interviews, and Verification for DSNAP

Interviews

All applicants must be interviewed. The interviewer shall advise the household orally or in writing of the disposition of its application, its rights and responsibilities, when its emergency certification period ends, and of the regular SNAP program.

The interviewer shall advise the household of the civil and criminal penalties for violations of the Food and Nutrition Act, and of the fact that the household may be subject to a post-disaster review.

The interviewer shall inform each household certified eligible of the proper use of and the amount of SNAP benefits, and the period the benefits are intended to cover. If the application is denied, the household must be given an explanation of the basis for denial.

If the household also wishes to file an application for the ongoing SNAP program, the interviewer shall advise the household orally or in writing of the address and telephone number of the appropriate office.

Oregon Administrative Rule(s)

461-135-0493 — Eligibility and Benefit Amount for DSNAP

Verification

The applicant must verify the following:

- The identity of the head of household;
- The location of the applicant's residence in the disaster area. This can be determined using clearly marked area maps;
- The applicant's residence in the disaster area at the time of the disaster. Use rent receipts and utility bills, or when necessary, through sources such as telephone books or city directories.

Emergency Certification: Since documents can be destroyed or be unobtainable in a disaster situation, the emergency certifier may use a collateral contact as a source of verification when the household's identity and residency cannot be verified through documentary evidence, or when a collateral contact would expedite the household's certification. It is program intent that in those instances where the household has arrived in the area just prior to the disaster and residency cannot readily be verified, the household would not be denied if residence is the only requirement that cannot be verified. The worker must be satisfied that this is actually the case.

Oregon Administrative Rule(s)

461-135-0494 — DSNAP Treatment of Households Already Certified and Receiving SNAP Benefits

Issuance of benefits

Disaster SNAP benefits will be issued to an eligible household immediately after completion of the application and eligibility determination (benefits can be issued to the head of the household, spouse or properly identified authorized representative). Households determined eligible shall receive benefits no later than three days after the date of application. If the third day falls on a weekend, issue benefits on either the first or second day.

Oregon Administrative Rule(s)

461-135-0495 — Recertifications for DSNAP

Treatment of households already certified and receiving SNAP

Households certified and receiving SNAP benefits may also be eligible for emergency SNAP assistance. They may get a replacement allotment.

If the households are later determined eligible for disaster benefits, they may receive a supplement up to the maximum allotment amount per household size.

Ongoing program benefits will be used to reduce the disaster benefits unless the household's food has been damaged by the disaster and the household must replace the food.

Oregon Administrative Rule(s)

461-135-0497 — Household Liability in the DSNAP

Recertifications

If FNS extends the authorization period beyond the original designation and the extension goes beyond the end of the original disaster benefit period, FNS may authorize CAF to permit certified households who have already received emergency benefits to apply for recertification and receive additional SNAP benefits for an additional benefit period, if they still meet the disaster eligibility criteria.

A household applying for recertification must again submit a DHS 0349 and be interviewed.

At recertification, identity and residency need not be reverified unless the branch office believes these items to be questionable. If an extension is granted, the State Office shall issue a press release notifying households that the disaster authorization period has been extended for emergency SNAP benefits. The press release will advise households of where they may apply for additional emergency benefits and the date by which a household must file an application to receive extended benefits.

Oregon Administrative Rule(s)

461-135-0493 — Eligibility and Benefit Amount for DSNAP
461-135-0495 — Recertifications for DSNAP

Hearings

Households denied emergency SNAP benefits may request a hearing. Households requesting hearings shall be offered immediate supervisory reviews of their cases due to the time that is likely to pass before a hearing decision can be rendered. The supervisory review shall not replace the regular hearing. The request for a hearing may be withdrawn if the situation is resolved by the supervisory review. Requests must be withdrawn in writing.

Household liability

Households will be held liable for any overissuances discovered in the course of postdisaster audit activities.

CAF will establish claims and apply penalties in accordance with OARs 461-195-0501 through 461-195-0621 against any household that received more emergency SNAP benefits than it was entitled to receive.

Regardless of whether overissuances are discovered in the course of the post-disaster review or by other means, in accordance with OARs 461-195-0501 through 461-195-0621, a claim will be established against any household that received more emergency SNAP than it is entitled to receive.

Oregon Administrative Rule(s)

461-135-0497 — Household Liability in the DSNAP

Chapter 2:
Eligibility

Section 9: Employed Persons with Disabilities (EPD)

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Employed Persons with Disabilities (EPD)

Introduction

The Employed Persons with Disabilities (EPD) program is designed to help individuals living with a disability who wish to work. Often, a person who has a disability is hesitant to obtain employment and risk losing Medicaid. The cost of paying for a provider or adaptive equipment by oneself can use up most of a person's paycheck. The purpose of this program is to allow people who have a disability to work and not lose Medicaid coverage.

To be eligible for EPD, an individual must meet all of the following:

- Be employed;
- Have a physical or mental impairment that meets the definition of disability as used by the Social Security Administration;
- Have an adjusted income less than 250% of the Federal Poverty Level for a family of one;
- Have countable resources under $5,000;
- Meet all other OSIPM financial and non-financial eligibility;
- Not be assumed eligible for other Medicaid programs; AND
- Pay the participant fee each month.

An individual on EPD may be eligible for a full OHP Plus benefit package and long-term care (LTC) services.

Determining eligibility for EPD is similar to determining eligibility for other OSIPM programs. EPD is an OSIPM program and can be found in rule as OSIPM-EPD.

Non-financial eligibility

Individuals must meet all current OSIPM non-financial eligibility requirements, unless otherwise noted, and have the additional requirement of being employed.

Eligibility groups

The individual applying will be the only person in any of the eligibility determination groups (EDGs), which include household groups, filing groups, financial groups, need groups and benefits groups.

Age

Individuals must be at least 18 years old, but there is no upper age limit.

Basis of need

The basis of need must be disability or blindness. The basis of need cannot be age. However, a person who is age 65 or older can be eligible for EPD, if the person is blind or has a disability which meets the definition of disability used by the Social Security Administration (SSA).

If a new applicant is not currently receiving SSA benefits based upon their disability, a presumptive Title XIX

determination will need to be conducted by the Presumptive Medicaid Disability Determination Team (PMDDT).

PMDDT does not look at the current employment as part of the individual's Past Relevant Work. PMDDT looks at Substantial Gainful Activity (SGA) differently than the SSA. They do not consider a working individual to be earning above SGA unless their adjusted earned income is in excess of the EPD Adjusted Earned Income Standard, which is 250% of the Federal Poverty Level.

If an ongoing EPD participant was determined to have a disability by SSA and lost their SSDI eligibility due to their own income, the SSA determination remains effective for one year from the date that the individual loses eligibility for SSDI. This automatic extension of disability applies only to individuals who are eligible for and receiving EPD at the time they lost SSDI due to earnings.

Note: Basis of need may NOT be determined at the local office level or by a Community Developmental Disability Program (CDDP).

Pursuit of assets

EPD applicants and recipients are required to pursue assets unless good cause exists with the exception of SSI. EPD applicants and recipients are considered to have good cause to not pursue SSDI or Medicare because SSA will consider their current work as part of the Past Relevant Work calculation and they will be ineligible. EPD participants can and should be encouraged to apply for SSDI and Medicare but cannot be disqualified for failure to do so.

EPD applicants and recipients must pursue cost-effective employer-sponsored health insurance, as well as cash medical support when applicable.

Employment

Employment means an ongoing work activity for which the individual provides ODHS|OHA with one of the following:

- Tax payment verification under the Federal Insurance Contribution Act (FICA);
- Tax payment verification under the Self-Employment Contribution Act (SECA); or
- Clear and convincing evidence of self-employment. This can include a business plan, profit and loss statement, or other documents that verify an individual is engaged in a self-employment enterprise. There are number of different types of self-employment enterprises an EPD participant could become involved in. In some cases, an enterprise might not produce significant earned income immediately. In those cases, other types of verification of self-employment, as mentioned above, would need to be gathered from the individual or from third parties knowledgeable about the individual's situation. Self-employment requirements in the EPD program are more stringent than those for other programs.

For more information on self-employment, see Treatment of specific assets.

The definition of "employment" does not include bartering or trading. Also, individuals who work for organizations that are not required to pay FICA under federal tax laws are considered to meet the definition of employment even if the employer does not file FICA.

Self-employed individuals often file or pay SECA payments. These payments are often made on a quarterly basis. However, individuals are not required to do so to meet the definition of employed for EPD purposes.

Assumed eligibility

Assumed eligibility for OSIPM applies only to recipients of SSI benefits and people deemed eligible for SSI under Sections 1619(a) or 1619(b) of the Social Security Administration. Individuals who are eligible for SSI or are in 1619(b) status are not eligible for EPD.

Oregon Administrative Rule(s)

461-135-0010 — Assumed Eligibility for Medical Programs
461-001-0035 — Definitions; OSIP-EPD and OSIPM-EPD
461-120-0330 — Requirement to Pursue Assets
461-125-0370 — Disability as the Basis of Need
461-110-0410 — Filing Group; OSIPM, QMB
461-120-0510 — Age Requirements for Clients to Receive Benefits
461-135-0725 — Specific Requirements; OSIPM-EPD

Financial eligibility

Financial eligibility for EPD is significantly different from other OSIPM sub-programs. These differences allow individuals to have higher income without losing Medicaid.

Differences include:

- Unearned income is excluded for determining eligibility.
- Individuals are eligible if their adjusted earned income is less than 250% of the Federal Poverty Level for a household of one.
- Impairment-Related Work Expenses (IRWEs), Blind Work Expenses (BWEs) and Employment and Independence Expenses (EIEs) can be used to reduce the individual's adjusted income.
- If an individual meets all other eligibility factors for the EPD program and their countable earned income is under $5,453 per month they will meet the income requirement for this program. If the individual's income is in excess of $5,453, they may still be eligible for EPD because of the deductions of EIEs, IRWEs, and BWEs as discussed below.

Calculating countable income

Countable income is gross income minus exclusions. Income exclusions can include self-employment business expenses and the Earned Income Tax Credit, for example.

Calculating adjusted income

Adjusted income is determined as follows:

1. Exclude all unearned income.
2. Determine countable earned income as described above.
3. From countable earned income, deduct one standard income deduction of $20.

4. Deduct one standard earned income deduction of $65.
5. Divide the remainder by two.
6. Deduct any costs allowed as EIEs, IRWEs, or BWEs.
7. The remainder is adjusted income.

Note: In the regular OSIPM program, steps 5 and 6 are reversed. By using the EIEs, IRWEs and BWEs after the 50% earned income deduction, the EPD program effectively doubles the usefulness of the deductions.

Deductions

EPD offers three income deductions that allow individuals to retain eligibility for Medicaid when they are employed. IRWEs, EIEs, and BWEs allow participants' costs to be taken into account for Medicaid eligibility. IRWEs, EIEs, and BWEs do not offer the individual more benefits; they merely allow the individual to have their eligibility for Medicaid judged on realistic values. Money that the individual uses, or plans to use, on independence and employment expenses will not be counted when eligibility is determined.

Impairment-Related Work Expenses (IRWEs)

Under the SSA definition, an IRWE is a payment for a service or an item that is excluded for SSI eligibility/payment purposes when the severity of the impairment is such that the individual must purchase or rent items and services in order to work. To be allowed as an IRWE, the expense must be directly related to work and it must be necessary, due to the individual's disability. However, it can meet the criteria for an IRWE even if the item is used for daily activities other than work.

Employment and Independence Expenses (EIEs)

EIEs are very similar to IRWEs. They are expenses that contribute to the person's ability to work and enhance independence. Any expense that can reasonably be expected to enhance the individual's independence and facilitate employment will be allowed as an EIE deduction. Examples can include, but are not limited to, any of the following:

- Vehicle modifications;
- Vehicle equipment;
- Maintenance on modified vehicles (contact policy for current mileage rates);
- Interpreter and Reader services;
- Assistive technologies;
- Non-covered medical expenses;
- Non-covered medical supplies; and
- Payments made to approved accounts.

To be counted as an IRWE or an EIE, the cost must be incurred and paid for by the individual. It cannot be a cost or item that is paid for by a third party, such as an employer under the Americans with Disabilities Act (ADA) or Vocational Rehabilitation. Expenses that a person without a disability would also incur and pay as a result of being

employed (taxes, car insurance, routine vehicle maintenance for non-modified vehicles) cannot count as IRWEs or EIEs.

It will be the responsibility of the individual to justify why the expense can be expected to enhance their independence and employment opportunities. ODHS|OHA staff will make the decision as to whether the expense is consistent with the policy.

Requests for EIEs are made using the SDS 0850B form.

Blind Work Expenses (BWEs)

BWEs are expenses incurred by blind individuals that facilitate employment and independence. They are very similar to IRWEs and EIES, except that:

- The person must be blind for the costs to count as deductions, and
- BWEs include costs that workers without disabilities must pay, such as taxes, union dues, and payroll mandatory contributions (pensions and disability insurance for example).

Examples of BWEs include:

- Utilizing the services of a reader to "read" everyday documents such as mail or magazines;
- Meals consumed during work hours;
- Federal, state, and local taxes; and
- Professional association dues.

Resource limits

The countable resource limit is $5,000. The EPD Program also allows exclusions from the resource limit, which other OSIPM programs do not. EPD participants may exclude resources from this limit if they are in a qualified approved account.

Other resources

Resources *includes screenshots: Reviews the resource categories and their respective screens. Describes how historical data appears on the Resource Questions screen..

Approved accounts

Many individuals with disabilities incur expenses that are directly related to a disability. These expenses are necessary to increase or maintain the individual's level of independence and employment.

An example of such an expense is transportation costs. An individual who uses a motorized wheelchair may require a van with a lift, hand controls or other vehicle modifications. The total cost can easily exceed $30,000. A worker with a disability should be able to save for the purchase or replacement of such an expense without being penalized by losing needed Medicaid benefits.

The EPD Program excludes from countable resources any monies that are in segregated accounts with the purpose of saving for future expenditures. These segregated accounts are known as approved accounts.

Funds in an approved account must:

- Be designated for a disability-related purpose or in a retirement account or Medical Savings Account (MSA).
  - Examples of appropriate retirement accounts include those regulated by the Internal Revenue Code and used for retirement planning, such as IRAs, TSAs, 401Ks and Keogh accounts.
- The account must be segregated from other accounts and must have only the individual's name on it.
- Deposits into approved accounts must be from the person's earnings or from an employer, based upon earnings. Payments from SAIF are considered to originate with an employer and are considered valid to fund an approved account.

Moneys in an approved account, assets purchased from these moneys and assets purchased as EIE's are not counted towards the $5,000 resource limit.

Individuals must seek approval of these accounts by providing the account information and description of how the account can be expected to enhance their independence and employment potential. The process to enter an Approved Account is the same as other resources except that the worker must make an entry under the Excluded Amount section and list the Description as Approved Account along with the corresponding amount/balance. As with EIEs, these accounts will be approved if it can be shown that future purchases can be reasonably expected to enhance the independence and employment opportunities for the individual, and if they are related to the person's disability.

If an individual uses money in an approved account for items other than those included on the agreement, the money used to purchase the item and money remaining in the individuals approved account will count toward the $5,000 resource limit for EPD. Example: an EPD participant is saving for a new wheelchair, which is listed on the Approved Account agreement. The individual then decides to withdraw the money to purchase a video game system. The money used for the system, and any money remaining in the account afterwards, count toward the EPD resource limit.

If an EPD participant loses employment and meets the requirements to remain on EPD for up to 12 months, all approved accounts remain excluded during the extended EPD timeframe.

Motor vehicles

If a vehicle was purchased as an EIE or with monies from an approved account, the total value of the vehicle is excluded.

Oregon Administrative Rule(s)

461-001-0035 — Definition; OSIP-EPD and OSIPM-EPD
461-155-0250 — Income and Payment Standard; OSIPM
461-160-0550 — Income Deductions; Non-SSI OSIP (except OSIP-EPD) and OSIPM (except OSIPM-EPD) in the Community When There Are No Children in the Household Group
461-145-0025 — Approved Accounts; OSIPM-EPD
461-145-0360 — Motor Vehicle

Participant fee

As a condition of eligibility, every EPD participant must pay a participant fee every month. This includes months in which the individual receives retroactive OSIPM-EPD eligibility. The fee serves as a buy-in for Medicaid and any LTC services.

The amount of the fee is based on the individual's countable income (earned and unearned). Use the following chart to determine the amount of the EPD participant fee.

Monthly countable income	Monthly Participant Fee
Under $850	$0
$850–$1,132.99	$50
$1,133–$2,831.99	$100
$2,832 and above	$150

Eligibility vs participation fee calculation

There are two income calculations that are critical for the participant. The first is the eligibility calculation. This calculation determines if the individual's income is under the EPD income standard for eligibility purposes. The second is the EPD participant fee calculation, which determines how much the individual will pay to remain in the EPD program. These calculations are different. The chart below shows the differences between the two types of income calculation for EPD.

Deduction	Eligibility	Participant Fee
Unearned income	Excluded	Countable
Earned Income	Countable	Countable
Earned and Unearned Income Exclusions	Yes	Yes
$20 Income Deduction	Yes	No
$65	Yes	No
½ earned income deduction	Yes	No
Deduct EIEs, IRWEs, and BWEs	Yes	No
Compare to 250% FPL Standard	Yes	No
Compare to FPL for Participant Fee Calculation	No	Yes

Making payments

Individuals approved for EPD will receive a system-generated notice (MED-046 Employed Persons with Disability Participation Fee) each month informing them of their participant fee amount and how to make the payment.

Participants have several payment options. Workers should strongly encourage payment through the online payment service at https://apps.oregon.gov/ECommerce/DHSOHA/EPS/. Online payments can be made 24/7 by using a Visa, MasterCard or Discover credit card. A debit card may also be used as long as it has a Visa or MasterCard logo. If participants experience difficulty while using the online payment service, they can call 1-855-255-4304 for assistance during regular business hours. At the website, EPD participants will be asked to enter their name, case number, branch number and month for which the payment is being made. This information has been added to the lower portion of the monthly participant fee payment notice they receive. The DHS 7312 Making Your Payments Online brochure may be given to participants paying online

Participants may also mail payment to PO Box 4263 Portland OR, 97208-9829 or return their payment to an APD/AAA office.

Failure to pay

If an individual fails to pay the Participant Fee, EPD eligibility ends. ODHS|OHA staff must review for nonpayment of participant fees at the beginning of each month. Staff must follow the reconciliation process described in the OSIPM EPD QRG at the beginning of each month to determine which individuals have not paid the participant fee. Each district should have a process for monitoring these payments on a monthly basis.

When staff find that an individual has missed a payment, they must take the follow steps:

- If the prior month's payment was missed, override the OSIPM-EPD TOA from approved to terminated.
- If the missed payment(s) do(es) not include the prior month (i.e. the most recent month's participant fee has been paid, but other months were not), do not terminate EPD in ONE.
- The participant fee does not have to be paid prior to opening/reopening benefits:
  - If the individual is being closed/reduced for nonpayment and requests to remain on EPD prior to closure, restore the case and inform the individual that payment must be made for the current month.
  - If the individual's case is closed or has been reduced for nonpayment, they must reapply following the application process and pay the participant fee by the end of the initial month.

Note: Payment plans to repay overdue participant fees are not permitted.

Additional participation fee payments

IIf an individual has made more than one payment in the month, add a case note explaining the reason for the additional payment(s) (ex. Payment on the 1st and 30th of June, 2nd payment was early payment for July EPD).

Hardship waiver

The participant fee must be paid monthly as a condition of eligibility. Any month where the participant fee is not paid will result in termination of EPD benefits unless waived due to significant economic difficulty such as financial issues resulting from homelessness, divorce, domestic violence, illness, or other situations. The individual must provide verification of the economic difficulty for the worker to evaluate eligibility for the waiver.

Refunding EPD participant fees paid in error

EPD participant fees paid in error can be reimbursed retroactively up to 12 months. Locate the payment(s) that need to be refunded by either locating them on the APD Receipting Solution Intake Report or asking for assistance from Receipting. Complete the APD Program Payment Refund Request and email the form to APD Client Receipting.

Other resources

Oregon Supplemental Income Program Medical (OSIPM) Employed Persons with Disabilities (EPD): Overview of OSIPM-EPD, how to enter relevant information into ONE, and reconciling EPD Participant Fee

Oregon Administrative Rule(s)

461-160-0800 — Determining Participant Fee; OSIP-EPD, OSIPM-EPD (Including In-Home Services)
461-195-0521 — Calculation of Overpayments

EPD and long-term care (LTC) services

Resource assessments are not required for EPD participants receiving long-term care (LTC) services. They also do not pay a liability. The participant fee replaces the liability, but those in residential settings will still be required to pay room and board.

When an individual is eligible for OSIPM with services under both the 300% of SSI standard (LTCSERV TOA in ONE) and EPD, ONE will approve EPD over LTCSERV. Rather than choosing one benefit over another based on the lowest cost to the participant (as was the process in the legacy systems), the system will instead set the EPD participant fee based on either the participant fee calculation or the patient liability calculation, whichever is lowest.

For example, Mia is eligible for OSIPM with long-term care services through the 300% rule (LTCSERV) and EPD. The participant fee would be $100 and the calculated liability would be $50. ONE will approve Mia in EPD (Eligibility screen will show OSIPMEPD and NMAGISERV TOAs approved) with a participant fee of $50 (liability calculation resulted in the lower cost). EPD participant fees that are based on a liability calculation are still paid and receipted like any other participant fee. They will not be paid to the facility.

EPD participants can also participate in the Independent Choices Program (ICP). When an EPD participant is eligible to receive APD in-home services and otherwise qualifies for ICP, the individual may be enrolled in the program. When in both EPD and ICP, an individual will have an EPD participant fee and an ICP cash benefit, which are both calculated separately.

ODHS|OHA will not deduct the participant fee from the ICP cash benefit. Furthermore, EPD participants who also participate in the ICP, will not have a liability for their LTC services.

Reporting changes

Individuals must follow the same reporting requirements as regular OSIPM. For changes in income that reduce the participant fee:

- If the change was reported timely, the change is effective the month the change occurred
- If not reported timely, the change is effective the month the change was reported or discovered

Oregon Administrative Rule(s)

461-170-0011 — Changes That Must Be Reported
461-180-0020 — Effective Dates; Changes in Income or Income Deductions That Cause Increases

Chapter 2: Eligibility

Section 10: Long-Term Care (LTC) services

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Long-term care (LTC) services

Introduction

Long-term care (LTC) includes a range of services that assist individuals who can no longer complete Activities of Daily Living (ADL) on their own (e.g. moving around their home, using the restroom, or eating). Eligibility for APD LTC services is based on a Service Priority Level (SPL) assessment conducted by an APD/AAA case manager in Oregon ACCESS. The Office of Developmental Disabilities Services (ODDS) determines eligibility for intellectual and developmental disabilities (I/DD) LTC services based on an Individual Support Plan (ISP) assessment conducted by the local Community Developmental Disability Program (CDDP) eligibility specialist in the Express Payment & Reporting System (eXPRS). Assessments are used to identify support needed based upon each individual's health and safety needs, interests, choices and goals. Each plan established uses a person-centered planning process.

Note: ODHS|OHA provides behavioral health focused Home and Community-Based Services to qualified Oregonians age 21 or older who receive OHP Plus benefits and are also determined eligible by local community behavioral health specialists outside of ONE. See Behavioral Health (BH) service eligibility below.

These services include nursing facility, in-home and community-based care to assist seniors and people with disabilities to live as independently as possible where they choose to live. This is because Oregon has several waivers related to Medicaid that allow the state to be more flexible by offering a larger variety of services.

To receive LTC services, individuals must be eligible for an OHP Plus medical benefit either through HSD's medical programs or APD's OSIPM program. OSIPM has income and resource tests while HSD medical programs use tax filing status and income tests to determine who may be eligible. Both HSD medical and OSIPM recipients can be otherwise eligible for Medicaid without services, but there are many who can only qualify for OSIPM if they also meet LTC service eligibility.

Note: There are various types of Medicaid benefits that an individual may qualify to receive. For a full list of HSD medical and APD medical programs, refer to the Types of Assistance (TOA) QRG.

Evaluations for Medicaid eligibility and LTC services can be done at the same time. Eligibility workers determine the individual's financial eligibility and case management staff assess their need for assistance with personal care tasks. Eligibility workers and APD case managers or DD eligibility specialists and service coordinators work together to help Oregonians through the application process, coordinate eligibility for long-term care and prevent interruptions in benefits once approved.

Note: Some individuals have income too high to receive Medicaid without services. There are special provisions related to OSIPM that allow for higher income limits for LTC and more resources for married individuals.

Once determined eligible for services, a service plan is approved and a service eligibility record is created on the SELG screen for the individual. If eligible for LTC, the state will pay for all or part of the individual's care, which might include a home care worker or services in a foster home, group care home or assisted living facility.

Except for care in a nursing home or for children, payment for room and board is normally the responsibility of the individual. However, depending on the income of the individual, they may be responsible to also contribute to the cost of the care, which is referred to as a service or patient liability.

All policies for OSIPM discussed in OPEN apply to LTC services unless noted otherwise in this section.

Other resources

Long-Term Services and Supports (LTSS) Talking Points for Eligibility Workers: Discusses EW key topics for LTSS intake, including financial eligibility and Service Priority Level (SPL); it also includes patient liability details for Oregonians with income above certain limits.

Long-Term Services and Supports (LTSS) Talking Points for Support Staff: Contains information helping SS determine if the case individual they are speaking with needs LTSS based on key phrases and questions.

Medicaid Long Term Care Services: This QRG covers Medicaid Long Term Care (LTC) Services and how the programs function in ONE. Service TOA's include MSERV, NMAGISERV, and LTCSERV. This QRG is geared towards eligibility workers new to LTC services and ONE. Coordination with APD and AAA case managers is necessary to begin services for a participant, as the service assessment is not done in ONE. This QRG references when and how that coordination should occur and how eligibility is determined across the multiple systems.

Patient Liability Manual Update: Describes the Patient Liability Manual Update screen and its purpose. Describes the data entry needed to determine the Community Spousal Income Amount (CSIA).

Application

LTC services may be requested as part of a medical application. For individuals applying for services, the individual's community spouse who currently lives with or was previously living with the individual immediately prior to the continuous period of care may complete the application process and sign the application. For someone who is incapacitated, or for a child under 18 who has no parent or legal guardian to apply, we can accept an application signed by anyone 18 or older acting responsibility on the person's behalf.

A new application is not required when a signed application (dated 2009 or later for an SDS 0539A and 2020 or later for an OHP 7210) is on file for those instances described in the "When to use an application" section and in the following situations:

- When an individual establishes a new date of request before the end of the month following the month of case closure due to failure to make a LTC liability payment or EPD participant fee payment.
- To add a program or make a program change if there is enough information and documentation to determine eligibility for the new program without a new application. For individuals who request services, staff should provide the individual with an Estate Recovery Program brochure (MSC 9093) with an Information of the Transfer of Assets Penalty form (SDS 0543) and add a case note.

For eligibility to be determined, the application must be completed and signed. A person may use their mark if it is witnessed by an ODHS|OHA employee unless the applicant is a resident of a public institution. Applications for individuals who reside in a public institution may be witnessed by an employee of the institution.

Oregon Administrative Rule(s)

461-115-0010 — Application Process; General
461-115-0020 — Application Requirements
461-115-0030 — Date of Request
461-115-0050 — When an Application Must be Filed
461-115-0071 — Who Must Sign the Application and Complete the Application Process
461-115-0190 — Application Processing Time Frames; Not Pre-TANF or SNAP
461-115-0430 — Periodic Redeterminations; Not EA, ERDC, SNAP, or TA-DVS

Other resources

Program of All Inclusive Care for the Elderly (PACE): Describes the process when an Oregonian is receiving or applying for PACE services.

Cold Caller and Outreach Pre-Call Process: Describes cold call and outreach pre-call process.

Withdrawing a Request for Long-Term Services and Supports *includes screenshots: Describes process and outcomes of withdrawing LTSS request after it has been initiated for various programs, including MAGI and OSIPM as well as LTCSERV.

Interviews

An interview must be completed at initial application for everyone applying for services, **including** assumed eligible and MAGI individuals. An interview must be completed at renewal for everyone receiving services, **except** assumed eligible and MAGI individuals. The same individuals who can complete the application process can also complete the interview.

Note: If the initial application was completed by someone acting responsibly on an incapacitated individual's behalf and that person is not the authorized representative, then they are not authorized to complete the interview at renewal. If it's clear that the individual cannot complete the interview process, the interview requirement can be waived. This means that the interview must be marked as completed with a case note explaining the waiver.

Other resources

APD Interview Guide *includes screenshots: Describes key data and processes involved in conducting an APD interview, including income, expenses and non-financial information.

NON-MAGI Driver Flow & Gatepost Questions QRG

Eligibility groups

Individuals applying for LTC services will always be the only one in the household, filing, financial, need, and benefit groups. However, the adult's spouse or child's parent, if any, will have their resources considered during the resource assessment/evaluation portion of the financial eligibility determination.

Note: For children, this means only their income is counted, not the parents'. However, parental resources are deemed to the child.

ONE will determine the EDG through the rules engine using the answers to questions within the system. When someone is "filtered out" of the EDG for services, they cannot be put back in except in community spouse and parent of an applying child situations.

Other resources

Non-MAGI Medical Eligibility Determination Groups & Status QRG.

Oregon Administrative Rule(s)

461-110-0210 — Household Group
461-110-0410 — Filing Group; MSP, OSIPM
461-110-0530 — Financial Group
461-110-0630 — Need Group
461-110-0750 — Benefit Group
461-135-0950 — Eligibility for Inmates and Residents of State Hospitals
410-200-0305 — Eligibility Determination Group—MAGI Medicaid/CHIP

Effective date of benefits

Medicaid eligibility

For applicants who are eligible for medical benefits because of their eligibility for long-term care, the effective date for the initial month's medical benefit is the first of the month in which the applicant becomes eligible for long-term care services. There is no retroactive service eligibility, so these individuals cannot receive retroactive OSIPM unless they are eligible without services in the three months prior to the date of request.

Service eligibility

APD/AAA case managers, Community Developmental Disability Program (CDDP) eligibility specialists, and community behavioral health services' behavioral health specialists determine eligibility for services outside of ONE. Service eligibility, start/termination dates and service setting are coded on the legacy SELG screen, then added to the ONE case (if applicable) through an interface.

Changes in liability

Increase in liability

For changes that increase liability, the effective date for reducing benefits is the first day of the month following the month in which the notice period ends.

Reduction in liability

For changes in income that reduce liability:

- If the change was reported timely, the change is effective the first of the month the change occurred.
- If not reported timely, the change is effective the first of the month the change was reported or discovered.

For changes in medical deductions that reduce liability:

- For both ongoing and one-time expenses, the change is effective the first of the month the change occurred, if reported timely.
- For ongoing expenses that are not reported timely, the change is effective the first of the month the change is reported.
- One-time expenses that have been paid in full but not reported timely will not be used.

For changes in marital status or number of eligible dependents that reduce liability:

- The change is effective the first of the month the change occurred, if reported timely.
- The change is effective the first of the month the change was reported or discovered if not reported timely.

For changes in service setting that decrease liability, the effective date is the date the individual moves into the new service setting.

If a change in income and service setting occur in the same month, the effective date is the day the individual moves into the new service setting.

Income cap trust (ICT)

The effective date for an income cap trust that makes an individual income eligible for LTC services is the first day of the month in which the trust document is signed.

Click here for examples: Effective dates.

Oregon Administrative Rule(s)

461-180-0020 — Effective Dates; Changes in Income or Income Deductions That Cause Increases
461-180-0030 — Effective Dates; Changes in Income or Income Deductions That Cause Reductions
461-180-0040 — Effective Dates; Special Needs and Services
461-180-0044 — Effective Dates; Income Cap Trust
461-180-0070 — Effective Dates; Initial Month Benefits
461-180-0090 — Effective Dates; Initial Month Medical Benefits
461-180-0140 — Effective Dates; Retroactive Medical Benefits
411-030-0040 — Eligibility Criteria

Individual information

Living arrangement

An individual's living arrangement and where they reside can affect several eligibility factors. This establishes what financial information is considered, which impacts the medical program or level of services individuals are determined eligible for. Whether the individual is in a nonstandard living arrangement (receiving LTC services) or a

standard living arrangement (not receiving LTC services) may determine if they incur a monthly cost. The type of nonstandard living arrangement (nursing facility, community-based care facility or their own home) helps determine the amount of their monthly cost.

State of residence in a medical facility

Residency of an individual living in a state or private medical facility, such as a hospital, mental hospital, nursing home or convalescent center, is determined as follows:

- An individual age 21 or older or an individual less than age 21 who is legally emancipated or married, who is capable of indicating intent to reside is considered to be a resident of the state where the individual is living with the intention to remain permanently or for an indefinite period.
- An individual age 21 or older who became incapable of indicating intent to reside after age 21 is considered to be a resident of the state where the facility is located unless the individual was placed in the facility by a state agency of another state. When a state agency of another state places an individual, the individual is considered to be a resident of the state that makes the placement.
- For an individual under age 21, who is incapable of forming an intent to reside, or an individual of any age who became incapable of forming that intent before age 21, the state of residence is one of the following:
  - The state of residence of the individual's parent or legal guardian at either the time of application or placement if the individual is institutionalized in that state.
  - The state of residence of the party who applies for benefits on the individual's behalf if:
    - » There is no living parent or the location of the parent is unknown,
    - » There is no legal guardian, and
    - » The individual is institutionalized in that state.
  - Oregon if the individual has been receiving medical assistance in Oregon continuously since November 1, 1981 or is from a state with which Oregon has an interstate agreement that waives the residency requirement.

Oregon Administrative Rule(s)

461-120-0030 — State of Residence for an Individual in a Medical Facility

Financial eligibility

Income

Individuals who are eligible for an OHP Plus medical benefit (HSD medical, OSIPM, Child Welfare medical) can also receive LTC services. Individuals needing services who are not eligible for OHP plus medical in a standard living arrangement are evaluated for OSIPM under the 300% SSI income standard and must meet the requirements below:

- The individual is eligible under one of the following service eligibility standards:
  - The criteria regarding eligibility for APD's nursing facility or Home and Community-Based Services,
  - The level-of-care criteria for an intermediate care facility for individuals with intellectual disabilities (ICF-

IID), or

- The service eligibility standards for the Children's Intensive In-Home Services (CIIS) programs.

- The individual resides or will reside in one of the following locations for a continuous period of care and receives long-term care services authorized by ODHS|OHA:
  - A Medicaid-certified nursing facility
  - An intermediate care facility for individuals with intellectual disabilities (ICF-IID), although we currently have none in Oregon
  - A home and community-based care setting covered by:
    - » A waiver under Title XIX of the Social Security Act, or
    - » The Independent Choices Program (OSIPM-IC).

Reminder: This does not include individuals receiving 1915(i) behavioral health services.

Note: Children who receive SSI, SSDI or have a presumptive determination and meet the services eligibility criteria are considered a benefit group of one. Only the child's income is counted (income could be child support, trust disbursements, etc.).

Note: If the individual's countable income is over the 300% of SSI, an income cap trust needs to be established.

Income cap trust (ICT)

Individuals whose income is more than 300% of the SSI standard may use an Income Cap Trust (ICT) to meet the income limit for OSIPM because they give up direct access to and control of that income.

When applying for LTC services, individuals should wait until after they have been assessed and meet service eligibility requirements to establish an ICT. However, discuss trust requirements with them as soon as possible so they are prepared and benefits aren't delayed.

If the applicant or their representative does not wish to or is unable to establish an ICT without an attorney, refer them to Legal Aid or elder law attorneys of their choice. If the applicant or their representative is able and wishes to establish the ICT without an attorney, see the APD worker guide on Understanding Trusts for more information on ICT requirements and how to assist the applicant.

Note: Do not ever give legal advice. You may indicate what will satisfy our requirements only.

Other resources

Income Cap Trust *includes screenshots: Explains when Income Cap Trusts are used and when the Income Cap Trust Screen is queued

Availability of income

Couple with an institutionalized spouse

This applies to an institutionalized spouse who began a continuous period of care on or after October 1, 1989. Determine the ownership of income from property that belongs to the institutionalized or community spouse as

follows, unless legal documents specifically provide otherwise:

- If the payment is made solely to the institutionalized spouse or the community spouse, the income is available only to that spouse.
- If the payment is made to both the institutionalized and the community spouse, one-half of the income is available to each.
- If the payment is made to one spouse and another person, or to both spouses and another person, the income available to each spouse is whatever their share of the income is. If the payment is made to both spouses and another person and it is not clear what each spouse's share of the income is, each spouse's share will be one-half of the couple's portion of the payment.
- If the institutionalized spouse can prove that the ownership of income is other than provided above, allow that amount.

Oregon Administrative Rule(s)

461-135-0750 — Individuals Applying for or Receiving Long-Term Care or Home and Community-Based Care

Resources

As part of the eligibility determination, ODHS|OHA is required to request resource verification from the Asset Verification System (AVS) for all individuals and their spouses who are applying for or receiving OSIPM-based LTC services. AVS requests need to be submitted, even when an individual reports having no assets, to determine if there are any undisclosed assets or transfers.

A resource assessment (RA) is required when a married individual applies for OSIPM-based LTC services and their spouse is not residing in a hospital or nursing facility.

Though OSIPM is the only medical program with a resource limit, married HSD medical recipients should be given the opportunity to complete a RA when applying for LTC services in anticipation that they may eventually require OSIPM and may have diminished ability to provide the needed information when the time comes.

Other resources

Resource Assessment *includes screenshots: Overview of the Resource Assessment Summary screen and describes the concept of a 'community spouse' and how to calculate the community spouse resource allowance.

Court Ordered Cost-Sharing Reduction (CSR) *includes screenshots: Describes the task and the conditions to trigger it. Provides steps for approving or denying the use of the court ordered amount.

Medical Asset Check via AVS *includes screenshots: Describes what benefit programs are eligible for the medical asset check and the different types of assets that are checked by the AVS interface. Provides instruction for initiating the check and responding to discrepant and undisclosed resources.

Tracking Submitted Requests in the Asset Verification System (AVS) *includes screenshots: Gives step-by-step process of how to check status of pending AVS requests via the Case Queue.

Call Center Software – Playing the Asset Verification System (AVS) recording & Capturing Verbal Signature *includes screenshots: Walks through the process of having the Oregonian listen to the AVS recording, capturing the verbal signature, downloading the recording and saving the file in ONE at the individual level.

Excluded resource: Payments received under a qualified partnership policy (QPP)

When an individual in a nonstandard living arrangement applies for OSIPM, ODHS|OHA excludes as a resource an amount equal to the insurance payments received under a QPP as of the initial month of eligibility.

This exclusion:

- Does not apply when home equity exceeds the program limits, and
- Applies to all other resources, notwithstanding other rules that designate the resources as countable.

Click here for more information about payments received under a QPP.

Community spouse resource allowance (CSRA)

This applies to an institutionalized spouse who has applied for benefits because the spouse is in or will be in a continuous period of care. This also applies to MAGI-based long-term care consumers who might require OSIPM-based long-term care at some point. Whether the couple lives together or not, determine if the couple's assets make the institutionalized spouse eligible or ineligible for OSIPM (not including EPD) as follows:

Step 1. Determine what the couple's combined countable assets were at the beginning of the most recent continuous period of care. (The beginning of the continuous period of care is the first month of that continuous period.)

- Determine which of the couple's assets were countable resources. The rules used to determine whether a community spouse's assets are countable are the same rules used with respect to an OSIPM applicant or recipient.
- Combine both spouses' countable resources.
- At this point in the computation, the couple's combined countable resources are considered available equally to both spouses.

Step 2. Calculate one half of what the couple's combined countable resources were at the beginning of the continuous period of care. Treat the community spouse's half of the couple's combined resources as a constant amount when determining eligibility.

Step 3. Determine the community spouse's resource allowance (CSRA). The CSRA is the largest of the four following amounts:

- The community spouse's half of what the couple's combined countable resources were at the beginning of the continuous period of care, but not more than $137,400
- $27,480 (the state community spouse minimum resource allowance)
- A court-ordered community spouse resource allowance.
  - In this rule, the term court-ordered community spouse resource allowance means a court-ordered CSRA that, in relation to the income generated, would raise the community spouse's income to a court-approved monthly maintenance needs allowance. In cases where the individual became an institutionalized spouse on or after February 8, 2006, this asset allowance must use all of the individual's available income and the community spouse's income to meet the community spouse's monthly maintenance needs allowance before any resources are used to generate interest income to meet the allowance.
- After considering the income of the community spouse and the income available from the institutionalized spouse, an amount which, if invested, would raise the community spouse's income to the monthly maintenance needs allowance.
  - This is the amount required to purchase a single premium immediate annuity to make up the shortfall and is considered only if the amount described in (1) below is larger than the amount described in (2) below; it is the difference between the following:

    1. The monthly income allowance computed as follows:
       - **Step A —** Determine the maintenance needs allowance. $2,288.75 is added to the amount over $686.63 that is needed to pay monthly shelter expenses for the principal residence of the couple. This sum or $3,435, whichever is less, is the maintenance needs allowance. For the purpose of this calculation, shelter expenses are the rent or home mortgage payment (principal and interest), taxes, insurance, required maintenance charges for a condominium or cooperative, and the full standard utility allowance (FUA) for the SNAP program. If an all-inclusive rate covers items that are not allowable shelter expenses, including meals or housekeeping in an assisted living facility, or the rate includes utilities, to the extent they can be distinguished, these items must be deducted from the all-inclusive rate to determine allowable shelter expenses.
       - **Step B —** Compare maintenance needs allowance with community spouse's countable income. The countable income of the community spouse is subtracted from the maintenance needs allowance determined in step 1. The difference is the income allowance unless the allowance described in step 3 is greater.
       - **Step C —** If a spousal support order or exceptional circumstances resulting in significant financial distress require a greater income allowance than that calculated in step 2, the greater

amount is the allowance.

2. The difference between:
   - The sum of gross countable income of the community spouse and the institutionalized spouse, and
   - One of the following applicable need standards:
     - $68.77 for an individual in a nursing facility or ICF-IID.
     - $90 for an individual who is eligible for VA benefits based on unreimbursed medical expenses. The $90 allowance is allowed only when the VA benefit has been reduced to $90.
     - $841 for community-based care (RES in SELG).
     - $1,341 for in-home care (IHC in SELG).

Step 4. Determine what the couple's current combined countable resources are when a resource assessment is requested or the institutionalized spouse applies for OSIPM. Use the procedure in step 1.

Step 5. Subtract the CSRA from the couple's current combined countable resources. The resources remaining are considered available to the institutionalized spouse.

Step 6. Compare the remaining assets to the OSIPM resource limit for one person. If the remaining resources are at or below the standard, the institutionalized spouse is eligible for OSIPM. If the remaining resources are above the standard, the institutionalized spouse is not eligible for OSIPM until the value of the couple's combined countable resources is reduced to the largest of the four amounts described in step 3.

Once eligibility has been established, assets equal to the community spouse's resource allowance (from above) must be transferred to the community spouse if those assets are not already in that spouse's name. The institutionalized spouse must indicate their intent to transfer the assets and must complete the transfer to the community spouse within 90 days. This period may be extended for good cause. These assets are excluded during this period. After this period, assets owned by the institutionalized spouse but not transferred out of that spouse's name will be countable and used to determine ongoing eligibility. Any transfer to the community spouse not made per this rule (for example, a transfer of the home, which is exempt and therefore not involved in the resource assessment) must comply with the sole benefit requirement of OAR 461-140-0242(2)(b) or be reviewed as being a potentially disqualifying transfer.

For individuals with a court ordered CSRA, ODHS|OHA may waive the requirement for income to be considered first if ODHS|OHA determines that the resulting CSRA would create an undue hardship on the spouse of the individual. These requests should be submitted to the APD Medicaid policy email.

Note: Excluded assets are not required to be transferred to the community spouse.

Note: For a single or married individual who needs to spend resources in order to meet the OSIPM resource limit, be sure to advise that resources must be spent on items worth fair market value. If resources are gifted or transferred for less than fair market value, the individual may be disqualified from receiving long-term care services. Purchase of gift cards or certificates cannot meet the spend-down requirement because it is simply an exchange for a cash equivalent and is not considered spending the resource.

When an individual or spouse purchases an annuity in order to spend down excess resources to meet the resource limit, the date the resources are considered spent is the date the annuity issuer accepts payment and issues the annuity.

If an institutionalized spouse is determined eligible, send a basic decision notice to each spouse or each person's authorized representative. Use the SDS 3402 form.

Click here for more information on treatment of annuities.

Click here for examples: Resources.

Oregon Administrative Rule(s)

461-175-0225 — Notice Situation; Institution/Income and Resource Allowances
461-160-0580 — Excluded Resource; Community Spouse Provision (OSIPM except OSIPM-EPD)

Disqualifying transfer of assets

Transfers of assets must be evaluated on a case-by-case basis. The decision about whether a disqualification results will depend on the unique facts surrounding each case. Individuals in standard living arrangements are not disqualified for transfers of assets. However, if a disqualifying transfer is within the look-back period when the individual later applies for services, the individual must be disqualified at that time even if the asset was transferred before there was a service need.

An individual receiving SSI or deemed to be eligible for SSI in a nonstandard living arrangement who would otherwise be ineligible for OSIPM due to a disqualifying transfer of assets is not eligible for LTC services. The individual can continue to receive OSIPM but is disqualified from receiving LTC services until the disqualification period has been served. This policy is not retroactive. It only applies to disqualifying transfers that occur on or after July 1, 2007.

The form Information on the Transfer of Assets Penalty (SDS 0543) provides general information about disqualifying transfers and is optional. Consider providing this form when:

- An individual assumed eligible for OSIPM in a standard or nonstandard living arrangement owns assets that could result in disqualification from LTC services if transferred,
- An individual eligible for OSIPM has already transferred property that would result in disqualification from LTC services, but the individual is currently in a standard living arrangement.
- Medicare Savings Program individuals (QMB, SMB, SMF) in standard living arrangements own or have already transferred property that could be subject to the rules on disqualifying transfers if the individual were in a nonstandard living arrangement.

The OHP 7210 also provides individuals with information regarding the transfer of assets on page 40. The information should be reviewed with applicants during intake.

Note: An HSD medical recipient applying for LTC services on or after October 1, 2014, is evaluated for transfer of asset penalties in the same manner as if they were receiving or applying for OSIPM. The following additional guidelines apply to HSD medical recipients that applied for LTC services prior to October 1, 2014:

- Transfers that occurred prior to October 1, 2014 are not subject to transfer penalties.
- Transfers occurring on or after October 1, 2014 are subject to transfer penalties.

When an individual or the individual's spouse transfers assets within the look-back period and for less than fair market value for the purpose of maintaining or becoming eligible for Medicaid, a disqualification period is calculated for the need group.

Facts that may affect the decision include, but are not limited to, the following:

- The value of the asset transferred
- The amount of compensation received
- The date the asset was transferred in relation to the application date for medical benefits
- The individual's state of health and anticipated need for medical benefits at the time of the transfer
- The documentary evidence or testimony provided by the individual or knowledgeable witnesses.

If a transfer is made for less than fair market value and is not exempt from disqualification, there is a rebuttable presumption that the asset was transferred for the **purpose of establishing or maintaining eligibility**.

To rebut the presumption, the individual must present evidence other than their own statement and must provide to ODHS|OHA the information it requests for the purpose of evaluating the purpose of the transfer. To meet the burden, it is sufficient for the individual to show one of the following:

- The decision to make the transfer was not within the individual's control,
- At the time of transfer, the individual could not reasonably have anticipated applying for medical assistance,
- Unexpected loss of assets or income occurred between the time of transfer and the application for medical assistance, or
- Because of other, similarly convincing circumstances, it appears more likely than not that the transfer was not made, in whole or in part, for the purpose of establishing or maintaining eligibility for benefits.

The fact that a recipient was already eligible for benefits is not sufficient to rebut the presumption because the asset may not always be excluded and if the individual had received full compensation for the asset, the compensation received would have been used to determine future eligibility.

The financial group members who transfer an asset must do all the following in order to be eligible for benefits:

- Report any transfer of assets for all members of the financial group at application, renewal and when the transfer occurs,
- Provide documentation of the terms of the sale or disposal of the assets, and
- Provide evidence that the transfer was not disqualifying.

Transfers that are not disqualifying

For the purposes of this transfer policy, "child" means a natural or adoptive son or daughter who is:

- Under age 21, or
- Any age and has been determined to meet the criteria for blindness or disability.

A transfer of an asset by an individual or the spouse of the individual in a nonstandard living arrangement is a disqualifying transfer unless:

- The transfer was made exclusively for purposes other than establishing eligibility or maintaining benefits.
- The transferred item was personal belongings.
- The asset was sold or traded for compensation equal to or greater than fair market value.
- The asset was transferred between members of the same financial group, including members who are ineligible non-citizens or disqualified people.
- The title to the asset was transferred to the individual's spouse, to the individual's child who is blind or has a disability under the criteria of the Social Security Administration, or another for the "sole benefit" of the spouse or a child who is blind or has a disability under the criteria of the Social Security Administration.
  - The transfer must be structured in such a way that no individual or entity except this spouse or child can benefit in any way from the asset transferred, whether at the time of transfer or any time in the future.
  - A direct transfer, transfer instrument or trust that provides for funds or property to pass to a beneficiary who is not the spouse or child who is blind or has a disability under the criteria of the Social Security Administration is not considered to be established for the benefit of one of those individuals.
  - In order for a transfer or a trust to be considered for the "sole benefit" of one of these individuals, the instrument or document must be irrevocable and provide for the spending of the funds involved for the benefit of the individual based on the life expectancy of the individual.
- The transfer was made to an irrevocable trust described in 461-145-0540(9), except that a transfer to a trust under 461-145-0540(9)(a) is disqualifying if the individual is age 65 or older.
- The transfer was made to a trust described in 461-145-0540(10) established solely for the benefit of an individual under 65 years of age who has a disability that meets the criteria of the Social Security Administration. This subsection applies to all transfers made on or after July 1, 2006.
- The transfer settled a legally enforceable claim against the asset or individual.
- A court ordered the transfer (within the look-back period) and the amount of assets allocated to a community spouse does not exceed the largest of the four amounts described under step 3 of Community Spouse Resource Allowance above.
- The individual was a victim of fraud, misrepresentation, or coercion, and legal steps have been taken to recover the asset.
- The amount of the resource was equal to or less than the following amounts excluded as payments received under a Qualified Partnership Policy:
  - For new applicants, the amount that ODHS|OHA determines can be excluded at the initial month of eligibility, or

- For ongoing recipients, the amount of the current exclusion allowed for the Qualified Partnership Policy.

- The title of a home was transferred to the individual's:
  - Child under age 21,
  - Sibling who has equity interest in the home and was residing in the home for at least one year immediately before the individual's admission to long-term care, or
  - Son or daughter who meets the requirements of each of the following:
    - » The son or daughter resided with the individual in the individual's home continuously for at least two years immediately prior to the individual's admission to long-term care other than an absence from the home that is not intended to, and does not, exceed 30 days.
    - » The son or daughter provides convincing evidence that they provided care services that permitted the individual to reside at home for at least two years rather than in an institution or LTC facility.
    - » Without receiving payment from ODHS|OHA, the son or daughter must have directly provided the LTC services required as described in both of the following for a total of at least 20 hours per week:
      - On a daily basis, one or a combination of any of the following activities of daily living:
        - Eating
        - Dressing/Grooming
        - Bathing/Personal Hygiene
        - Mobility
        - Elimination
        - Cognition/Behavior
      - One or a combination of any of the following instrumental activities of daily living:
        - Housekeeping
        - Laundry
        - Meal preparation
        - Medication management
        - Shopping
        - Transportation

- The asset is an annuity with the individual or the spouse as the annuitant:
  - **Purchased on or before December 31, 2005**, and the entire amount of principal and earned interest is paid in equal installments during the actuarial life expectancy of the annuitant.
  - **Purchased on or after January 1, 2006, through June 30, 2006**.
- The asset is an annuity purchased **on or after July 1, 2006**, and the annuity meets the requirements of 461-145-0022(10).

Note: Use the following forms for transfers involving a caregiving child:

- SDS 3306 Letter to Doctor regarding Long-Term Care Services
- SDS 3307 Collateral Statement (best if completed by disinterested individuals who would not benefit from the transfer)
- SDS 3308 Statement of Services Provided to Medicaid Applicants

Note: An individual receiving Oregon Project Independence (OPI) benefits is not considered to be "in an institution or long-term care facility" for the purposes of this policy. Therefore, it is possible for the child to provide the necessary level of unpaid care along with the help of OPI paid caregivers during the 2 years that the individual resided at home prior to needing facility care. However, remember that the child must still have provided at least 20 hours per week of care and that the required level of care must have included provision of both ADL and IADL care each day. If the OPI care plan covered all or most of the individual's needs, then the child does not qualify for the home transfer.

Fair market value (FMV)

Except as provided above for a home, an asset is considered to be transferred for fair market value if the following apply:

- The compensation received for the asset is in a tangible form with intrinsic value.
- ODHS|OHA presumes that services provided for free at the time were intended to be provided without compensation and that a transfer to an individual for services provided for free in the past is a disqualifying transfer of assets. This presumption is rebuttable with convincing evidence. This evidence must also show that there was an express agreement to provide services for compensation at the time the services were provided.
- Compensation for services is valued at the average market rate at the time the services were provided, unless the express agreement provides a lower rate.
  - Examples of average market rate:
    - » For LTC services, use a reasonable rate as requested by the individual or the appropriate Medicaid rate.
    - » For other services, contact three local service providers to determine the average rate.

If an asset is owned by more than one person, by joint tenancy, tenancy in common or similar arrangement, the share of asset owned by the individual is considered transferred when any action is taken either by the individual or any other person that reduces or eliminates the individual's control or ownership in their share of the asset.

Look-back period

Transfers on or before June 30, 2006

The following transfers made without compensation equal to or greater than fair market value may be disqualifying:

- **Transfer from a revocable trust:** If the transfers occurs on or after the date that is 60 months prior to the date of request.

- **Transfer to an irrevocable trust:** If the transfers occurs on or after the date that is 60 months prior to the date of request.
- **Assets in an irrevocable trust are now unavailable to the individual:** If the transfer occurs on or after the date that is 60 months prior to the date of request.
- **Transfer from an irrevocable trust:** On or after the date that is 36 months prior to the date of request.
- **All other asset transfers:** On or after the date that is 36 months prior to the date of request.

Transfers on or after July 1, 2006

A transfer of an asset may be disqualifying if the transfer occurs on or after the date that is 60 months prior to the date of request.

Determining the uncompensated value of a transferred asset

The uncompensated value of a disqualifying transfer of an asset is used to calculate the ineligibility period of the need group.

To determine uncompensated value, the value of the compensation received for the asset is subtracted from the fair market value of the asset.

- For transfers made on or after the DOR for LTC service, this result is the uncompensated value.
- For transfers made before the DOR for LTC services, this result is the uncompensated value unless the financial group had countable resources of less than the resource limit at the time of the first transfer. In that event, the remainder (the resource limit minus the countable resources) is then credited by adding it to the other compensation received for the asset.

The compensation received for a transferred asset includes encumbrances assumed by the buyer and goods or services provided to the individual, limited to their true value, if there was a prior agreement to exchange the asset for the goods or services.

Calculating the disqualification

Note: Be sure to allow the resource limit before calculating the disqualifying transfer of assets.

Divisor

A financial group containing a member disqualified due to the transfer of an asset is disqualified from receiving benefits. The length of a disqualification period resulting from the transfer is the number of months equal to the uncompensated value for the transfer divided by the following dollar amount:

- If the initial month is on or after:
  - October 1, 1993 and prior to October 1, 1998 — **$2,595**
  - October 1, 1998 and prior to October 1, 2000 — **$3,320**
  - October 1, 2000 and prior to October 1, 2002 — **$3,750**
  - October 1, 2002 and prior to October 1, 2004 — **$4,300**
  - October 1, 2004 and prior to October 1, 2006 — **$4,700**

- October 1, 2006 and prior to October 1, 2008 — **$5,360**
- October 1, 2008 and prior to October 1, 2010 — **$6,494**
- October 1, 2010 and prior to October 1, 2016 — **$7,663**
- October 1, 2016 and prior to October 1, 2018 — **$8,425**
- October 1, 2018 and prior to October 1, 2020 — **$8,784**
- On or after October 1, 2020 — **$9,551**

Calculation

For transfers before July 1, 2006:

- Add together the uncompensated value of all transfers made in one calendar month and treat this total as one transfer.
- If the uncompensated value of the transfer is less than the divisor, there is no disqualification.
- If there are multiple transfers in amounts equal to or greater than the divisor, each disqualification period is calculated separately.
- The number of months is rounded down to the next whole number.
- Except as provided in the next bullet, the first month of the disqualification is the month the asset was transferred.
- If disqualification periods overlap, the periods are applied sequentially so that no two penalty periods overlap.
- If both spouses of a couple are in a nonstandard living arrangement and made the disqualifying transfer, part of the disqualification is apportioned to each of them.
  - If one member of the couple is serving a disqualification when the other member of the couple begins living in a nonstandard living arrangement, any remaining disqualification is apportioned equally to each member of the couple.
  - If one spouse is unable to serve the resulting disqualification period for any reason, the remaining disqualification applicable to both spouses must be served by the remaining spouse.

For transfers on or after July 1, 2006, and for income cap trusts that accumulate funds in excess of the applicable divisor amount:

- If there are multiple transfers, the value of all transfers is added together before dividing by the divisor. This includes any transfer less than the divisor. For an income cap trust, the calculation is performed as soon as, but not before, funds have accumulated to at least the applicable divisor amount.
- The calculated number of months is not rounded. The whole number of the quotient is the number of full months the financial group is disqualified. The remaining decimal is used to calculate an additional partial month disqualification. This remaining decimal is converted to number of days by multiplying the decimal by the number of days in the month following the last full month of the disqualification period. If this calculation results in a decimal, the decimal is dropped.
- The first month of the disqualification (DQ) is as follows:
  - For an individual who is already receiving ODHS|OHA-paid LTC services, the disqualification begins the

month following the month of the asset transfer, except that if disqualification periods calculated in accordance with this rule overlap, the periods are applied sequentially so that no two penalty periods overlap.

  - For a new applicant and for an individual who is already receiving benefits in a standard living arrangement, the disqualification begins on the date of request for LTC services as long as the individual would otherwise be eligible but for this disqualification period (this includes the determination of service eligibility through CA/PS). If the individual is not otherwise eligible on the date of request, the disqualification begins the first date following the date of request that the individual would otherwise be eligible but for the disqualification period.

- If both spouses of a couple are in a nonstandard living arrangement and made the disqualifying transfer, part of the disqualification is apportioned to each of them.
  - If one member of the couple is serving a disqualification when the other member of the couple begins living in a nonstandard living arrangement, any remaining disqualification is apportioned equally to each member of the couple.
  - If one spouse is unable to serve the resulting disqualification period, for any reason, the remaining disqualification applicable to both spouses must be served by the remaining spouse.

Note: The DQ period cannot begin until the expiration of any existing period of ineligibility.

For an annuity that is a disqualifying transfer, the disqualification period is calculated based on the total balance of the payments owing to the annuitant, unless the only requirement that is not met is that the annuity pays beyond the actuarial life expectancy of the annuitant. If the annuity pays beyond the actuarial life expectancy of the annuitant, the disqualification is calculated as outlined below.

If an individual or the spouse of an individual purchases an annuity on or before December 31, 2005, and the annuity pays benefits beyond the actuarial life expectancy of the annuitant, as determined by the life expectancy tables in Treatment of annuities, a disqualification period is assessed for the value of the annuity beyond the actuarial life expectancy of the annuitant.

A single transfer of an asset may cause a disqualification for both a medical assistance program and the SSI cash grant. The period of the disqualification is likely to be longer for SSI than for the medical assistance program, so a person may be eligible again for the medical assistance program while still disqualified from receiving SSI. The provisions of this rule are applied without regard to the related disqualification for SSI.

Ending the disqualification

The disqualification ends if the transfer that caused the disqualification is rescinded.

The duration of the disqualification is recalculated if the terms of the transfer are modified.

ODHS|OHA may waive the disqualification if the disqualification would create an undue hardship on the individual.

Hardship waiver process for disqualifying transfer of assets

When a disqualification period is calculated for a transfer of assets, individuals are sent a decision notice. The notice incudes information explaining that a waiver of the disqualification can be requested if the disqualification

will cause an undue hardship. The individual, their representative or the facility in which the individual resides (on behalf of the individual) can apply for the waiver.

If the individual alleges a hardship, the decision about a hardship waiver will be made, and a new notice will be sent if the waiver is denied. The individual will have hearing rights on this decision. If the individual is a recipient and a hearing is requested within 10 days of the notice date or by the effective date of the notice (whichever is later), benefits can continue until the hearing decision and while the hardship waiver decision is pending if the individual requests continuing benefits.

Note: If the individual does not allege a hardship and requests a hearing, there is no change in procedure.

To apply for a hardship waiver, the request must be made on the Application for Hardship Waiver form (APD 0544). The request must explain what basic need will not be met due to the disqualification.

To be eligible for the waiver, the disqualification must create an undue hardship that meets the requirements of the following subsections:

- The individual has no other means for meeting their needs. The individual has the burden of proving that no other means exist by:
  - Exploring and pursuing all reasonable means to recover the assets to the satisfaction of ODHS|OHA, including legal remedies and consultation with an attorney, and
  - Cooperating with ODHS|OHA to take action to recover the assets.
- The disqualification would deprive the individual of:
  - Medical care such that the individual's health or life would be endangered, or
  - Food, clothing, shelter or other necessities of life without which the health or life of the individual would be endangered.

If the individual is in a facility receiving care but the facility is not being paid, ODHS|OHA will consider them deprived of medical care, because the facility could take action to evict them due to non-payment. An eviction notice is not required to prove this hardship. The request also must explain what legal action has been taken to try to recover the asset that was transferred for less than fair market value. To be eligible for a waiver of the disqualification, the individual must have taken all legal actions ODHS|OHA determines are reasonable to recover the asset, including consultation with an attorney. They also must agree to cooperate with ODHS|OHA in taking action to recover the asset.

For processing, email the individual's Application for Hardship Waiver (APD 0544) and a copy of the disqualification notice to APD Medicaid policy. ODHS|OHA will make a decision on whether to grant the waiver within 45 days. If the waiver is granted, the individual can receive benefits without serving the disqualification. If the waiver is denied, an applicant's case remains denied and a recipient's case remains reduced or closed (unless the individual requested a hearing and continuing benefits within the required timeframe).

If the financial group receives new countable income or resources after an undue hardship waiver has been granted, redetermine the eligibility of the individual.

Click here for examples: Disqualifying transfer of assets.

Oregon Administrative Rule(s)

411-015-0006 — Activities of Daily Living
411-015-0007 — Instrumental Activities of Daily Living
461-140-0210 — Asset Transfer; General Information and Timelines
461-140-0242 — Disqualifying Transfer of Assets Including Home; OSIP and OSIPM
461-140-0296 — Length of Disqualification Due to an Asset Transfer; OSIP and OSIPM
461-140-0300 — Adjustments to the Disqualification for Asset Transfer
461-145-0220 — Home
461-145-0405 — Plan for Self-Support
461-145-0540 — Trusts
461-175-0310 — Notice Situation; Asset Transfer Disqualification
461-140-0250 — Determining the Uncompensated Value of a Transferred Asset
461-145-0390 — Personal Belongings
461-160-0580 — Excluded Resource; Community Spouse Provision (OSIPM except OSIPM-EPD)
461-160-0855 — Excluded Resources for Payments Received Under a Qualified Partnership Policy; OSIPM

Other resources

LTC Hardship Request Task *includes screenshots: Describes the Long-Term Care (LTC) hardship task triggers and business process to close the task.

Post-eligibility

Individuals who receive LTC services must make their liability payment, except as provided below. These individuals must apply their adjusted income to the cost of their care or service. If their adjusted income exceeds their cost of care or service, they must pay the full cost of care but have no additional liability.

Individuals exempt from having to pay a liability:

- Individuals who receive 1915(i) behavioral health services.
- Individuals who receive SSI or are deemed eligible to receive SSI under section 1619(b).
- Individuals who receive long-term care services in their home.
- The following individuals are exempt only if they receive Home and Community-Based Services, not nursing facility services:
  - Disabled adult child (DAC)
  - Disabled widow or widower
  - Pickle Amendment individuals
  - An individual residing in an acute care hospital is exempt from payments required by this rule while in the hospital. If a service benefit was received prior to admission to the acute care hospital, payment must be made for that service.

Note: The Independent Choices (IC) service payment of individuals is reduced by the amount of their liability.

Calculating the liability

Allow deductions in the order below for individuals who are OSIPM eligible and receiving LTC services.

Note: SSI recipients do not have a liability; however, when an SSI recipient enters a nursing facility, workers should complete the SDS 0538A and send it to the Social Security Administration.

- Deduct one standard earned income deduction of $65.
- Allow deductions under the plan for self-support.
- Deduct one of the following need standards:
  - A $68.77 personal needs allowance for individuals in a nursing facility.
  - A $90 personal needs allowance for individuals in a nursing facility who are eligible for VA Aid & Attendance benefits (UME). The $90 allowance is only allowed when the VA benefit has been reduced to $90.
  - For an individual who receives community-based care (AFH, ALF, RCF, etc.), the OSIPM standard.
- Deduct the **community spouse monthly income allowance** from the income of the institutionalized spouse to the extent that the income is made available to or for the benefit of the community spouse, using the following calculation.
  - **Step 1 —** Determine the maintenance needs allowance. $2,288.75 is added to the amount over $686.63 that is needed to pay monthly shelter expenses for the principal residence of the couple. This sum or $3,435 whichever is less, is the maintenance needs allowance.
    - » For the purpose of this calculation, shelter expenses are the rent or home mortgage payment (principal and interest), taxes (do not allow a deduction for deferred taxes), insurance, required maintenance charges for a condominium or cooperative. Also allow the full standard utility allowance (FUA) for the SNAP program if any utilities are paid (including only telephone).
  - **Step 2 —** Compare maintenance needs allowance with the countable income of the community spouse. The countable income of the community spouse is subtracted from the maintenance needs allowance determined in step 1. The difference is the income allowance unless the allowance described in step 3 is greater.
  - **Step 3 —** If a spousal support order or exceptional circumstances resulting in significant financial distress require a greater income allowance than that calculated in step 2, the greater amount is the allowance. **Requests to raise the monthly maintenance needs allowance must be submitted to central office; they cannot be approved at the branch level. Email requests to APD Medicaid policy**.
- Deduct a **dependent income allowance** for each eligible dependent as follows:
  - For a case with a community spouse, a deduction is permitted only if the monthly income of the eligible dependent is below $2,177.50. To determine the eligible dependent's income allowance, subtract the monthly income of the eligible dependent from $2,177.50 and calculate one-third of the amount remaining after the subtraction. This is the income allowance of the eligible dependent.
  - For a case with no community spouse, the allowance is the TANF adjusted income standard for the individual and eligible dependents. The TANF standard is not reduced by the dependent's income.

- **Deduct costs for maintaining a home** if the individual is in a nursing facility and meets ODHS|OHA criteria. The amount allowed is the individual's total housing costs, including taxes and insurance, plus the SNAP Limited Utility Allowance (LUA).

Note: This is not considered a shelter exception or accommodation allowance. A shelter exception/ accommodation allowance is a special need paid to the individual and has different criteria (see Medical Related Payments for more info). In general, the deduction is only for **single individuals** who are expected to be in a nursing facility temporarily. There is no requirement that the individual receive in-home services upon discharge, such as with the accommodation allowance.

- **Deduct allowable medical costs**.

The balance is the adjusted income.

Click here for examples: Calculating the liability.

Oregon Administrative Rule(s)

461-145-0405 — Plan for Self-support
461-160-0610 — Patient Liability; OSIPM (except OSIPM-EPD)
461-160-0620 — Income Deductions and Patient Liability; Long-Term Care Services or Home and Community-Based Care; OSIPM
461-160-0630 — Deduction for Maintaining a Home; Nursing Facility Care Client
461-175-0225 — Notice Situation; Institution/Income and Resource Allowances

Other resources

Medical Expenses: Medical expenses are allowable deductions for SNAP and Medical Programs. QRG covers the policy for medical expenses, screen steps, and verification requirements.

Medicaid Service Liability Calculation: Describes how to calculate Medicaid Service Liability, who is subject to Service Liability, and how to work with Service Liability in ONE and MMIS.

Patient Liability Manual Update *includes screenshots: Describes the Patient Liability Manual Update screen and its purpose. Describes the data entry needed to determine the Community Spousal Income Amount (CSIA).

Community Based Care System and ONE: Describes using Community Based Care system to authorize and pay for residential long-term care services.

Community Spouse Income Allowance (CSIA)

This section explains how to determine what portion of the CSIA (formerly LDS) should be allowed, so that the amount is correct under the rule and to the individual's and community spouse's best advantage.

Individuals in a nonstandard living arrangement are allowed a deduction for the income allowance (support) of the community spouse, to the extent that the support is made available to the spouse. We commonly refer to this support as the "LDS," taken from the legacy code meaning "less diverted to spouse." However, it is called the Community Spouse Income Allowance (CSIA) in ONE.

The basic calculation for the CSIA involves starting with the need standard given in the rule (currently $2,288.75) and adding shelter costs in excess of the shelter standard in the same rule (currently $686.63). This sum or $3,435 (maximum in the rule), whichever is less, is the maintenance needs allowance. The countable income of the community spouse is subtracted from the maintenance needs allowance. The result is the amount of CSIA (as long as it does not exceed the maximum in the rule that the spouse is entitled to get from the individual if it is made available). The CSIA is usually calculated on the middle section of the Liability Worksheet (SDS 0450).

In most cases, allowing the full CSIA amount is of the most benefit to the couple. However, sometimes it is more beneficial if none or only part of the CSIA is allowed.

Any time the Oregonian is paying a different amount than the system-calculated Community Spouse Income Allowance (CSIA, previously referred to as LDS), the worker needs to enter the actual amount into the "Manual CSIA" section on the Patient Liability Manual Update screen in ONE and rerun eligibility.

Click here for examples: Deciding to what extent to allow the CSIA.

Other resources

Patient Liability Manual Update *includes screenshots: Describes the Patient Liability Manual Update screen and its purpose. Describes the data entry needed to determine the Community Spousal Income Amount (CSIA).

Medical costs

Costs are considered incurred when they are billed by the provider. Determine the amounts of the medical expenses to be deducted for purposes of the liability calculation (not eligibility), using one of the following methods:

Allowable deductions:

- A cost or portion of a cost that has already been paid must be reported within 10 days of the date the cost was paid. When reported timely, the deduction is allowed and is used in the month the cost or portion of a cost is paid.
- A one-time cost that has been incurred but not yet paid is allowed in the month the individual reports they will pay the expense.
- One-time medical expenses that have been incurred, not yet paid in full, and that will be paid over more than one month are allowed as follows:
  - The amount allowed as a deduction is the amount the individual expects to pay each month until the outstanding balance would be paid in full (cannot be more than the total amount due when the expense is reported).
  - If the cost is allowed, but the individual doesn't actually pay it, no more deductions are allowed for that cost. In other words, we will never allow more than the total amount due when the cost is reported.
  - The deduction begins the month the individual reports they will begin making payments. If a payment has already been paid, as long as it was reported within 10 days of the payment, that payment is allowed as a deduction in the month it was paid.
- Deductions for one-time medical expenses that have been paid by credit card are allowed as follows:

- The amount allowed as a deduction is the amount the individual expects to pay or is already paying each month until the outstanding balance of the medical cost would be paid in full.
  - » For new costs with no payment history, use the amount the individual expects to pay each month. Verify the medical cost, amount paid by credit card, and count the entirety of each payment toward the principal balance.
  - » For balances on a credit card that are from previous allowable medical costs that have not been used in the past and were not billed during a disqualification period, verify the date the original medical bill was paid to the provider, the amount paid with the credit card and all payments made to the credit card since to determine the outstanding balance. Assume each payment to the credit card goes entirely to the principal balance.
- When allowable medical costs are charged to a credit card along with non-allowable or non-medical costs, assume all payments to the card go toward paying the allowable medical costs first.
- The deduction must be updated when the individual reports they will be changing the payment amount or has made subsequent charges to a credit card for allowable medical costs.
- If the cost is allowed, but the individual doesn't actually pay it, no more deductions are allowed for that cost. In other words, we will never allow more than the total amount due when the cost is reported.

- Recurring costs, such as those for ongoing prescription medications, can be anticipated and allowed through the next annual redetermination. So, if the initial month of eligibility was July, and a recurring cost was reported and verified in September, it can be used in September–June, when the annual redetermination is due.
- The amount used/anticipated should reflect actual and verified costs.
- Recurring costs may not be averaged; however, co-pays for prescriptions filled less than monthly can be converted to a monthly amount.

Note: If a medical cost is sent to collections, it is no longer an allowable deduction

Deductible costs

The following medical costs, incurred by the individual (not a spouse or dependent), are deductible when not covered by Medicaid:

- Health and hospitalization insurance premiums and coinsurance are deductible, including Medicare Part D and Part B premiums not covered under buy-in. Health insurance premiums paid less frequently than monthly may be prorated over the period covered by the premium. When a single premium covers the individual and a spouse and/or dependent, do one of the following:
  - Count the amount the premium would be for the individual alone, or
  - Count half the premium as the individual's portion.

Note: The individual must provide verification of the premium amount. However, when a single premium covers the individual and a spouse and/or dependent and the individual is unable to provide verification for the premium amount for the individual alone, you should count half the current premium. Do not pend for additional verification. If verification is provided for the individual's cost at a later date, update the case with the verified premium amount.

- Long-term care insurance premiums are deductible if the insurance pays for one of the following:
  - Home and community-based care,
  - Nursing facility services, or
  - An intermediate care facility for the intellectually and developmentally disabled (ICF/IID).

Note: A LTC insurance policy that is set up to pay a lump sum (similar to life insurance) is not deductible.

- The cost of a medical service is deductible if it is:
  - Provided by, prescribed by or used under the direction of a licensed medical practitioner, or
  - A medical necessity approved by ODHS|OHA.
- Medical deductions are also allowed for, among other things, the cost of:
  - Medical and dental care, including psychotherapy, rehabilitation services, hospitalization and outpatient treatment.
  - Prescription drugs and over-the-counter medications prescribed by a licensed practitioner, the annual fee for a drug prescription card (including Medicare Part D co-pays), medical supplies and equipment, dentures, hearing aids, prostheses and prescribed eyeglasses.
  - Reimbursement to the person responsible for a medical marijuana grow site for the costs of supplies and utilities associated with the production of the marijuana. No other costs are allowed, including labor. Marijuana is a schedule I narcotic and cannot be legally sold or prescribed per federal law. Therefore, no reimbursement for the cost of the marijuana itself is allowed.
  - Weight management programs if used under the direction of a physician. The deduction may not exceed $50.
  - Payments on past-due bills from a nursing facility or community-based facility during a time period when an individual was not on Medicaid. For amounts owed to a CBC, allowable costs only include the service portion. If the CBC can or will not itemize or break down the room and board amount from the service amount, then deduct the current Medicaid CBC room and board amount to determine the allowable deduction.
  - A medical deduction is allowed for a lift chair if it was medically necessary and prescribed.

Note: If an individual's medical provider indicates that an individual needs a nutrition supplement such as Ensure or Boost, the cost should not be considered a medical deduction. It could be considered as a special diet. See Medical Related Payments to determine whether the individual is eligible for a special need for the cost of the diet.

The following costs are not deductible:

- A cost paid by someone outside the filing group through a reimbursement, vendor payment or in-kind benefit.

- A cost that is paid by a person or company outside the filing group or that is written off by a medical facility. These are referred to as third-party payments.
- The cost for a service provided by someone in the filing group, such as childcare provided by the father while the mother works.
- A cost used as an income deduction in one budget month or averaged over several months cannot be used again.
- A cost that the individual incurred while the individual was serving a disqualification from Medicaid for a transfer of assets for less than fair market value.

How to use medical costs

For individuals who have stable costs, these costs can be anticipated over the eligibility period. For individuals whose costs change monthly, costs must be reported, and liability should be adjusted each calendar month. Prescriptions that are consistently filled every 60 or 90 days can be converted to a monthly amount by dividing by 2 or 3, respectively, and applied as an ongoing, anticipated monthly cost until the next renewal, when it should be reviewed.

If an individual has both stable and unstable costs, more than one payment duration can be used. The payments are coded with the appropriate end date. Once the end date has passed, the deduction will no longer be used in the liability calculation and the liability will increase.

Medicare Part D

There are two categories of Medicare Part D related costs that may be used to reduce the liability: the individual's premium costs and prescription co-payments.

- Premiums: The amount of the plan premium that is above the "low average premium" (e.g. "above the benchmark") is an allowable deduction. This is an anticipated cost and should be reviewed at renewal.
- Prescription co-payments for drugs that could be covered by the Part D plan, but not offered in the plan's formulary: These are costs (coded as MDC in legacy) associated with off-formulary drugs that may only be used as a cost if the individual has filed an exception with their Medicare Part D plan and the exception has been denied. The plan's denial notice will be used as verification for deducting the costs of non-formulary drugs.

Legacy actions needed when adding/updating costs in ONE

When an individual provides verification of new or updated medical costs, the liability will be updated once the cost is entered into ONE and notice will be sent informing them or the new payment amount. However, action must be taken to update the payment systems in legacy. Eligibility workers must coordinate with case managers to complete these actions.

If the individual has not paid the liability for the month, the case manager must adjust the liability through the SFMU legacy screen using the OM (other medical) adjustment reason code. If the individual has paid the liability, the same adjustment is made in SFMU, but the individual will receive a refund check for the amount the liability was reduced.

Click here for examples: Medical costs.

Oregon Administrative Rule(s)

461-160-0030 — Overview of Costs
461-160-0055 — Medical Costs That Are Deductible; OSIP, OSIPM, and SNAP
461-160-0620 — Income Deductions and Patient Liability; Long-Term Care Services or Home and Community-Based Care; OSIPM

Other resources

Medical Expenses: Medical expenses are allowable deductions for SNAP and Medical Programs. QRG covers the policy for medical expenses, screen steps, and verification requirements.

Non-financial eligibility

There are some additional non-financial eligibility requirements concerning individuals applying for or receiving services.

Service priority level (SPL)

SPL is a term specific to APD LTC services that means the individual needs help to meet their daily needs. To qualify, the assistance must be with things like moving around inside their home, using the restroom, eating, getting up and down from furniture or in and out of bed, and/or help understanding how to meet their daily health and safety needs. Needing assistance with housekeeping, cooking meals, laundry and/or shopping does not impact SPL eligibility.

Long-Term Services and Supports (LTSS) screeners will gather most of the information about the individual's care needs, but the conversation frequently starts during an eligibility interview for other benefits. Once the Oregonian has spoken to the LTSS screening team, a case manager will meet with the individual where they live to assess their needs.

To establish SPL eligibility, an individual must be evaluated using ODHS|OHA's standardized assessment tool as meeting at least the requirements for assist or full assist in activities of daily living as defined in Priority of Paid Services Eligibility Levels (Stat. Auth.: ORS 410.070 Stats. Implemented: ORS 410.070).

If the individual is SPL eligible, the case manager will complete and approve the service plan in Oregon ACCESS to create a service eligibility (SELG) record.

Other resources

LTC Service Request Task *includes screenshots: Describes the Long-Term Care (LTC) services request task, including how it is triggered, its queue, and steps to process and manually close the task.

Level of care (LOC)

For information on Level of Care for DD services, see DD services.

Medical assignment

For those with long-term care insurance who are receiving or applying for services, there are additional steps needed to meet the medical assignment requirements:

For those applying for nursing facility (NF) services, a legally responsible individual must do one of the following:

- Complete paperwork with the LTC insurance company to start receiving payments and have the NF as payee for the LTC insurance benefits, or
- If the LTC insurance company will not pay the NF directly, the individual must submit paperwork to receive payments and then promptly turn them over to the NF.

For those applying for home and community-based care, a legally responsible individual must do one of the following:

- Complete paperwork with the LTC insurance company to start receiving payments and have ODHS|OHA as payee for the LTC insurance benefits, or
- If the LTC insurance company will not pay ODHS|OHA directly, the individual must submit paperwork to receive payments and then promptly turn them over to ODHS|OHA.

Note: The automatic medical assignment provisions trump any inaction on the part of the service recipient in this situation, meaning state statue allows ODHS|OHA to seek payment directly from a LTC insurer (see ORS 659.830 and ORS 743B.470).

For additional information regarding LTC insurance refer to OSIPM worker guides.

Acute care (ACS) or nursing facility (NF) settings

Oregonians who require a continuous period of care in an acute care setting such as hospital, nursing facility or hospice, and who are otherwise over-income for OSIPM are evaluated for ACS.

An individual in an acute care hospital or nursing facility is evaluated for OSIPM under the acute care setting rule as follows:

- The individual must meet all non-financial eligibility requirements for OSIPM.
- The individual is considered in their own household and filing group.
- The financial group consists of only the individual applying for benefits. However, the spousal impoverishment guidelines apply, so a resource assessment must be completed. AVS must also be run.
- The individual must have countable income at or below 300 percent of the full SSI standard or have established a qualifying trust, and
- The individual must require a continuous period of care, which means the individual **must be expected to stay** in the hospital, nursing facility or another service setting for at least 30 days or until death.
  - Evidence of the expectation is required, but do not wait until the 31st day to determine if they met the requirements.
  - The 30-day continuous period of care could include multiple settings.

Note: Individuals who are eligible for MAGI or OSIPM under a standard living arrangement do not need to be evaluated for ACS. This rule is here for those who would otherwise be over income or resource limits. It establishes that these individuals are treated as if they were receiving or applying for services.

If an individual needs a long-term care payment (not post-hospital extended care) and does not have Medicare, determine eligibility under the long-term care or home and community-based care rule.

Note: An individual in an acute care hospital may accumulate resources. If they are above the resource limit, they will need to spend-down or become ineligible.

For an individual already receiving OSIPM when they are admitted to an acute care hospital, benefits can continue as long as they continue to meet program requirements. Remember that after 30 days, individuals are no longer part of their original household group, if it contained other individuals, and eligibility is evaluated under the acute care setting rule.

Other resources

OSIPM - Acute Care Settings (ACS) *includes screenshots: Describes how to evaluate medical benefits for Oregonians who have a continuous period of care in an acute care setting like hospital or nursing facility.

Independent Choices (IC) program

To be eligible for OSIP/OSIPM-IC a person must:

- Meet Title XIX waiver criteria for in-home services contained in 411-030-0040, and
- Meet eligibility criteria for the Independent Choices program in 411-030-0100.

Oregon Project Independence (OPI)

OPI is a program designed to help people stay in their homes whose care needs meet at least one of the service priority levels (SPL) 1-18 of OAR 411-015-0010 and are not eligible for Medicaid long-term care services. All personal care and homecare services are provided by a state-registered homecare worker or in-home care agency. OPI recipients may be required to pay a fee towards their cost of services based on a sliding scale.

Workers should refer interested individuals to the Aging and Disability Resource Connection (ADRC) at 1-855-673-2372.

Note: Individuals receiving OPI services are housed in the local AAA branch and individuals receiving APD LTSS or SPPC services are housed in the local APD branch.

For additional information about OPI, refer to the OPI WG on APD staff tools, ADRC of Oregon website, OPI on Oregon.gov or see the OPI brochure (DHS 2454).

Estate recovery

The Estates Administration Unit (EAU) will seek reimbursement from an individuals' estate after they pass away (as defined in ORS 416.350) for all medical assistance benefits received since age 55 while getting long-term care benefits. If there is a surviving spouse, natural or adopted child under the age of 21, or child of any age who is

visually impaired or disabled as determined by the SSA, the EAU will not seek payment until their spouse and/or child pass away.

Workers should inform applicants and/or their representative of the estate recovery process at the time of application and provide the individual with the Estate Recovery Program brochure (MSC 9093). Individuals can be referred to the Estates Administration Frequently Asked Questions webpage for additional information. Written notification is also included on the Notice of Eligibility (NOE).

If you speak to family or friends of the deceased, encourage the individual handling the deceased's affairs to contact the EAU (Estate Administration Unit) at 503-378-2884 or estate.admin@dhsoha.state.or.us before disposing of assets or spending any of the deceased's money.

Note: Do not ever provide any legal advice to the individual or their representative.

There are several scenarios in which a deceased household member should remain on the case. These reasons include, but are not limited to:

- Medical cases where the individual was in a nursing facility or community-based care, and the medical and/or services request is pending, or
- If the deceased individual's spouse is still living and files taxes as, 'Married, Filing Jointly'

Referral procedure

For legacy cases, follow the instructions provided in the Financial Eligibility Closing Procedure for Deceased Individual document.

For cases in ONE, manual referrals are no longer needed as EAU will be notified via monthly reports. Direct any questions to EAU at 503-378-2884 or estate.admin@dhsoha.state.or.us.

Oregon Administrative Rule(s)

411-015-0010 — Priority of Paid Services
411-015-0015 — Current Limitations
411-032-0020 — Eligibility and Determination of Authorized Services
461-120-0315 — Medical Assignment
461-135-0726 — Specific Requirements; OSIP-IC and OSIPM-IC
461-135-0745 — Eligibility for Individuals in Acute Care Settings; OSIPM
461-135-0750 — Individuals Applying for or Receiving Long-Term Care or Home and Community-Based Care
461-135-0837 — Administering Medicaid Estate Claims When the Recipient of Assistance was a Native American Indian or Alaskan Native Village Tribal Member
461-135-0838 — Administering Estate Claims
461-145-0540 — Trusts

Other resources

Report of a Deceased Medicaid Recipient *includes screenshots: Describes the process for acting on a report of a deceased Medicaid Recipient.

Developmental disabilities (DD) services

The term "DD services" or "DD" refers to all LTC services offered through the Office of Developmental Disabilities Services (ODDS). This includes services for adults and children with intellectual or developmental disabilities (I/DD), children with intensive behavioral issues and children who are medically fragile or needing medically involved care.

Terminology

Developmental disability (DD): Certain disabilities that originate in childhood, significantly impact adaptive behavior (impairment of daily living skills) and for which both the condition and impairment are expected to last indefinitely. Developmental disabilities may include autism, cerebral palsy, epilepsy or other neurological disabling conditions that require training and support similar to that required by individuals with an intellectual disability (ID). To be considered a developmental disability, the disability must:

- Originate in and directly affect the brain,
- Constitute significant impairment in adaptive behaviors diagnosed and measured by a qualified professional,
- Have existed prior to age 22 (both the condition and significant impairment), and
- Be not primarily attributed to another condition including, but not limited to, a mental or emotional disorder, substance abuse, Attention Deficit Hyperactivity Disorder (ADHD), a learning disability, personality disorder or sensory impairment.

Intellectual disability (ID): History of intellectual disability and significant impairment in adaptive behavior directly related to the intellectual disability must be evident prior to the individual's 18th birthday. Intellectual disability means significantly sub-average general intellectual functioning. This is defined as full scale intelligence quotients (FSIQs) 70 and under, as measured by a qualified professional, existing concurrently with significant impairment in adaptive behavior directly related to an intellectual disability that manifested prior to an individual's 18th birthday. Individuals with a valid FSIQ score of 66–70 require verification of intellectual disability with an assessment of adaptive behavior showing significant impairment directly related to the intellectual disability. Individuals with valid FSIQ scores of 71–75 require an adaptive behavior assessment showing significant impairment and a diagnosis of intellectual disability by a licensed clinical or school psychologist.

Community Developmental Disabilities Program (CDDP): A case management entity (CME) that is responsible for I/DD disability determination for eligibility, plan authorization, delivery and monitoring of services for individuals with I/DD provided by a service coordinator. A CDDP operates in a specific geographic service area of the state under a contract with the Office of Developmental Disabilities Services (ODDS), local mental health authority or other entity as contracted by ODDS.

Brokerage: A CME that is responsible for plan authorization, delivery and monitoring of support services for adult individuals with I/DD provided by a personal agent (PA). A brokerage operates in a specific geographic service area of the state under a contract with the ODDS.

In-home supports: Like APD, individuals with I/DD may choose to have services provided in their own home. Individuals may choose to hire a personal support worker (PSW), use an agency with direct service providers (DSP) or use a combination of both to provide care.

Supported living: A comprehensive service available only to DD adults who are case managed by a CDDP, not a

brokerage. Individuals may live in-home or in a provider-controlled site. There is a variety of allowable models in supported living.

Provider controlled:

- Providers own the apartment building and the individual rents from the provider who also provides the services.
- Providers co-sign with individuals that rent apartments in community housing stock. This is often used when the individual could not afford the full rent, has negative rental history, there are more than one individual in the home needing support or the provider otherwise needs additional space, such as a second bedroom for staff.
- A Provider employs a family member as a live-in caregiver who is also the lease holder or owns the home.

Note: The Supported Living service cannot be tied to the individual's housing. If the individual chooses to use a different provider, it cannot result in an eviction for exercising the choice of provider.

Not provider controlled:

- The individual rents or owns their own housing that is available to the general community without any financial entanglement from the provider.

Other resources

Intellectual or Developmental Disability Service

Eligibility overview

Medicaid eligibility

Like many others, individuals with I/DD and children needing intensive in-home services can be eligible for an HSD medical program including CHIP, Child Welfare (CW) medical or OSIPM. These individuals may receive DD Comprehensive or K Plan services if they choose and if they meet the Level of Care requirements.

Note: A child receiving CHIP Title XXI benefits is not eligible to receive DD Comprehensive services. CHIP eligible children may only receive K Plans services.

Although the Medicaid eligibility rules are the same for DD LTC as they are for APD LTC, the types of Home and Community-Based Services (HCBS) are different for individuals with DD services.

The main differences are:

- Individuals with I/DD may choose to receive services under the DDC waiver, DDK State Plan Amendment, or they may choose to receive case management services only (no waiver).
- DD waivers are waiving the requirement to reside in an intermediate care facility for individuals with intellectual disabilities (ICF-IID), nursing facility or hospital, and
- **For adults**, case management services are provided through either a CDDP or a brokerage.
- **For children**, case management services are provided through the CDDP or ODDS programs such as Children's Intensive In-Home Services (CIIS) and Medically Fragile/Involved Children's Unit.

Medicaid eligibility is determined by ODHS|OHA eligibility workers and the process is essentially the same for all individuals. The primary difference is in who determines service eligibility and provides the case management services. This may be done by many different entities. The primary use of the service category code is to identify the basis of the individual's service eligibility and the range of services (waivered services, personal care, etc.). The service category codes also help identify the group that makes the service eligibility decision.

Staff that perform case management are:

- For individuals who meet both APD and DD service eligibility criteria: **APD/AAA case managers**, **CDDP service coordinators**, or **brokerage personal agents**, depending on individual's choice.
- For individuals with DD service eligibility and:
  - Who receive 1915(i) behavioral health services (adults), adult and child foster homes, supported living and children living in their family home: **CDDP service coordinators**.
  - Are adults living in their own or family homes and are not receiving supported living services: **brokerage personal agents** or **CDDP service coordinators**.
  - Are children receiving 1915(i) behavioral health services: **children's residential specialists**.
- For individuals whose mental health issues are the primary driver for the disability: The local County Office of Behavioral Health Services' **behavioral health specialists**.
- For children who are medically fragile, medically involved or have intensive behavioral issues: **CIIS service coordinators**.

Service eligibility

Individuals who have been determined eligible for DD services and have open Medicaid may receive LTC services. Like APD, those may include employment, transportation and ADL/IADL services, among others. Those who do not have Medicaid are eligible for case management only or, for children, the general fund Family Support Program provides a limited annual support allotment.

The I/DD or CIIS disability determination is completed within 90 days and eligibility is approved through the ODDS system called Express Payment & Reporting System (eXPRS). Once the case is assigned to the appropriate case management staff, choice advising occurs, in which the individual decides which K plan and/or waiver services they are interested in, and an individual support plan (ISP) is created with the individual within 90 days from the date of the completed application for DD services or start of Medicaid eligibility. If the individual chooses a waivered service, then the Oregon Needs Assessment (ONA) will be completed by a qualified assessor and establish an institutional Level of Care (LOC) for an ICF/IID. Once the DD service eligibility information is submitted through eXPRS, the Technical Assistance Unit (TAU) will add the appropriate codes to the non-CAPS service eligibility system (SELG).

Click here for a helpful chart: ODDS Cases…Who Does What?

There are several types of DD service options available for individuals who meet the eligibility criteria. Each requires Medicaid eligibility through OSIPM, Child Welfare medical or HSD medical and have different codes in the SELG system.

The different types are as follows:

- **DD Community First Choice K-State Plan "K Plan" (1915k) Amendment**: A variety of services and supports that may include one of the following living arrangements regulated by ODHS|OHA, depending on the choice: a 24-hour residential program, a foster home, a supported living program, and community living in-home supports (personal support worker and/or community living supports agency).
- **DD Adult (1915c) waiver**: Employment services including specialized medical supplies, vehicle modifications, family training and environmental safety modifications.
- **State general-funded services**: These will be given in some cases on a limited basis until the individual is found to be eligible for Title XIX through Medicaid for those who require services or supports to maintain health and safety and are expected to be eligible for Medicaid.

To be eligible for DD services, an individual must meet all three qualifications:

- **Oregon Needs Assessment (ONA)/Level of Care (LOC)**: An individual with I/DD must have a completed ONA submitted to establish LOC, verifying support requirements are similar to an intermediate care facility for Individuals with intellectual disabilities (ICF/IID).
- **Service plan/Receiving services**: The individual must have an active service plan within 90 days of all qualifications being met.
- **Financial eligibility**: The individual must be OSIPM eligible. The DD waiver and K Plan amendment are for home and community-base services (HCBS), like the Aged and Physically Disabled (APD) Long-Term Care Waiver. The Oregon Administrative Rules (OARs) used in determining financial eligibility for a service-eligible individual apply to all HCBS Waivers and the K-State Plan Amendment, whether under APD or DD. This includes the use of income cap trusts and income up to 300% of the SSI standard for OSIPM eligibility.

Note: Individuals cannot receive services under more than one waiver concurrently.

Adult DD services

For adults with I/DD, the local APD/AAA office manages the medical case while the ODDS case management entity (CDDP or brokerage) provides case management services.

DD service eligibility for adults under 65

Individuals must have their I/DD determination established through the local CDDP office prior to any service authorization. A comprehensive review is completed using the individual's medical records and test scores. If found to meet the disability eligibility requirements according to Oregon Administrative Rule (OAR), all services are then coordinated via the chosen case management entity (CME), except for nursing facility stays.

Individuals under 65 may receive APD/AAA services while they are waiting to be evaluated or approved for DD services if they meet State Plan Personal Care or SPL and all other eligibility requirements. Once they are approved for DD services, however, APD/AAA services should close following a timely continuing benefit notice and coordinate with opening services at the CDDP or brokerage of the individual's choice.

DD service eligibility for adults over 65

Individuals with I/DD who are 65 and over may choose to be served within the APD/AAA or DD system, if they meet service eligibility for both. This assessment is most often facilitated via the DD service planning team process.

Services cannot be provided to these individuals under both waivers at the same time. If a person is transitioning from one service system to another, the sending agency will send a timely continuing benefit notice and stop providing services with services opening through the receiving agency immediately following for a seamless transition.

Adult residential or in-home care and State Plan Personal Care (SPPC)

To establish service eligibility:

- CDDP staff will complete I/DD disability determination prior to service eligibility.
- If the individual is to be enrolled into a DD waivered or K plan service, CDDP staff will send enrollment information to the Technical Assistance Unit (TAU) for initial waiver service entry.
- The TAU will enter the service category and create/update the Non-CAPS Service Eligibility record (SELG).
- CDDP staff may need to:
  - Enter additional information into the eXPRS payment system, or
  - Assist the individual in establishing medical eligibility with ODHS|OHA.

Note: The individual must already be on Medicaid for SPPC.

Child DD services

For children with DD services, ODHS|OHA manages the medical case while the DD case management entity (CDDP or CIIS) provides case management services. Children who receive HSD medical's CHIP benefits are not eligible for waivered services but may be eligible to receive K Plan services. Children ages 18 to 21 can sometimes retain their OSIPM eligibility.

Note: Individuals requesting LTC services are a household of one. For children, this means only their income and resources are counted, not the parents'.

Children's residential placements

The local CDDP will:

- Establish service eligibility,
- Submit a Presumptive Medical Disability Approval form (DHS 0620) to ODHS|OHA's Children's Residential Service Unit, when applicable,
- Assist with completion of a medical application, when needed,
- Set-up residential placement information in the DD system,
- Submit a Title XIX Level of Care Waiver Form to TAU for waiver eligibility determination and to create/update the Non-CAPS Service Eligibility record (SELG), and
- For foster care placements, send a Data Personal Care Form to ODHS|OHA's Provider Payments Unit, Community Based Care Payment Processor for entry.

The ODHS|OHA eligibility worker will determine eligibility for Medicaid.

Note: Children in foster care must all participate in the Trust and Agency (T&A) account system. Workers must also determine if the foster parent or other person should be listed as the authorized representative.

Children's Intensive In-Home Services (CIIS)

CIIS has three 1915(c) Home and Community-Based Services (HCBS) model waivers to address the needs of children with disabilities. A child could qualify and receive services through the Intensive Behavior, Medically Involved or Medically Fragile Programs. The intent is to provide appropriate supports and services to ensure health and safety in the family home to prevent out of home placement. CIIS supplement the services that are available through the State Medicaid Plan and other federal, state and local programs, as well as the natural supports that families and communities provide.

Anyone can refer a child for CIIS; however, they must use the appropriate form for the specific program for which they are making the referral, as follows:

- Intensive Behavior program form SDS 4539
- Medically Involved program form SDS 4538
- Medically Fragile program referral form

The CIIS Service Coordinator will:

- Establish service eligibility, and
- Send a Title XIX Level of Care Waiver Form to the TAU for enrollment and to create/update the Non-CAPS Service Eligibility (SELG) record (these programs have a time-limited enrollment up to the last day of the child's 17th year).

The ODHS|OHA eligibility worker will determine Medicaid eligibility.

Note: A child receiving CHIP Title XXI benefits is not eligible to receive supports and services through CIIS. CIIS staff will make a presumptive decision based on CIIS eligibility for those who do not have a Social Security Administration determination of disability.

Intensive Behavior Program

The Intensive Behavior Program serves children who demonstrate challenging behaviors, such as aggression, self-injury, elopement and sleep disturbances, which require constant adjustments to their environment and routines to maintain safety in their home.

Children referred to the Intensive Behavior Program must first be eligible for their county's developmental disability (DD) program.

Medically Involved Program

The Medically Involved Program serves children who require moderate to full support with all of their routines and daily activities such as grooming, bathing, dressing, elimination and mobility supports. This can include children requiring specialized medical intervention such as respiratory treatment, tube feeding or seizures.

To receive this service, the child must already be on Medicaid and receive SSI or SSDI.

Medically Fragile Program

The Medically Fragile Program serves children who have extremely intense medical and nursing needs, are generally dependent on specialized medical technology to survive and require a hospital level of care. Their providers are usually registered nurses (RN) or overseen by RN's to ensure safety.

Note: CIIS may be received as Non-Waivered/Basic State Plan Services under this program as well. Children may receive both Children's Foster Care service under DDC and Medically Fragile Children non-waivered services.

Oregon Administrative Rule(s)

411-300-0120 — Eligibility for CIIS

Medical transportation for DD children

This process is under construction. For questions regarding how to submit medical transportation requests for children receiving DD services, email APD Medicaid policy.

I/DD and nursing facility stays

The PASRR II coordinator must be contacted via email at OR.PASRR@state.or.us to request and receive approval before a nursing facility (NF) plan of care (POC) can be opened in MMIS. The local APD/AAA office sets up the nursing facility service plan and POC for I/DD adults and children under age 18 if approved in the PASRR-II process.

Individuals whose primary diagnosis is I/DD or a serious mental illness are not eligible for NF services if their needs can be met in the community regardless of age.

To open nursing facility services ODHS/AAA must:

- Receive approval for NF admission (an APD/AAA case manager or nursing facility staff must email OR.PASRR@state.or.us to request approval). If approved, the ODHS/AAA case manager sets up the NF service payment.
- If possible, contact the DD case management entity to coordinate dates.
- Contact the TAU at DD-Eligibility.ENROLLMENT@dhsoha.state.or.us so they can remove the DD SELG coding.
  - The DD services and NF services cannot overlap.

Note: The local ODHS/AAA office is responsible for managing the nursing facility services and closing when the individual returns to DD services.

I/DD post-eligibility

All post eligibility OSIPM rules apply. Excess income used to reduce the cost of care will be contributed through the appropriate payments system based on financial information. The significant difference is the system used for collection of the individual contribution:

- Liabilities (or offsets/pay-ins), for those DD individuals who are required to pay them, are calculated the same as APD service individuals. Staff can use the SDS 0450 form to calculate the liability.

Note: While individuals receiving supported living services may live in their own home, their liability is calculated using the residential allowance.

- For individuals receiving APD services, the CBC/512 payment system handles the service contribution.
- For individuals receiving DD services, the eXPRS payment system handles the service contribution based on what is calculated in ONE.
- For individuals whose services are provided in-home there is no liability.

Other resources

CBC/512 Systems and ONE QRG

Behavioral health (BH) service eligibility

ODHS|OHA serves thousands of individuals with mental health (MH) impairments. These impairments can include such disorders as schizophrenia, schizoaffective disorder, bipolar disorder, and major depressive disorder, to name only a few. The Addictions and Mental Health (AMH) Division provides access to health, mental health and addiction services and support to many of these individuals through community behavioral health services while working in partnership with APD, who provides medical coverage to those who are eligible.

Mental health services are provided under the 1915(i) state plan option. This is similar to the 1915(k) option but is specific to behavioral health services. This specific HCBS State Plan option allows for a higher income standard of 150% FPL in addition to other eligibility factors for individuals receiving 1915(i) services who do not otherwise qualify for OSIPM. Individuals receiving behavioral health services do not pay a liability. All other OSIPM eligibility criteria must be met.

To qualify for behavioral health services, individuals must be age 21 or older and eligible for Medicaid (HSD medical or OSIPM).

Individuals with mental health impairments can be eligible for OSIPM in any one of the following ways:

- Assumed eligibility for OSIPM
- Protected eligibility as a Pickle, DAC or widow/widower
- The individual has a disability that meets the SSA definition of “disabled”, resides in a standard living arrangement and has adjusted income under the OSIPM adjusted income standard
- The individual is working and is eligible for the Employed Persons with Disabilities (EPD) program, or
- The individual is eligible to receive 1915(i) behavioral health services and meets all other OSIPM eligibility requirements for these services.

Note: Just like EPD and MSP recipients, these individuals will be protected each year from January until the FPL income standards are implemented (usually March).

The current version of ONE does not contain a Type of Assistance (TOA) that can accommodate these individuals who require the higher 150% FPL limit for Medicaid. These cases are maintained in legacy systems by the APD Central Coordination Unit (APD CCU). Once an individual has been determined OSIPM eligible, the worker must coordinate with APD CCU.

Review MMIS for case descriptors indicating an individual is currently receiving behavioral health services. If the individual has **MAN** or **MAR** case descriptors on their case in MMIS, their medical benefits **must** be processed in legacy systems by APD CCU.

For cases in ONE, mark them as "Not Applying" for medical and process all other benefits in ONE. Workers can use this template to send referrals for new applicants to APD CCU by email at APD.CentralCoordinationUnit@dhsoha.state.or.us. and these individuals will be contacted by APD CCU to continue the application process for Medicaid. Enter a case note stating that the individual has been referred to APD CCU for an OSIPM determination in legacy.

APD CCU staff will email VEC eligibility workers at Oregon.Benefits@dhsoha.state.or.us for case updates needing to be made in ONE. This process helps eligibility workers identify when an individual's medical case should be referred to the APD Central Coordination Unit to be processed in legacy systems.

Note: The local CBHS office updates the MMIS system with the behavioral health services Plan of Care (POC) for 1915 (i) behavioral health service eligibility, therefore you will not find it in CA/PS or in SELG.

An individual can be eligible to receive 1915(i) services and 20-Hour Personal Care services (SPPC), and in some cases DD or APD services simultaneously. These cases are captured on SELG. SPPC services (BPM) will not be in CA/PS, but other SPPC services should be (BPO for MAGI recipients or BPA for OSIPM recipients).

Waivered service and 1915(i) service eligibility can impact the financial eligibility for Medicaid, so workers should check both MMIS and SELG. Remember that SPPC benefits do not entitle someone to a higher income standard; the person must be otherwise eligible for OSIPM or MAGI to receive these benefits.

The Medicaid.gov website has additional information about 1915(i) services.

Other resources

Behavioral Health Referral to APD Central Coordination Unit: Describes the process for eligibility workers to refer Oregonians who are receiving or applying for behavioral health services and need to be evaluated for medical in legacy systems to the APD Central Coordination Unit.

Coordination

Planning and implementation of services must be coordinated between all relevant ODHS|OHA staff (APD/AAA, CDDP or CIIS), other local human service agencies and any other providers as appropriate to meet the needs of the individual. Communication between eligibility workers and staff who determine service eligibility is essential to coordination at initial application, renewal and any time a change is reported or discovered.

For DD services:

If a family approaches the local office with a request for DD services, they can complete the Medicaid application and be referred to the CDDP at the same time. The local CDDP contact information can be found at http://www.dhs.state.or.us/spd/tools/dd/directory.pdf

When an individual receiving DD services changes addresses, service setting or reports any other change that may affect the OSIPM case, DD case management staff should notify ODHS|OHA so the case can be updated.

When an individual with DD services is eligible for retroactive medical, becomes eligible for EPD or requires an immediate/retro adjustment in liability, the eligibility worker should notify the TAU as these changes require manual updates in eXPRS. Any other change that may affect services should be sent to the local CDDP office.

Other resources

Service Categories *includes screenshots: Helps identify the type of services an Oregonian is receiving based on their Service Category in ONE, so you know who to notify when there are changes on the case.

Notification to Case Manager or Family Coach of Case Update: Process for eligibility workers, family coaches and APD central coordinators to notify a case manager or family coach when any updates are made to a case

APD Central Coordination Unit: Provide an in-depth overview of the APD CCU.

APD CCU Flowchart QRG: provides guidance to eligibility staff who encounter medical cases that have historically been assigned to branch 5517 or 5510 (children's medical eligibility unit and behavioral health services).

Medical Service Termination Task: Describes the Medical service Termination task and its triggers. Provides steps for the APD central coordinator's team to complete the task and notify the case manager. Provides guidance for the case manager to notify the customer and close services.

Medicaid Long Term Care Services *includes screenshots: This QRG covers Medicaid Long Term Care (LTC) Services and how the programs function in ONE. Service TOA's include MSERV, NMAGISERV, and LTCSERV. This QRG is geared towards eligibility workers new to LTC services and ONE. Coordination with APD and AAA case managers is necessary to begin services for an individual because the service assessment is not done in ONE. This QRG references when and how that coordination should occur, and how eligibility is determined across the multiple systems.

Coding

Service Eligibility (SELG) coding in legacy

Once a service plan is approved, a SELG record is created for the individual. The information is transmitted to the SELG screen in the Mainframe and then to the Service Eligibility screen in ONE. This information indicates to all payment systems that the individual is eligible for service-related benefits.

Note: Staff may view the Service Eligibility record by typing "SELG, {prime number}" on a blank screen in the Mainframe. If the SELG screen does not display the information needed, staff can access SL01 by selecting F3 from the SELG record. If a record exists, it will show up with the beginning and ending dates of eligibility as well as the service or waiver eligibility category.

Note: To see the SELG record in ONE, navigate to the Non-Financial Information Module, and the Service Eligibility Screen.

Case descriptors in SELG	
APD	Aged and Physically Disabled Home and Community Based Care 1915c Nursing Facility Waiver

BPA	Basic Plan Services paid under the CMS State Plan Personal Care Services for people who are Aged or Physically Disabled
BPD	Basic Plan Services paid under the CMS State Plan Personal Care Services for people who are Developmentally Disabled
BPM	Basic Plan Services paid under the CMS State Plan Personal Care Services for people who are under a Behavioral Health Service Plan
BPO	Basic Plan Services paid under the CMS State Plan Personal Care Services or individuals under OHP
DDB	In-Home Supports, Children's Behavioral Home and Community Based Care 1915c ICF-MR Model
DDC	Developmental Disabilities Comprehensive Home and Community Based Care 1915c ICF-MR Waiver
DDG	Developmental Disabilities In-Home Supports/Residential Care, General Fund
DDK	Developmental Disability K-Plan Services; Community First Choice (K-Plan) State Plan Services
DDP	Presumptive Eligibility for Developmental Disability Services when it has not been determined which waiver the individual will be on yet but are waiver eligible
FSG	Family Support, General Fund; child
FSL	Family Support, Long Term, General Fund; child
ICP	Independent Choices Home and Community Based Care 1115 Nursing Facility Waiver
KPS	State K Services for APD
MFN	Medically Fragile Children; Non-waivered
MFW	Medically Fragile Children; Home and Community Based Care 1915c Hospital Model Waiver
MIW	In-Home Supports, Medically Involved Children's Home and Community Based care 1915c ICF-IDD Model Waiver
NFC	Nursing Facility Care (custodial and skilled nursing care) or long-term hospital care (> 1 month)
NFS	Nursing Facility short stay
PAC	Program of All Inclusive Care 1115 waiver, referred to as PEP, PACE or ONLK
PTC	Psychiatric Treatment Facility
SPH	Spousal Pay In-Home Services
SSG	Support Services, General Fund

Service setting indicators	
IHC	In-home Care
RES	Residential Care Facility

Note: For APD LTC services, the Oregon ACCESS benefit must match with the corresponding TOA benefit that is authorized in ONE.

TOA coding in ONE

If the individual is eligible for medical benefits after evaluating for the additional criteria and has an SELG record, ONE will assign one of the following TOAs:

- **LTCSERV:** OSIPM eligible. The individual is dependent on being eligible for services in order to be eligible for OSIPM.

- **NMAGISERV:** OSIPM eligible. The individual is not dependent on being eligible for services in order to be eligible for OSIPM.
- **MSERV:** MAGI eligible.

Note: The OPI benefit is not dependent on a TOA.

Other resources

Medicaid Long Term Care Services *includes screenshots: This QRG covers Medicaid Long Term Care (LTC) Services and how the programs function in ONE. Service TOA's include MSERV, NMAGISERV and LTCSERV. This QRG is geared towards eligibility workers new to LTC services and ONE. Coordination with APD and AAA case managers is necessary to begin services for an individual because the service assessment is not done in ONE. This QRG references when and how that coordination should occur and how eligibility is determined across the multiple systems.

Contacts

Behavioral Health Service Referrals:	APD Central Coordination Unit (CCU) 503-945-5659
Email:	APD.CentralCoordinationUnit@dhsoha.state.or.us
CBC Payment Processing:	Kristen Hutton..... 503-945-6741
DD Business Analyst:	Kolette Ropp 503-945-5984
ODDS Eligibility Policy:	Rebecca Smallwood..... 503-957-9016
OSIPM/MSP Eligibility:	APD Medicaid Policy Unit 541-507-7423
Email:	APD.MedicaidPolicy@dhsoha.state.or.us
Pre-admission Screening Resident Reviews (PASRR):	
Email:	OR.PASRR@dhsoha.state.or.us
Technical Assistance Unit (TAU):	DD Central Support.....503-945-5984
Email:	DD-Eligibility.ENROLLMENT@dhsoha.state.or.us

Chapter 2:
Eligibility

Section 11: Medical Related Payments (MRP)

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Medical Related Payments (MRP)

Introduction

Medical Related Payments (MRP) include special needs payments, K-Plan ancillary services and other payments previously generated through the special cash pay system (aka 437s). **This section will focus only on Special Needs MRP**.

Special needs MRP are needs not included in the basic standard. They may be one-time needs or ongoing needs. Payments can be issued as a check, revolving fund check or an electronic funds transfer.

Ongoing special needs are needs that last several months at a consistent cost. ODHS|OHA will authorize payment for one-time and ongoing special needs for the following, in accordance with the policies in this section:

- One-time needs for the following:
  - Home repairs
  - Moving costs
  - Property taxes
  - Community transition services
  - Community based care room and board, and
  - Diversion services
- Ongoing needs for the following:
  - Food for guide dogs and special assistance animals
  - Laundry allowance
  - Personal incidentals and room and board allowance
  - Accommodation allowance
  - Special diet allowance
  - Supplemental communication allowance
  - Prescription drug co-pay coverage, and
  - In-home supplement.

To be eligible for a special need item, individuals must be receiving OSIPM and have no other available resources in the community or in their natural support system to meet the need (including K-Plan ancillary services). Individuals also must not be eligible for the item through Medicare, Medicaid or any other medical coverage.

Individuals may be eligible for an ongoing special need item if providing the ongoing special need item is authorized in lieu of additional long-term care (LTC) provider service hours pursuant to 411-030-0002 through 411-030-0090 and is more cost-effective.

Oregon Administrative Rule(s)

461-155-0010 — Use of Payment Standards to Establish Need
461-155-0500 — Special Needs; Overview

Effective dates

The effective date for a special need is the later of the following:

- The date of request for the special need item, or
- The effective date for OSIPM.

The effective date for a reduction or termination of an ongoing special need is the end of the timely continuing benefit notice period.

Oregon Administrative Rule(s)

461-180-0040 — Effective Dates; Special Needs and Services
461-115-0030 — Date of Request

Community transition services

Staff must use the K-Plan ancillary services MRP for community transition services that are authorized under OAR 461-155-0526 (Special Need; Community Transition Services; OSIP and OSIPM) if they can also be authorized under OAR 411-035-0070/0075/0080. Some services necessary for an individual to transition out of an institutional setting may not be covered under the K-Plan. This is the appropriate time to use funds covered under this rule. For example, an individual can qualify for items not covered by the K-Plan, such as ID replacement. For this reason, the community transition services special need MRP is still available but should **only** be used when the service cannot be covered under the K-Plan MRP.

When an individual who has been admitted as an inpatient is leaving a psychiatric hospital or is being transitioned out of a nursing facility:

- ODHS|OHA may authorize one-time payments for allowable expenses necessary to set up housing in Oregon in an individual's own home or apartment or a community-based care facility (CBC) if the CBC is not required to provide the item covered by the payment by contract or by the administrative rule governing assisted living facilities (411-054-0000 to 411-054-0300).
- Payments are allowed only for individuals leaving a psychiatric hospital or nursing facility and returning to the community if the individual meets the criteria for one of the service priority levels served by ODHS|OHA according to 411-015-0015(1).

Examples of allowable expenses include:

- Expenses for moving belongings
- Housing security deposits
- Essential furnishings

- Eating utensils
- Food preparation items
- Deposits for utility hook-ups for heat, electricity and telephone
- Climate control, and
- Health and safety measures such as pest eradication or allergen control.

Allowable expenses do not include ongoing housing or utility payments and recreational items such as television, cable or internet access.

Payment will be authorized only for the minimum amount necessary to establish the individual's basic living arrangement.

Oregon Administrative Rule(s)

461-155-0526 — Special Need; Community Transition Services; OSIP and OSIPM

Food for guide dogs and special assistance animals

For OSIPM recipients who receive SSI, have adjusted income less than the OSIPM program standard or receive Home and Community-Based Services (HCBS), a food allowance may be provided for guide dogs and special assistance animals that are individually trained to:

- Meet the individual's specific medical needs by performing tasks, such as alerting and protecting an individual who is having a seizure, or
- Perform specific physical tasks that the individual is unable to do, such as picking up items that are dropped, turning on light switches and pulling a wheelchair.

The allowance should be the actual monthly cost of food, with a maximum amount of $50 per month.

Authorization of this special need must be based on a proven medical need to sustain the individual's independence.

Note: Companion animals do not usually meet the requirements for this allowance. They must be specially trained to meet the medical needs and sustain independence for the individual.

Oregon Administrative Rule(s)

461-155-0530 — Special Need; Food for Guide Dogs and Special Assistance Animals

Laundry allowances

OSIPM individuals who receive SSI, have adjusted income less than the OSIPM program standard or receive Home and Community-Based Services (HCBS) are eligible for a laundry allowance if they have proven, excessive, coin-operated laundry facility costs and do not:

- Have their own laundry facilities, or
- Reside in an adult foster home, assisted living facility, nursing facility, residential care facility or specialized

living facility, unless the specialized living facility is apartment based.

This allowance may not exceed an amount required to wash and dry the individual's laundry.

Oregon Administrative Rule(s)

461-155-0580 — Special Need; Laundry Allowances

Home repairs

To be eligible for a home repair, the OSIPM individual must be eligible to receive in-home services under OAR chapter 411 division 030.

ODHS|OHA will authorize a medical related payment for home repairs for homeowners or buyers as a one-time special need within the following limits:

The repairs must be needed to remove a physical hazard to the health and safety of the individual.

Payment for repairs authorized by this rule:

- Is limited to the least expensive means possible,
- Cannot exceed $1,000 in any 24-month period, and
- When the home is jointly owned, is limited to a percentage of the cost of the repairs equal to the percentage of individual ownership. An OSIPM in-home services recipient who is married to a community spouse may qualify for a waiver of this criterion. See APD-PT 17-040.

The repairs must cost less than moving to another home.

Payment is limited to the lowest possible cost that will provide adequate facilities. The individual must provide three competitive bids for the repairs, unless there are not three providers of the service in the local area.

Before approving payment for repairs or new installations, ODHS|OHA will consider the use value and will determine whether it is consistent with the care plan for the individual to remain in the house.

Contractors who complete the repairs or new installations must ensure that the work being completed meets current building codes. Payment is only made for home repairs performed by a licensed and bonded construction contractor.

Repairs or replacements include, but are not limited to:

- Electrical wiring that does not constitute conversion to electrical space heating but that is needed:
  - To avoid condemnation; or
  - To remove a definite fire or shock hazard as documented by appropriate public officials.
- Plumbing, but not including the costs of plumbing items with which the house is not already equipped, except that a toilet may be paid for when newly required by the creation or extension of a sewer district. Examples of what plumbing-related items may be covered include:
  - Toilets and sinks.

  - Cleaning or replacing septic tanks or cesspools,
  - Installing sewer connections from house to street—but not sewer installation—if required by the creation of a new sewer district or the extension of an existing district.
- Repair or replacement of existing electric pumps for wells needed to continue the water supply (this does not include drilling a new well),
- Heating equipment—repair of heating stoves, furnaces and water heaters and, if repair is not possible, replacement with the least expensive adequate equipment,
- Repair of roofs, and repair or replacement of steps and repair of floors.

Individuals with life estates are not eligible for this special need allowance. The person who will benefit from the life estate following the death of the participant is considered responsible for the home repairs.

Oregon Administrative Rule(s)

461-155-0600 — Special Need; Home Repairs; OSIP and OSIPM

Moving costs

ODHS|OHA will authorize payment for the cost of moving an individual's household effects as a one-time special need if the individual is 18 years of age or older and meets at least one of the following requirements:

- Moving is essential to provide non-hazardous housing.
  - "Hazardous" housing means a building so deteriorated and unsafe that it is uninhabitable or subject to condemnation.
  - If no official certification to that effect can be obtained, the condition of the dwelling must have been seen by an ODHS|OHA employee and documented in the case record.
- The individual has been evicted for reasons other than their own neglect or failure to make rent or house payments.
- The move is necessary to ensure the safety of the individual and is a result of the individual being a victim of domestic violence or abuse.
- For an individual in a nonstandard living arrangement, the move is necessary because the level of services the individual needs increases or decreases.
- The individual's needs would be better met out of state.

Payment for moving costs authorized by this rule:

- May be authorized for not more than one move in any 12-month period,
- Is limited to the least expensive means possible, and
- May not exceed $1,000 in any 12-month period.

Payments necessary for a one-time move may be made over a period not to exceed 30 consecutive days.

A filing group that has received a payment for moving costs under this rule is not eligible for a moving cost payment again until the first day of the twelfth month following the receipt by the filing group of the most recent payment for

moving costs.

Oregon Administrative Rule(s)

461-155-0610 — Special Need; Moving Costs; OSIP and OSIPM

Property taxes

Individuals who are homeowners or buyers are allowed a special need in an amount equal to the cost of one year of delinquent real property taxes, penalties and interest, if needed to prevent imminent foreclosure.

Individuals whose property taxes have not been paid and who are eligible for the Oregon Property Tax Deferral Program must opt to defer property taxes. If necessary, the state may provide payment for back property taxes to bring the tax current and allow individuals to defer their ongoing property taxes.

Individuals who have not chosen to defer their property taxes and whose property taxes have not been paid will not receive a property tax special need payment unless an exception is authorized by ODHS|OHA's Estates Administration Unit (EAU). The exception will be based on the value of the property, the potential of foreclosure and the potential of an EAU recovery of such property.

Imminent foreclosure is indicated by a formal notice of foreclosure.

Oregon Administrative Rule(s)

461-155-0620 — Special Need; Property Taxes

Community-based care

Notwithstanding the definition at 461-001-0000, for the purposes of this section, an individual is considered living in community-based care (CBC) if the individual resides at one of the following care settings licensed by ODHS|OHA:

- Adult Foster Home
- Residential Care Facility
- Assisted Living Facility
- Specialized Living Facility, or
- Group Care Home

If an individual who meets the applicable income requirements begins living in a CBC facility:

- Payment for room and board may be authorized during the month of admission at the initial placement, limited to the approved rate.
- Room and board payments may be paid to the facility during the temporary absence of an individual if all of the following criteria are met:
  - The absence occurs because the individual is admitted to a hospital or nursing facility,
  - ODHS|OHA determines the intent of the individual to return to the CBC facility,

- The CBC facility is willing to accept the room and board payment, and
- The individual returns within the calendar month following the month in which the absence began.

Note: If an individual moves from one CBC facility to another mid-month, the individual should ask that the provider return the remaining room and board amount (if the individual has given sufficient notice). However, the provider is not obligated to return the funds. If necessary, this special need can be used to pay the prorated room and board amount for the first month in the new facility.

Spouses who each receive SSI and receive services in a CBC facility are eligible for a payment in the amount that equals the difference between the OSIPM standard for a one-person need group and the individual's total countable income. If one spouse has income above the OSIPM standard, the excess income is applied to the other spouse's countable income.

Oregon Administrative Rule(s)

461-155-0630 — Special Need; Community-Based Care; OSIPM

Accommodation allowance

An OSIPM recipient who is 18 or older and either receives SSI, has adjusted income less than the OSIPM income standard, or is eligible to receive or is receiving in-home services is potentially eligible for an accommodation allowance if the individual:

- Is temporarily absent from their home,
- Has a documented increase in housing costs associated with access by a person with a disability, or
- Has a documented increase in housing costs associated with a need for a home with an additional bedroom for an in-home service provider.

An individual whose primary residence is a nursing facility is not eligible for an accommodation allowance. An individual living in a nonstandard living arrangement is not eligible for an accommodation allowance unless they are receiving, or are eligible to receive after a temporary absence, home and community-based care in-home services.

Note: This is one of the factors that distinguish this special need from the deduction to maintain a home authorized under OAR 461-160-0630.

Temporary absence of individual from home

A temporary accommodation allowance may be authorized, where permitted above, if an individual meets the following criteria:

- The individual must own, rent or lease a primary residence and leave their home or rental property and temporarily enter an adult foster home, assisted living facility, group care home, hospital, nursing facility, residential care facility, specialized living facility or state psychiatric institution.
- The individual must be unable to afford to keep the home without the allowance.
- The individual must be able to return home within six months of leaving, according to a written statement from a primary practitioner, RN or PAS (pre-admission screening) RN, and

- When the individual returns home, the individual must be eligible to receive in-home services under OAR chapter 411 division 030 and the home must accommodate the individual's service plan.

The allowance may be authorized for six months. If the individual continues to meet the criteria after six months, an extension may be approved in writing by a supervisor.

The accommodation allowance equals the total of the individual's housing cost, including taxes and homeowners insurance, plus the limited standard utility allowance for the SNAP program provided in 461-160-0420.

Note: Update the LUA amount annually during the financial redetermination.

Additional cost accommodation based on increased rent due to a disability

An additional cost accommodation may be authorized, where permitted above, if:

- The individual's shelter cost exceeds $451 for a 1-person need group or $559 for a 2-person need group, and
- The individual has a documented increase in rent associated with access by a person with a disability. Only the additional increase in cost associated with the individual's access needs for the accommodation is allowed.

The accommodation allowance is determined as follows:

For an individual who receives an accommodation allowance based on increased costs associated with access by a person with a disability, the amount of the accommodation allowance is limited to the amount of the increase in housing cost associated with the individual's access needs.

Additional cost accommodation based on need for additional bedroom for service provider

An accommodation allowance based on increased costs associated with the individual's need for a home with an additional bedroom for a service provider may be provided to an individual who:

- Receives in-home services under OAR Chapter 411 Division 030, and
- Requires full assistance in at least four of the six activities of daily living as determined by the assessment described in OAR chapter 411 division 015,
- Receives services from one or more homecare workers [see OAR 411-030-0020(28)] who routinely sleep at the individual's home as part of the individual's service plan [see OAR 411-015-0008(2)],
- For an individual who receives an accommodation allowance based on the need for one or more homecare workers [see OAR 411-030-0020(28)] who routinely sleep at the individual's home, the amount of the accommodation allowance is the limited standard utility allowance (LUA) plus:
  - One-third of the monthly rental cost, or
  - One-third of the monthly payment on the property agreement (including mortgage, trust deed or land sale contract). The property agreement is the agreement existing at the time the individual is approved for the accommodation allowance. The accommodation allowance for the housing portion ends if the debt is refinanced, unless the refinancing was done only to reduce the original property agreement's interest rate or total monthly payment amount and the owner realized no direct or indirect payment of the home's

equity value from the refinancing.

» If the refinancing requirement under this paragraph is met, the amount of the accommodation allowance is one-third of the refinanced property agreement amount plus the LUA.

» If the refinancing requirement under this paragraph is not met and the housing portion of the accommodation allowance ends, the individual remains eligible only for the LUA.

Special requirements

An individual who rents and qualifies for an additional cost allowance, must take the steps necessary to obtain subsidized housing under any federal or state housing program. An individual who fails, at any time, to take the steps necessary to obtain subsidized housing reasonably available is ineligible for the allowance. An individual, who has been denied or revoked from participation in any rent subsidy program based on the individual's own actions is ineligible for benefits under this rule.

An individual who rents housing and refuses subsidized housing will no longer be eligible for an accommodation allowance, except that if the housing that is offered is not suitable, related to accommodations, and the individual continues to have increased costs related to accommodations in the individual's current living situation. The accommodation allowance may continue until such time as appropriate subsidized housing is found.

Click here for examples: Accommodation allowance.

Oregon Administrative Rule(s)

461-001-0030 — Definitions; OSIP, OSIPM Long-Term Care or Home and Community-Based Care
461-155-0660 — Special Need; Accommodation Allowance

Special diet allowance

Individuals are not eligible for a special diet allowance if they are receiving any of the following:

- Room and board,
- LTC services in one of the following settings:
  - Residential care facility
  - Assisted living facility
  - Nursing facility, or
  - Adult foster home
- An allowance for restaurant meals, or
- A commercial food preparation diet.

An OSIPM individual receiving SSI, having adjusted income less than the OSIPM standard or receiving in-home services under OAR chapter 411 division 030 is eligible for a special diet allowance if **all** of the following requirements are met:

- An ODHS|OHA-approved medical authority must provide documentation of the following:

- That the individual must adhere to a special diet, and
- The individual's specific nutritional need (such as low carbohydrates, high protein), and
- That the individual would be in an imminent, life-threatening situation without the special diet.

- A licensed dietitian must provide documentation of the following:
  - The individual's current diet items being replaced or removed, if any, and
  - The special diet items being added, relating to the individual's specific nutritional need, and
  - The recommended quantity of each special diet item.
- The individual requesting a special diet allowance must provide documentation of the following:
  - Verification of the monthly cost for any current diet item being replaced or removed, and
  - The monthly cost of any special diet item being added.

Note: A USDA food chart is not an acceptable form of monthly cost verification. Special diet items must be purchased at the lowest cost available for that item.

For individuals who have difficulties understanding what documentation is needed, staff may include the information found in the three primary bullet points above as part of the pending notice.

The amount of a special diet allowance is calculated as follows:

- The monthly cost of the special diet items, less the monthly cost of the current diet items being replaced or removed. If no items are being replaced or removed, the allowance is the actual monthly cost of the special diet items.
- Management staff must approve or deny any request for a special diet allowance that is $300 or less. An exceptional amount may be authorized by the APD financial eligibility and waiver unit.
- Each special diet allowance must be reviewed at each renewal.

Click here for examples: Special diet allowance.

Oregon Administrative Rule(s)

461-155-0670 — Special Need; Special Diet Allowance
461-125-0830 — Medical Documentation; Disability and Other Determinations

Supplemental communication allowance

A communication allowance is allowed for the following OSIPM individuals who live in their own home, are 18 years of age or older and are unable to leave their residence without the assistance of another person due to a documented medical condition:

- Individuals receiving SSI,
- Individuals with adjusted income less than the OSIPM program standard , or
- Individuals receiving in-home services under OAR chapter 411 division 030.

The communication allowance may cover the following, and is limited to a maximum of $25 per individual per

month:

- The least expensive appropriate monthly telephone service or the basic rate, whichever is less,
- The cost of telephone adaptive equipment if the individual has a medically documented need (e.g., TDD, a special headset, dialing mechanism or emergency response system),
- A necessary landline telephone installation charge, or
- Broadband internet service.

Eligible individuals must apply for or receive a payment through the Oregon Lifeline program (Formerly the Oregon Telephone Assistance Program, or OTAP). See Lifeline for more information about the Oregon Lifeline program. ODHS|OHA may provide a maximum supplemental payment of $30 for necessary installation charges.

Each individual is eligible for a single communication allowance valid for either telephone service or broadband service.

Note: For emergency response systems (ERS), follow your office procedure to authorize through DMAP.

Oregon Administrative Rule(s)

461-155-0680 — Special Need – Supplemental Communication Allowance; OSIPM

Personal incidentals and room and board allowances

Personal incidentals and room and board allowances are allowed for the following individuals to avoid placement in a nursing facility or who are leaving a nursing facility or an acute care hospital to reside in a community-based care (CBC) facility. The payment amount is prorated in the first month for individuals who move to a CBC facility on any day other than the first day of the month.

- An individual who is determined eligible based on a disability determination made by ODHS|OHA,
  - To receive this payment, an individual must pursue SSI by completing an application with the SSA and appealing denials until SSA makes a final administrative decision. If SSI is denied at the final administrative level, the individual is no longer eligible for this payment.
  - The payment is the difference between the individual's countable income and the OSIPM adjusted income standard.
- An individual who is leaving a nursing facility and limited to a maximum SSI payment of $30 or to a maximum veteran benefit payment of $90. The payment is the difference between the individual's countable income and the OSIPM adjusted income standard.
- An individual who is a qualified non-citizen who is not eligible for SSI due to not meeting the requirements to become a naturalized citizen within the SSI time limit.
  - The individual must pursue naturalization.
  - The payment is the difference between the individual's countable income and the OSIPM adjusted income standard.
- An individual who does not have sufficient income to divert to the individual's community spouse due to the difference between the personal needs allowance related to a nursing facility placement and the personal

needs allowance and room and board related to a CBC facility placement. The allowance is issued only when the individual or community spouse requests or chooses a nursing facility placement rather than a CBC facility placement because the community spouse needs the resulting higher diversion amount to meet their monthly expenses.

- For all individuals, the allowance is the difference between the amount of the individual's income that would be available to divert to the community spouse under a nursing facility placement and the amount of the individual's income available under the CBC facility placement, using the liability calculation.
- For an individual whose income is less than the adjusted OSIPM program standard, the allowance is the amount calculated under the paragraph above plus the difference between the OSIPM program adjusted income standard and the individual's countable income.

Room and board only, **without personal incidentals**, may be paid for an individual to reside in a CBC facility to avoid placement in a nursing facility when an individual is leaving a public institution and the individual's SSI is suspended, subject to the following provisions. The payment amount is prorated in the first month for an individual who moves to a CBC facility on any day other than the first day of the month.

- The individual's SSI was suspended due to placement in a public institution.
- The individual must pursue SSI and verification must be provided to ODHS|OHA.
- The payment is the difference between the individual's countable income and the OSIPM Room and Board Standard.
- If SSI is reinstated or reinstatement is denied, the individual is no longer eligible for this payment.

When approving one-time payments, send a 541 with the amount of the payment in the initial month field and $0 in the ongoing months field. The notice should use the ONE case number. If there is not a ONE case number generated and a manual notice is still needed, utilize the application number. Then add any needed details in the comments section of the form.

Please see the Issuing Special Needs Payments for Personal Incidentals and/or Room & Board WG for special notice requirements when issuing this special need.

Oregon Administrative Rule(s)

461-155-0700 — Special Need; Personal Incidentals and Room and Board Allowances; OSIPM
461-155-0630 — Special Need; Community Based Care; OSIPM
461-125-0370 — Disability as the Basis of Need
461-120-0125 — Non-citizen Status Requirements
461-160-0620 — Income Deductions and Patient Liability; Long-Term Care Services or Home and Community-Based Care; OSIPM
461-135-0950 — Eligibility for Residents of Public Institutions
461-155-0270 — Room and Board Standard; OSIPM

Diversion services

ODHS|OHA may authorize one-time payments for expenses that ODHS|OHA has determined are necessary to divert OSIPM individuals who might otherwise be served in nursing facilities to community-based care (CBC). Payments

are allowed for individuals who meet SPL 1 through 13 under 411-015-0015(1)(a).

Payments will be authorized at the lowest possible cost.

To be eligible for payment, individuals may not be eligible for the item through Medicare, Medicaid or any other medical coverage.

Payment for a household item is not allowed if the CBC facility is required to provide the item by contract or administrative rule. This includes payment for lift chairs if the other requirements for this special need are met.

Payment is not allowed if the item or service may be provided under any other special needs rule in this section.

These payments do not need to be approved in advance by central office staff.

Examples:

- Purchase of a lift chair, or
- The cost of moving out-of-state when $1,000 is not sufficient (see Moving costs above).

Contact Amy Gordin at (503) 945-5659 or amy.gordin@state.or.us if you have any questions.

Oregon Administrative Rule(s)

461-155-0710 — Special Need; Diversion Services; OSIP and OSIPM

Prescription drug co-pay coverage

For an OSIPM individual who is receiving SSI income:

- ODHS|OHA will provide a payment for all Medicare Part D or Veteran's Administration Health Care prescription co-pays if an individual's co-pays exceed $10 per month.
- Payment for Medicare Part D co-pays is limited to the current Low-Income Subsidy (LIS) program amounts for a fully dual eligible individual under 100 percent of the Federal Poverty Limit.
- If the payment exceeds $30 per month, central office staff must approve it. This only has to be approved once. If the amount changes and is still over $30, it must be approved again.
  - If payment approval is needed by central office, a ONE task is generated. If approved and the issuance type is revolving fund check, another ONE task is generated for the financial clerk. Leadership will communicate the determination to the case manager, if applicable (IM, email, etc.).

Note: For mail order prescriptions, a co-pay covering three-months of prescriptions must be calculated as a monthly amount for the payment.

Oregon Administrative Rule(s)

461-155-0688 — Prescription Drug Co-pay Coverage

In-home supplement

For OSIPM, ODHS|OHA may provide a supplementary payment for an individual who meets the following

requirements:

- The individual must receive SSI as their only source of income.
- The individual must receive home and community-based care in-home services or State Plan Personal Care (SPPC) services authorized under chapter 411, division 034 of Oregon Administrative Rules. This includes Intellectual/Developmental Disability (I/DD) and Mental Health (MH) service recipients.

  Note: I/DD individuals must have an SELG code of DDC with IHC as the setting. The setting code cannot be RES for residential settings such as group care homes (GCH) or community-based facilities (CBF).
- The individual must not married

The amount and duration of payments authorized is subject to availability of funding. The current authorized payment amount is $22 per month (all eligible individuals will receive this amount). Payments are considered a reimbursement of assistance needs, so do not impact other program benefits.

If an individual chooses to pay their homecare worker for completing any assistance covered by this special need, they need to advise the homecare worker that they are not considered a homecare worker while providing the assistance, they will not be covered by workers' compensation while providing the assistance and any hours worked while providing the assistance will not count toward eligibility for health insurance or the accrual of paid leave.

Oregon Administrative Rule(s)

461-155-0575 — Special Need; In-home Supplement; OSIPM

Benefits for less than a full month

If in a month a benefit group is eligible for less than a full month's benefits (such as the initial and closing months), benefits for that month are determined as follows:

- The benefit amount for a full month is determined.
- The full benefit amount is divided by the number of days in the payment month to determine the daily benefit.
- The daily benefit is multiplied by the number of days in the month the group is eligible. The result is the benefit amount for the partial month (prorated benefit), except as adjusted by rounding below.
- The prorated benefit is not rounded.

Oregon Administrative Rule(s)

461-160-0070 — Benefits for Less Than a Full Month

Coding

In ONE, you will select **Other Payment Summary** from the **Case Summary Screen** to process a medical related payment. After you enter the **Payment Details** and click on **Evaluate**, you will see the **Payment Evaluation** pane to authorize payment.

Note: Some payments will generate a task for supervisor or Central Office authorization.

After you complete this in ONE, you will also need to send a notice. The notice for approving, denying and ending special needs payments is not sent automatically through ONE.

Manual notices

For programs in ONE, the system will automatically generate most required notices and correspondence with the exception of medical related payments.

Situations where manual notices are needed:

- When additional information or verification is needed, use the Pend for Additional Information form (OHP 0646A) or Notice of Pending Status (DHS 0210). This will need a local process for tracking and taking action if the pend is not satisfied.
- When payments are approved, use the Payments Approved form (APD 0541).
- When payments are reduced, denied or end, use the Payments Reduced/Denied/End form (APD 0540).
- When Client Buy In (CBI) is approved, use the Notice of Planned Action-Medical Costs form (SDS 540M).

The notices should use the ONE case number. If there is not a ONE case number generated and a manual notice is still needed, utilize the application number.

Note: Add language from the Decision Notice Prep Tips in the reason section of the notice on 540 series forms.

Other resources

Program Payments and Supports * includes screenshots: This QRG reviews the various steps to request payments using the Other Payments module, including how to process Medical Related Payments.

Chapter 3: Processes and procedures

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Chapter 3:
Processes and procedures

Section 1: Acting on reported changes

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Acting on reported changes

Introduction

When individuals receive benefits through ODHS|OHA, they are required to report changes that occur, such as changes to who is residing in their household or income changes. Some programs require reporting of all changes that occur during the certification period, while others only require certain changes to be reported. Simplified Reporting System (SRS), Change Reporting System (CRS), Transitional Benefit Reporting System (TBS) and medical programs have individual requirements.

When ODHS|OHA requires an individual to report a change in circumstances, the report may be made by telephone, online, office visit, report form or other written notice. A change is considered reported effective the date the individual (participant, authorized representative, etc.) reports the information to ODHS|OHA. A change reported for one program is considered reported for all programs in which the individual participates.

Other resources

Notification to Case Manager or Family Coach of Case Update: Process for eligibility workers, family coaches and APD central coordinators to notify a case manager or family coach when any updates are made to a case

Documents/Information Received — No Oregonian in Local Office: This process walks support staff through handling documents which are not received in person

Documents/Information Received in Person: This process walks support staff, eligibility workers, case managers and family coaches through handling documents which are received in person

Walk-in Contact: Describes the process for support staff and eligibility workers on how to serve Oregonians in local office

Rights and Responsibilities — Phone Applications: Covers options to capture signature for R&R including verbal signature

Third Month Application Processing

Third Month Eligibility Flow Chart

Add or Remove a Person Flow Chart

Case Changes *includes screenshots: Explains how to process reported changes to cases in ONE

Case Actions: Performing case actions as an authorized user to update information on the case; note that this may affect case status/mode and program status/mode

Simplified Reporting System (SRS)

This applies specifically to SNAP.

The Simplified Reporting System is a system in which only certain changes are required to be reported. The intent

of this system is to create as much stability for participants as possible, while ensuring that necessary changes are still being reported.

An individual assigned to SRS must report when the gross income of the filing group exceeds the SNAP countable income limit (130% of the federal poverty level) by the 10th day of the month following the month of occurrence. Individuals are also required to report the receipt of gambling or lottery winnings of $3750 or more. If an ABAWD is subject to time limits, must report when weekly hours go below 20 hours per week.

When multiple changes are reported at the same time, they must be acted on at the time of reporting and have the same effective date. This applies specifically to the SNAP program.

SNAP Filing groups certified to receive SNAP benefits for less than six months or that include a member working under a JOBS Plus agreement are not eligible for SRS.

SRS is assigned to all possible SNAP cases. To inform participants of their SRS reporting requirements, ODHS|OHA provides them with the Simplified Reporting System for Supplemental Nutrition Assistance Program form (DHS 0853).

Individuals in SRS living in SNAP time limit areas who have been identified as able-bodied adults without dependents (ABAWDs) also have to report when their weekly work hours (paid or unpaid) go below 20 hours per week. This must be reported within 10 days of the change. To inform participants that are ABWDs of their SRS reporting requirements, ODHS|OHA provides them with the Simplified Reporting System for Able-Bodied Adults Without Dependents form (DHS 0854).

Limits to ODHS actions for Simplified Reporting System (SRS) cases

Cases assigned to SRS receive certain protections from changes between certification and periodic change report times.

Benefits may be changed for these groups during these in-between times only as follows:

- The reported change creates an increase in the SNAP allotment.
- The household requests a closure of benefits.
- Unclear information is information from which you cannot readily determine whether it will negatively impact an active household's SNAP benefits.
  - Staff may receive unclear information from a third party or from the SNAP household itself. The information may be UNVERIFIED, or it may be verified but such that the effect on the household's SNAP eligibility is not apparent.
    - » Example: If an active SNAP case on Simplified Reporting verifies that a new member has joined the household but does not provide any information about the new member's income, the information is unclear. Because the new member may have income more than the household's gross limit, you cannot add the new member to the household without first seeking additional information.
- Verification was received with the report of the change. (This is called "verified upon receipt.")
  - If the information received is significantly conflicting or the information is a subset of unclear

information. Unclear information is significantly conflicting, if it contradicts the circumstances used to certify the household at their reporting period. This information would not be acted upon.

- The individual reported information that results in loss of eligibility.
- The individual reports financial group income exceeding the SNAP countable income limit. This includes all income when added a new member to the Household.

ODHS|OHA checks and acts on information reported through computer matches (including IEVS) only when the Periodic Report Form (SNP-069) is processed, when the individual is recertified, or when the monthly match with the Department of Corrections indicates a member is incarcerated, or daily SOLQi data match is updated. If an individual reports a change in income, but it is unclear if the filing group will exceed 130% of the federal poverty level, eligiblity worker should add a case note into ONE with information received that it is not being acted upon due to unclear information. If the individual is reporting gambling or lottery winnings of $3750 or more.

TANF This does not apply to the TANF program.

ERDC This does not apply to the ERDC program.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Oregon Administrative Rule(s)

461-170-0101 — Simplified Reporting System (SRS); SNAP
461-150-0020 — Prospective Eligibility and Budgeting
461-150-0060 — Prospective or Retrospective Eligibility and Budgeting; ERDC, REF, REFM, SNAP, TANF
461-170-0011 — Changes That Must be Reported
461-170-0010 — Reporting Changes Overview
461-170-0130 — Acting on Reported Changes; OSIPM, MSP
410-200-0125 — Acting on Reported Changes

Other resources

Able-Bodied Adults Without Dependents (ABAWD) Process: This process walks eligibility workers and leadership through ABAWD referrals and working monthly lists.

Change Reporting System (CRS)

The Change Reporting System is a 10-day reporting system with many reporting requirements. While in CRS, program benefits may change each time the household reports a change that is expected to continue. To inform participants of their CRS reporting requirements, ODHS|OHA provides them with the Change Report (DHS 0943).

SNAP Filing groups certified to receive SNAP benefits for less than six months or that include a member working under a JOBS Plus agreement are placed into CRS.

The following changes are required to be reported within 10 days when SNAP cases are in CRS:

- A change in earned income of more than $150
- A change in unearned income of more than $150
- A change in an income's source
- A change in membership of the filing group and any resulting change in income (earned or unearned)
- A change in residence and the shelter costs associated with the new residence
- A change in the legal obligation to pay child support
- When the household's resources reach or exceed SNAP resource limits (including cash on hand, stocks, money in a checking or savings account or any other form of liquid assets), and
- Acquisition of or change in ownership of a non-excludable vehicle.

When multiple changes are reported at the same time, they must be acted on at the time of reporting and have the same effective date. Individuals are also required to report the receipt of gambling or lottery winnings equal to or greater than the resource limit for elderly or disabled households.

TANF TANF cases are in CRS.

The following changes are required to be reported within 10 days:

- Acquisition of or change in ownership of a non-excluded vehicle
- A change in earned income of more than $100
- A change in unearned income of more than $50
- Job loss or employment separation
- A change in membership of the household group
- A change in marital status or other changes in membership of the filing group
- A change in mailing address or residence
- A change in pregnancy status for any member of the filing group
- A change in source of income
- A change in who pays shelter costs if they are paid by a non-custodial parent, and
- Sale or receipt of a resource that causes total resources to exceed TANF resource limits.

ERDC ERDC cases are in CRS.

Individuals receiving ERDC benefits must report any of the following within 10 days of occurrence:

- A change in child care provider
- A change in employment status

- A change in mailing address or residence
- A change in membership of the filing group
- A member of the filing group is discharged from the U.S. military and returning from active duty in a military war zone, and
- A change in income above the ERDC ongoing and exit income limit that is expected to continue.

Changes that will increase the copay or decrease approved child care hours during the certification period will not be acted upon in most cases, with the exception of changes to the household or error made at determination (administrative error). When multiple changes are reported at the same time, they must be acted on at the time of reporting and have the same effective date.

Individuals receiving ERDC may report changes on the Change Report form (DHS 0943) or the Change Report for Employment Related Day Care form (DHS 0862).

Click here for Income changes.
Click here for Adding or removing a household member.

REF REF cases are always in CRS.

The following changes are required to be reported within 10 days:

- Acquisition of or change in ownership of a non-excluded vehicle
- A change in earned income of more than $100
- A change in unearned income of more than $50
- Job loss or employment separation
- A change in membership of the household group
- A change in marital status or other changes in membership of the filing group
- A change in mailing address or residence
- A change in pregnancy status for any member of the filing group
- A change in source of income
- If an individual enrolls in higher education full-time
- Sale or receipt of a resource that causes total resources to exceed TANF resource limits.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Oregon Administrative Rule(s)

461-150-0020 — Prospective Eligibility and Budgeting
461-150-0060 — Prospective or Retrospective Eligibility and Budgeting; ERDC, REF, REFM, SNAP, TANF
461-170-0011 — Changes That Must be Reported

Transitional Benefit Reporting System (TBA/TBS)

This applies specifically to SNAP.

SNAP When a SNAP participant is receiving TANF and their TANF case closes, their SNAP case may be eligible to be placed into Transitional Benefit Reporting System (TBA aka TBS). SNAP cases that meet the below eligibility requirements are placed into TBA for five months following the TANF case closure.

An individual assigned to TBA is not required to report any changes.

If the filing group separates into two or more groups during the TBA period, only the group containing the head of household continues in the TBA. TANF cases that close for no eligible child in the household will still include the child on the SNAP case while in TBA, unless someone else has applied for SNAP for that child.

Click here for Case closures and transitions between programs.

The benefit level for the transition period is based on the countable income for SNAP during the last month before TBA begins, excluding the TANF grant. Once the TBA SNAP benefits allotment is established, the benefit level is changed only when—

- The filing group submits a new SNAP application and will receive more SNAP benefits if they are not using the TBA reporting system.
- A member of the filing group leaves and applies for SNAP benefits as a member of another household.
  or
- ODHS|OHA initiates certain changes due to cost-of-living adjustments or changes other eligibility criteria based on legislative or regulatory actions.

A group may not participate in TBA when any of the following situations apply:

- A member of the filing group is receiving benefits of the TANF program.
- TANF benefits are stopped because the household does not reside in Oregon.
- TANF benefits are stopped because of a change that results in ineligibility for TANF and the household failed to complete a timely report or to complete a required action on time.
- As of the date the TANF case closed, an individual in the household was serving a penalty imposed in the TANF program.
- TANF benefits are stopped at the request of the household after the household is informed of an impending disqualification in the TANF program.
- The head of household becomes ineligible for SNAP because that person lives in an institution or in a facility that provides at least 50 percent of the meals.
- A member of the financial group is subject to a penalty in SNAP because of the individual's conduct; e.g., because the individual:
  - Was excluded from the need group

- Was penalized for failure to meet a requirement of an employment program
- Was ineligible for SNAP benefits, or
- Was ineligible for or disqualified from participation in SNAP because of a failure to comply with a requirement of the program to provide complete and accurate information to ODHS|OHA.

TANF No additional program-specific information.

Please see SNAP for information regarding TBA.

ERDC This does not apply to the ERDC program.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Oregon Administrative Rule(s)

461-135-0506 — Transitional Benefit Alternative (TBA) in the SNAP Program
461-150-0020 — Prospective Eligibility and Budgeting
461-150-0060 — Prospective or Retrospective Eligibility and Budgeting; ERDC, REF, REFM, SNAP, TANF
461-170-0011 — Changes That Must be Reported
461-170-0200 — State and Federal Government-Initiated Changes

Other resources

TANF Transitions *includes screenshots: Explains the requirements for timely reporting of details about new or changed income for ONE to reduce, close and transition TANF cases accurately.

Medical reporting requirements

Individuals receiving medical benefits are informed of the changes they must report on their approval notice. Program participants are not required to submit a change report form when reporting changes. Individuals are required to report within 10 days all changes in income, resources, or circumstances that may affect their eligibility for assistance or the amount of assistance they receive. Changes that must be reported include:

- A change in mailing or home address,
- When someone gets or loses other health coverage or if any other health coverage changes (this includes employer-sponsored health coverage),
- A change in membership of the household group, including when someone moves in or out of the household,
- A change in marital status,
- A change in legal name,
- When someone becomes pregnant, a pregnancy ends, or a child is born, or

- A change in citizenship or immigration status.

Note: When an individual reports a claim for personal injury the following information shall be reported:

- The names and addresses of all parties against whom the action is brought or claim is made,
- A copy of each claim demand, and
- If an action is brought, the case number and the county where the action is filed.

They must report within the following time frames:

- Changes must be reported within 10 days of occurring. The 10-day time frame starts when the change occurs.
- For earned income, individuals have 10 days to report from the first day work begins or 10 days from the day employment is terminated.
- For unearned income, the 10-day time frame starts on the day the individual receives the new or changed payment.

Processing changes

- Add reported change to the case in ONE.
  - If an individual reports both a non-eligibility address change AND an eligibility change at the same time (new job and new address), process the non-eligibility update first. Process the eligibility related change after the address so that the address change goes to MMIS immediately. Otherwise, processing both changes in the same action may impact timely medical CCO enrollment.
- If the reported changes can potentially impact financial eligibility, run eligibility and authorize all programs to determine if additional information or verification is needed.
- If additional information or verification is needed, determine if a manual RFI needs to be sent (ONE sends most RFIs automatically, but there are a few exceptions).
- If a manual notice is needed, send out an RFI or DHS 0210A form allowing 10 days from the date the written request is mailed for return of requested information. The worker should only allow more than 10 days if circumstances require more time (e.g. individual must send away for financial documentation); however, the deadline should allow sufficient time to complete the eligibility determination before the 45th day following the date the change was reported or discovered (unless there is good cause to extend beyond the 45th day).
- Add a case note for any action(s) that require an explanation or additional information.
- If the individual does not return the requested information by the deadline on the RFI or DHS 0210A form, ONE will automatically deny or close benefits with timely notice.
- When a reported change has a potential impact on case management (e.g., TANF JOBS status, LTC Services Programs, address change), notify the appropriate SFO via the branch transfer email.
  - Refer to the Notification to Case Manager or Family Coach of Case Update ETOP.

When an individual makes a timely report of a change that could reduce or end medical assistance, ODHS|OHA must review each individual in the filing group for other medical program eligibility prior to reducing or ending medical assistance.

If additional information is needed to act on the timely reported change, members of the benefit group remain eligible from the date the change was reported until ODHS|OHA determines their eligibility in accordance with the application processing time frames.

Mass changes initiated by the state or federal government affect significant portions of the caseload. Because ODHS|OHA is notified of these changes by the agencies responsible, individuals do not need to report the following changes when they occur:

- Periodic cost-of-living adjustments to SSB, SSD or SSI benefits
- Periodic cost-of-living adjustments to other assistance programs administered by ODHS|OHA
- Changes in eligibility criteria due to legislative or regulatory actions.

If ODHS|OHA discovers that an individual failed to report changes they are required to report and, as a result, the benefit group received benefits they were not entitled to, ODHS|OHA must file an overpayment against the financial group.

Refer to Medical Related Payments for processing changes.

Refer to Long Term Care for processing changes that may affect service eligibility.

Click here for Overpayments.

Click here for Fraud.

MSP Even though MSPs have no resource limit, reporting changes in resources can be extremely important for individuals who would otherwise qualify for OSIPM if not for resources. Workers should notify individuals when applicable.

Additional changes that must be reported for MSP include:

- Any change in employment status,
- Any change in source or amount of income, and
- For residents of a public institution whose medical benefits have been suspended, a change in incarceration status.

OSIPM Additional changes that must be reported for OSIPM include:

- A change in resources, if it would affect eligibility,
- Any change in employment status,
- Any change in source or amount of income,
- A change in out-of-pocket medical expenses, and
- If someone becomes incarcerated or is released from the public institution in which they were a resident.

HSD Additional changes that must be reported for HSD medical programs include:

- A change in tax filing status,
- With the exception of MAGI CHIP, a change in availability of employer sponsored health insurance,

- For an EDG member age 19 or older:
  - Change in source of income,
  - A change of more than $50 unearned income, and
  - When someone starts or stops working, or has a change of more than $100 earned income.
- Acting on reported changes:
  - If eligibility continues, the original renewal date is maintained.

Click here for examples: Medical reporting requirements.

Oregon Administrative Rule(s)

461-150-0020 — Prospective Eligibility and Budgeting
461-170-0011 — Changes That Must be Reported
461-170-0200 — State and Federal Government-Initiated Changes
461-170-0010 — Reporting Changes Overview
461-170-0130 — Acting on Reported Changes; OSIPM, MSP
461-135-0010 — Assumed Eligibility for Medical Programs
461-180-0020 — Effective Dates; Changes in Income or Income Deductions That Cause Increases
461-180-0030 — Effective Dates; Changes in Income or Income Deductions That Cause Reductions
410-200-0235 — Changes That Must Be Reported
410-200-0125 — Acting on Reported Changes

Adding or removing a household member

When a new person is reported to have entered the household, it may affect program eligibility. All changes of this nature will generally occur the month after they are reported, although there are some exceptions to this, such as in the case of an infant being born.

Sometimes individuals may report a group member has moved out. This may also affect program eligibility. The effective date for removing an individual from the benefit group depends on the following for all programs:

- If the individual has left the benefit group in the current budget month because they are ineligible, disqualified or have left the household, the effective date is:
  - The first of the month after timely notice can be sent , if the change will reduce benefits, or
  - The last day of the month in which timely notice can be sent, if the change will end benefits; or
  - The first of the month following the change being reported if the change will increase benefits.
- If the individual is reasonably expected to leave the household the next month, the effective date is the later of the following:
  - The first of the month following the month in which the individual is expected to leave the household, if the change will reduce benefits, or
  - The end of the month in which the individual is expected to leave the household, if the change will end benefits, or

- The first of the month following the month in which the individual is expected to leave the household, if the change will increase benefits.

- For all programs except OSIPM and MSP, when an individual in a benefit group of more than one person passes away, the effective date is:
  - The first of the month after timely notice can be sent if the change will reduce benefits, or
  - The last day of the month in which timely notice can be sent if the change will end benefits, or
- The first of the month following the change being reported if the change will increase benefits.

SNAP Adding a member to benefits (other than a newborn)

When an individual reports the addition of a person to their household, ODHS|OHA collects all necessary information including, but not limited to:

- Income and resources,
- Any counting months for the current SNAP Time Clock,
- Citizenship status,
- Student status, and
- Identity (date of birth, SSN, etc.).

Action is taken on the following effective date after the request to add a member is received:

- The first of the month after timely notice can be sent if the change will reduce benefits,
- The last day of the month in which timely notice can be sent if the change will end benefits, or
- The first of the month after they have reported the individual has joined the household if the change will increase benefits. If the individual reports in advance that a person will join their household, benefits are not increased until the month following when the change occurs.

Adding a newborn member to benefits

If a request is received from a member of the filing group or an authorized representative to add a newborn to a SNAP case or ODHS|OHA receives notification of the birth of a newborn from a member of the filing group or an authorized representative, ODHS|OHA collects the information regarding the newborn baby and adds the child to the SNAP case the first of the month following report of the birth. Note that this doesn't include reports from hospitals regarding medical benefits. If a report from a hospital is received, it is not used for SNAP unless the information has been verified through conversation or notification by the filing group or their authorized representative. If ODHS|OHA has been informed that the alleged father (or other parent of the newborn) was residing with the mother during the pregnancy, the other parent's information is collected as well. In this circumstance, both newborn and the other parent must be added to the SNAP case at the same time. If it is voluntarily reported to ODHS|OHA that the newborn is still residing in the hospital or did not go home with the parent(s), e.g., the child was taken into Child Welfare custody, the newborn is not added to the SNAP case at that time.

A newborn may be included in a SNAP benefit group for six months following the date the child is born or until the next recertification of the benefit group, whichever is later, without applying for or providing an

SSN.

Click here for Social Security number (SSN).

TANF Adding a household member (other than a newborn)

When adding a new person (other than a newborn) to an open case, a new application or an addendum must be received to establish a filing date. If a new filing date is not established, the individual is added to the case when eligibility is met.

Establishing a filing date with the Application for Services (DHS 0415F) or "Additional space for other people living with you" (DHS 0415X) will ensure the TANF supplement will start on the filing date once the new person clears eligibility.

ODHS|OHA takes the following steps when an addition to the household is reported:

- Determines if the individual must be added to the filing group and adjusts the household number on UCMS.
- If the person is included in the filing group, ODHS|OHA determines the eligibility factors the new person must meet.
- If adding this person will increase benefits, they are added effective the date when all eligibility requirements are met and verified, unless an application was submitted and a new filing date was established. If a filing date was established and all eligibility was cleared within 30 days of the filing date, the individual is added effective the filing date.
- The new household member's actual current income is used to determine eligibility and the amount of potential supplement when they are added.
  and
- If benefits have been issued for the month and adding the new person would reduce benefits, the person is added the first of the month following the month in which the notice period ends.

Adding an eligible newborn

The effective date for adding an eligible newborn to an open case is:

- The date of birth, if all eligibility requirements are met and verified within 30 days after the birth, or
- The date all eligibility factors are met and verified, if the verification is completed more than 30 days after the date of birth.

When adding a newborn child born in an Oregon hospital to a case, proof of birth or Social Security number is not required.

Click here for Social Security number (SSN).

Removing a household member

Removing a person from their TANF grant means either reducing or terminating the benefits of the benefit group. A timely continuing benefit decision notice is required except:

- When a child is removed from the home because of a court decision or a voluntary placement in foster care by their caretaker relative, a basic decision notice is sent to close the child's benefits only. Child Welfare cannot remove a child from the child's home without a court order; therefore, a basic decision notice is sufficient when Child Welfare has custody of the child.

ERDC Adding a household member

When a parent or spouse moves into the home:

- If the parent being added has income and the income will increase the copay, ODHS|OHA sends timely notice. If the income puts the household income at or above the ERDC ongoing income limit, the case is closed with timely notice.
- If the parent is not employed and is looking for work, they are added to the ERDC case and authorized work search (AWS) is applied to that parent. AWS can only be applied to one parent at a time.

Click here for Authorized work search (AWS).

When a child moves into the home:

- If the child needs care, they are added to the case in the month the child is reported in the home. If the child will use the same provider as the other child, an email should be sent to DPU to reissue the billing form.
- If the child does not need care, they are added to the case the month after the child is reported in the home.

In both situations, any income that comes with the child will need to be added (verify income). ONE will allow for a timely closure notice if it will increase the copay.

Removing a household member

When it is reported that a filing group member has left the household, that person is removed from the case. If the action will cause decrease (higher copay) in benefits, a timely closure notice will be sent.

REF Adding a household member

When adding a new person (other than a newborn) to an open case, a new application or an addendum must be received to establish a filing date. If a new filing date is not established, the individual is added to the case when eligibility is met.

Establishing a filing date with the Application for Services (DHS 0415F) or "Additional space for other people living with you" (DHS 0415X) will ensure the REF supplement will start on the filing date once the new person clears eligibility.

ODHS|OHA takes the following steps when an addition to the household is reported:

- Determine if the individual must be added to the filing group and adjusts the household number on UCMS.
- If the person is included in the filing group, ODHS|OHA determines the eligibility factors the new

person must meet.

- If adding this person will increase benefits, the individual is added effective the date when all eligibility requirements are met and verified, unless an application was submitted and a new filing date was established. If a filing date was established and all eligibility was cleared within 30 days of the filing date, the individual is added effective the filing date.
- The new household member's actual current income is used to determine eligibility and the amount of potential supplement when they are added.

and

- If benefits have been issued for the month and adding the new person would reduce benefits, the person is added the first of the month following the month in which the notice period ends.

Removing a household member

Removing a person from their REF grant means either reducing or terminating the benefits of the benefit group. A timely continuing benefit decision notice is required.

Pregnancy

When an individual becomes pregnant, they are required to apply for TANF in the month before the due date falls.

Click here for Pregnancy.

MSP

Adding a household member

For QMB, the effective date for adding a new person to the benefit group is the first of the month after the new person has been determined to meet all eligibility criteria and ODHS|OHA receives the required verification.

For SMB and SMF, the effective date is the first of the month in which the new person has been determined to meet all eligibility criteria and ODHS|OHA receives the required verification.

Removing a household member

When an individual in a benefit group of more than one individual dies, the effective date of the closure or reduction in benefits is the date of the individual's death.

OSIPM

Adding a household member

The effective date for adding a new person to the benefit group is whichever of the following occurs first:

- The first of the month in which the individual requests assistance, if it is verified that they were eligible as of that date, or
- The first of the month in which all eligibility requirements are met, if met within 45 days of the date of request.

Removing a household member

If the person has left the benefit group in the current budget month because they are ineligible, disqualified or left the household, the effective date for the individual leaving the household is the later of the following:

- The last day of the month in which medical eligibility was redetermined if completed between the 1st of the month and the timely notice cutoff date, or
- The last day of the month after the month in which medical eligibility was redetermined if completed after the timely notice cutoff date.

If the change will reduce assistance and there is no MAGI eligibility, the effective date for the remaining benefit group members is the later of the following:

- The first of the month following the month in which the change was processed if completed between the 1st of the month and the timely notice cutoff date, or
- The first day of the second month after the month in which the change was processed if completed after the timely notice cutoff date.

If the change will end assistance and there is no MAGI eligibility, the effective date for the remaining benefit group members is the later of the following:

- The last day of the month in which medical eligibility was redetermined if completed between the 1st of the month and the timely notice cutoff date, or
- The last day of the month after the month in which medical eligibility was redetermined if completed after the timely notice cutoff date.

When an individual in a benefit group of more than one individual dies, the effective date of the closure or reduction in assistance is the date of the individual's death.

HSD Adding a household member

The effective date for adding a new person to the household group is the earlier of the following:

- The earliest date of eligibility within the month in which the date of request is established,
- If ineligible within the month in which the DOR was established, the first day within the following month in which the individual is determined to be eligible,
- If requesting retroactive medical benefits, the first day of the earliest date of eligibility within the three months preceding the month in which the DOR was established,
- If the addition of a household member results in a reduction or loss of eligibility for EDG members, the effective date for the change is:
  - If the determination is made on or before the 15th of the month, the first of next month,
  - If the determination is made on or after the 16th of the month, the first of the month following the next month.

Removing a household member

When an individual is permanently removed from the household group, ONE will end benefits and send

timely notice. The effective date the benefits will be ended is as follows:

- If the determination is made on or before the 15th of the month, the first of next month, or
- If the determination is made on or after the 16th of the month, the first of the month following the next month.

- When a deceased individual is removed from the household, the effective date is the individual's date of death.
- When an individual is removed from the household due to incarceration, the effective date of benefit suspension is the day following the date of incarceration.

Click here for examples: Adding or removing a household member.

Oregon Administrative Rule(s)

461-180-0010 — Effective Dates; Adding a New Person to an Open Case
461-170-0010 — Reporting Changes — Overview
461-170-0011 — Changes That Must be Reported
461-180-0120 — Effective Dates; Removing an Individual
461-170-0130 — Acting on Reported Changes; OSIPM, MSP
410-200-0115 — Effective Dates

Other resources

Add or Remove Member / Change Head of Household *includes screenshots: Adding and removing household members; changing the head of household (HoH)

Third Month Eligibility Flow Chart

Income changes

Income changes during the benefit period should be reported by participants according to the program's specific reporting system. For changes that are required to be reported, individuals may report by telephone, office visit, online, report form, fax or other written notice. Changes reported for one program are considered reported for all programs in which the individual participates and should be acted on according to the requirements of each program. If the income change is required to be reported, verification of new income is required unless it clearly places the household above the ongoing and exit income limits for a program or, for medical programs, it meets reasonable compatibility.

Changes in income are generally effective the next month after they are reported; however, there are some situations and programs that allow the change to take effect the same month in which the change is reported.

Whenever a change results in a reduction in benefits, there must be enough time for a timely reduction notice to be sent. Increases in benefits do not require timely continuing benefit decision notice.

Click here for Simplified Reporting System (SRS).
Click here for Change Reporting System (CRS).

Click here for Transitional Benefit Reporting System (TBA/TBS).
Click here for Medical Reporting Requirements.

SNAP When any change is reported, regardless of whether it was required, it must be acted on for SNAP.

The reported data must be entered into ONE, and a case note added. ONE will determine if any action is required, and will recalculate the SNAP benefit if appropriate.

Some changes initiated by the state or federal government affect significant portions of or the entire caseload. Because ODHS|OHA is notified of these changes by the agencies responsible, individuals do not need to report the following changes when they occur:

- Periodic cost-of-living adjustments to SSB, SSD or SSI benefits
- Periodic cost-of-living adjustments to other assistance programs administered by ODHS|OHA
- Changes in eligibility criteria due to legislative or regulatory actions
- Adjustments to SNAP countable and adjusted income limits, Thrifty Food Plan, dependent care deduction, utility standard, excess shelter deduction, homeless shelter deduction, and/or standard deduction. These adjustments generally are effective Oct. 1.

No notice is required for these mass changes.

Employed children turning age 18

When an employed child on a SNAP case turns 18, the earned income of a child is counted in the budget month after the individual's 18th birthday.

TANF When a TANF participant obtains employment, their anticipated income will be addressed. Determine anticipated income by receiving critical information called the "Big 3." The Big 3 consist of the following reported information:

- How many hours the participant is scheduled to work per week
- The participant's hourly wage, and
- The date of the participant's first paycheck.

Using this information, ODHS|OHA is able to calculate the individual's ongoing anticipated income. If their income places them over the TANF exit limit, their case will close; if they receive their first paycheck on or before the 14th of the month, the case will close at the end of the month; and if they receive their first paycheck on the 15th or later during the month, the case will close at the end of the following month.

If income is less than the TANF exit limit (ELI), verification is required. It is added to the case with timely reduction notice.

If any of the Big 3 are not reported, ODHS|OHA will send a Notice of Information or Verification Needed (DHS 0210A) or Request for Information (RFI) to obtain this information, due by the 15th of the following month.

Click here for Case closures and transitions between programs.

ERDC Reporting income increases, decreases or a change in work hours during the certification period is not required for ERDC cases unless the household income goes over the ERDC ongoing income limit.

Click here for Income limits.

Decrease in income

When there is a decrease in income reported by the caretaker, ODHS takes the following steps:

- Determine if the change is anticipated to continue.
- If yes, ODHSIOHA sends a Request for Information (RFI) to request verification of income
  - If the caretaker does not respond to the notice, no action is taken on the case.
  - Once verification is received, ODHSIOHA updates the income record on the case which may change the copay amount and also updates the SNAP dependent care deduction in the expense record.
  - If verification shows increased income, no action is taken unless the income exceeds the ongoing exit limit.
  - Child care hours are not reduced during the certification period; even if verification shows the caretaker is working fewer hours, ODHSIOHA will not reduce authorized hours.
- If no, no action is taken.

Increase in income

When there is an increase in income due to a raise or new job resulting in higher income reported by the caretaker, no action is taken on the case unless they are working a greater number of hours. In this case, take the following steps:

- Determine if the change is expected to continue.
- If yes, ODHSIOHA sends Request for Information (RFI) to request verification of their new work hours.
  - If the caretaker does not respond to the notice, no action is taken on the case.
  - Once verification is received, ODHSIOHA updates the authorized child care hours on the case.
  - If verification shows increased income, no action is taken on the case. The copay is not adjusted.
  - If income is included with verification of hours and exceeds the ongoing income limit, the case is closed with timely notice.
- If no, no action is taken.

When a change in income results in the caretaker being unable to pay the copay in the month the change is reported, the Child Care Billing (CCB) may be able to be replaced. A billing form can be replaced in the following situations:

- **Administrative error –** The original billing form was incorrect because of an administrative error.
- **Job loss or reduction of income –** The individual reported in a timely manner a good cause job

loss or an ongoing reduction in pay, and the parent does not have enough income in that month to pay the copay. The change must make a difference of at least $25 or more in the copay amount.

- **Increased work hours –** The individual reported and verified an increase in work hours in the current month, and the parent does not have enough income in that month to pay the additional cost of child care caused by the increased hours.
- **Reported after CMS cut-off –** The individual reported a change during compute deadline, and the CCB has already been issued for the next month.

  or

- **Reported timely in the beginning of the next month –** A change that will benefit the family that occurs toward the end of the month is effective the month after the change occurs when it is reported within 10 days of the change.

REF When a REF participant obtains employment, their anticipated income will be addressed. Determine anticipated income by receiving critical information called "the Big 3." The Big 3 consists of the following reported information:

- How many hours the participant is scheduled to work per week
- The participant's hourly wage, and
- The date of the participant's first paycheck.

Using this information, ODHS|OHA is able to calculate the individual's ongoing anticipated income. If their income places them over the REF income limit, their case will close; if they receive their first paycheck on or before the 14th of the month, the case will close at the end of the month; if they receive their first paycheck on the 15th or later during the month, the case will close at the end of the following month.

If income is less than the REF income limit, verification is required. It is added to the case with timely reduction notice.

If any of the Big 3 are not reported, ODHS|OHA will send a Notice of Information or Verification Needed (DHS 0210A) or Request for Information (RFI) to obtain this information, due by the 15th of the following month.

MSP Individuals are required to report all changes in income that may affect their eligibility for benefits, including the following, within 10 days of occurrence:

- A change in employment status
- A change in source or amount of income.

The date of occurrence is determined as follows:

- A change in employment status is considered to occur the first day the individual starts work for a new job or the last day of employment for a job separation.
- For earned income, the change occurs upon the receipt of the first paycheck for a new job or the first paycheck reflecting a change in pay.
- For unearned income, the change occurs on the day the individual receives the new or changed

payment.

Changes are considered reported effective the date the information is received or discovered by ODHS|OHA and the change constitutes a new date of request. Program participants are not required to submit a change report form when reporting changes.

Processing income changes

- Add reported change to the case in ONE.
- If the reported changes can potentially impact financial eligibility, run eligibility and authorize all programs to determine if additional information or verification is needed.
- If additional information or verification is needed, determine if a manual RFI needs to be sent. (ONE sends most RFIs automatically, but there are a few exceptions.)
- If a manual notice is needed, send out an RFI or DHS 0210A form allowing 10 days from the date the written request is mailed for return of requested information. The worker should only allow more than 10 days if circumstances require more time (e.g. individual must send away for financial documentation); however, the deadline should allow sufficient time to complete the eligibility determination before the 45th day following the date the change was reported or discovered (unless there is good cause to extend beyond the 45th day).
- Add a case note for any actions that require an explanation or additional information.
- If the individual does not return the requested information by the deadline on the RFI or DHS 0210A form, ONE will automatically deny or close benefits with timely notice.

When an individual makes a timely report of a change that could reduce or end medical benefits, ODHS|OHA must review each individual in the filing group for other medical program eligibility prior to reducing or ending medical benefits. If a reported change results in insufficient information to determine how the change will affect the benefit group's eligibility and benefit level, ODHS|OHA may shorten the redetermination period and require a new application.

Mass changes initiated by the state or federal government affect significant portions of the caseload. Because ODHS|OHA is notified of these changes by the agencies responsible, individuals do not need to report the following changes when they occur:

- Periodic cost-of-living adjustments to SSB, SSD or SSI benefits,
- Periodic cost-of-living adjustments to other assistance programs administered by ODHS|OHA, or
- Changes in eligibility criteria due to legislative or regulatory actions.

OSIPM Individuals are required to report all changes in income that may affect their eligibility for benefits or the amount of benefits they receive, including the following;

- A change in employment status
- A change in source or amount of income.

They must report within the following time frames:

- Changes must be reported within 10 days of occurring. The 10-day time frame starts when the

change occurs.

- For earned income, individuals have 10 days to report from the first day work begins or 10 days from the last day employment is terminated.
- For unearned income, the 10-day time frame starts on the day the individual receives the new or changed payment.

Changes are considered reported effective the date the information is received or discovered by ODHS|OHA and the change constitutes a new date of request. Program participants are not required to submit a change report form when reporting changes.

Processing income changes

- Add reported change to the case in ONE.
  - If an individual reports both a non-eligibility address change AND an eligibility change at the same time (new job and new address) process the non-eligibility update first. Process the eligibility related change after the address so that the address change goes to MMIS immediately. Otherwise, processing both changes in the same action, may impact timely Medical CCO enrollment.
- If the reported changes can potentially impact financial eligibility, run eligibility and authorize all programs to determine if additional information or verification is needed.
- If additional information or verification is needed, determine if a manual RFI needs to be sent. (ONE sends most RFIs automatically, but there are a few exceptions.)
- If a manual notice is needed, send out an RFI or DHS 0210A form allowing 10 days from the date the written request is mailed for return of requested information. The worker should only allow more than 10 days if circumstances require more time (e.g. individual must send away for financial documentation); however, the deadline should allow sufficient time to complete the eligibility determination before the 45th day following the date the change was reported or discovered (unless there is good cause to extend beyond the 45th day).
- Add a case note for any actions that require an explanation or additional information.
- If the individual does not return the requested information by the deadline on the RFI or DHS 0210A form, ONE will automatically deny or close benefits with timely notice.
- When a change reported has a potential impact on case management (e.g., TANF JOBS status, LTC Services Programs), notify the appropriate SFO via the branch transfer email.
  - Refer to the Notification to Case Manager or Family Coach of Case Update ETOP.

When an individual makes a timely report of a change that could reduce or end medical benefits, ODHS|OHA must review each individual in the filing group for other medical program eligibility prior to reducing or ending medical benefits. If a reported change results in insufficient information to determine how the change will affect the benefit group's eligibility and benefit level, ODHS|OHA may shorten the redetermination period and require a new application.

Mass changes initiated by the state or federal government affect significant portions of the caseload. Because ODHS|OHA is notified of these changes by the agencies responsible, individuals do not need to

report the following changes when they occur:

- Periodic cost-of-living adjustments to SSB, SSD or SSI benefits,
- Periodic cost-of-living adjustments to other assistance programs administered by ODHS|OHA, or
- Changes in eligibility criteria due to legislative or regulatory actions.

HSD Income changes

- Changes in income must be reported within 10 calendar days of their occurrence. These changes include:
  - A change in source of income
  - A change in employment status
    - For a new job, the change occurs on the first day of the new job.
    - For a job separation, the change occurs on the last day of employment.
  - A change in earned income more than $100 per month or a change in unearned income of more than $50 per month
    - The change occurs upon the day the changed income is received.

Periodic cost of living adjustments to the federal Black Lung Program, SSB, SSDI, SSI and veterans assistance under Title 38 do not need to be reported.

Click here for Case closures and transitions between programs.

Click here for examples: Income changes.

Oregon Administrative Rule(s)

461-180-0020 — Effective Dates; Changes in Income or Income Deductions That Cause Increases
461-180-0030 — Effective Dates; Changes in Income or Income Deductions That Cause Reductions
461-170-0130 — Acting on Reported Changes; OSIPM, QMB
410-200-0235 — Changes That Must Be Reported

Authorized work search (AWS)

This applies specifically to the ERDC program but can also affect SNAP benefits.

While ERDC is initially certified for employment hours, parents may be eligible to maintain child care assistance even if they have temporarily or permanently lost their job. Child care can be allowed in these instances so the parent may look for work. This continuation of child care assistance is called authorized work search, or AWS.

Click here for Job separation and voluntary reduction of hours.

SNAP When a copay is waived due to AWS on a corresponding ERDC case, the child care deduction will need to be addressed with the participant. The child care deduction should reflect the actual amount the participant paid.

Click here for Expenses and deductions.

TANF This does not apply to the TANF program.

ERDC Authorized work search, or AWS, is an exception within the ERDC program that allows parents to continue to use child care if they have lost their employment. This may be a permanent or temporary job loss.

A permanent job loss means:

- The employee is fired, the job was a short-term job that has ended, the employee was permanently laid off (no return to work date), or the employee voluntarily quit.

A temporary job loss means:

- The employee has a break in work and the employer gave the employee a specific return to work date or time period to return. This can include:
  - Those who received layoff notification from their employer with a return to work date
  - Those who work for the school system and are not working during summer break
  - Those who work seasonal jobs, such as someone who works for a ski resort.

When a permanent job loss or temporary break in work occurs, ODHS|OHA will:

- Ask the participant why they are off work; were fired, quit or laid off; had a seasonal break, etc.
  - If fired or quit, review to determine good cause.
  - If there is no good cause, close the case with a timely notice.
- When good cause is determined, they will receive a full three-month work search period starting the first of the month following the job loss.
- If there is a break in work (from being laid off, having a seasonal, break, etc.), ask if a return to work date was given.
- If the participant has a return to work date, enter the information in ONE.
- AWS is not granted for more than three months past the certification end date, even if the return to work date is farther out.
- When no return to work date is given, AWS is granted with a full three-month work search period starting the first of the month following the job loss.
- Nonspecific return to work date – The employer is not specific about a participant's return to work date (such as three to four months).
  - The worker will enter the shortest time in ONE. If three to four months is expected, enter a return to work date of the third month.
  - If the participant reports they are not back to work in the third month, the worker can extend the date to the fourth month or adjust it based on new information the participant received from their employer.

When adding AWS, ODHS|OHA will:

- Not adjust the end certification date

- Not adjust the child care hours
- Not adjust the income
- Address the child care deduction for SNAP, if applicable.

AWS will cause the system to waive the copay until:

- The case closes based on the AWS end date, or
- AWS ends because of new employment or return to work.

When a participant reports new employment or has returned to work, the worker should enter that information in ONE which causes AWS to end with timely notice. Once AWS ends, the copay will no longer be waived. The copay amount will be based on the income prior to the job loss or layoff or based on the new income if lower. (Timely notice is required to decrease benefits.)

When a job loss or temporary break in work occurs in months 10–12:

- For a permanent job loss with good cause, a full three-month work search period is applied.
- For a break in work with no return-to-work date, full three-month work search is applied.
- For a break in work with a return date or time period, AWS is granted based on the date of return up to three months beyond the end date of the certification. AWS cannot be given for more than three months beyond the end date of the certification.

When employment is reported in months 1–10 of the certification period, before the AWS code closes the case:

- New or return-to-employment does not need to be verified when the AWS code is on the case, unless the participant requests a change because:
  - They are earning less; ODHS|OHA will verify new income only (the child care hours remain the same).
  - They are working more hours; ODHS|OHA will verify hours only (increase the child care hours but not the copay by entering the verification source in ONE as “verification hours only”).
- If the new income will result in a lower copay or higher child care hours, ODHS|OHA will send a Request for Information (RFI) to update the case. If the participant does not respond, no action will be taken on the case and the income/ hours will remain the same.
- ODHS|OHA will send a timely reduction notice because copay was zero during the AWS period.

ODHS|OHA will not verify income and will only address income if parent states it is lower or when income may be at or above the ongoing ERDC income limit. If the parent sends income verification and it would increase the copay, enter the new income record but choose “verification hours only” as the verification source.

If possible, ODHS|OHA will only verify the hours to avoid adverse reduction to other benefits (e.g., SNAP verified upon receipt); ERDC copays do not increase even if higher income is verified.

If the parent reports more hours or less pay, verification is required. The preferred method is a phone call to the employer or a letter from the employer.

Employment or return to work date in certification month 11:

When the participant reports new employment or return to work in month 11 of the certification period, the recertification for ERDC will still need to be completed in month 12.

- If there is time for timely notice in the 11th month, the normal process outlined above will be followed; notice is given of benefit reduction for the 12th month.
- If there is no time for timely notice in month 11, the case remains in AWS.
- A recertification will need to be completed for benefits to continue beyond the end certification date or AWS (whichever is later).
- If a current application has been received, ODHS|OHA will use that application.
- If there is no current application and participant states they did not receive one, mail an application or give options to download the application.
- The recertification process should be completed as normal.

Employment or return to work date in certification month 12 or one of the following three months due to AWS coding:

When the participant reports new employment or return to work in month 12 or after their end certification date, but before the AWS date, a recertification must be done.

- If an application was received during the AWS period, ODHS|OHA will use that application.
- If an application was not received, mail an application or give information to download an application and follow the regular recertification process.

Recertification application (Employment Related Daycare and Supplemental Nutrition Assistance Program Application — DHS 7476)

- The recertification application will be sent 45 days prior to the end certification date.
- If the participant re-applies during the AWS period but is not yet employed, the application will be denied. The AWS period remains intact; a closure will be sent to the participant if the AWS is not ended by the last AWS month.
- Applications denied due to work search can be used if employment is reported by the AWS date.

When a job loss, layoff or break in work is reported late

- When the job loss, layoff or break in work is not reported within 10 days:
  - ODHS|OHA will determine if good cause applies for the job loss.
  - If good cause applies, work search is allowable for any months remaining.
- If the job loss is reported in the third month, AWS is not granted, and the case will close with timely notice.
- If the change in employment status is due to a layoff or break in work, with a return to work date, AWS is granted based on the return date.
- The copay will not be waived for current or previous months when job loss is not reported within

10 days.

- If the job loss, layoff or break in work is reported after the three-month AWS period and the parent used the child care subsidy, the case may be reviewed for an overpayment.

Two-parent families and AWS coding

AWS is used on one- and two-parent families. If there are two parents in a household, they can each receive AWS, but the system will end benefits at the end of the first AWS time frame. For example, if a parent becomes unemployed and the other parent is working, AWS can be applied on the first parent. If the second parent becomes unemployed or laid off, AWS can be applied to the second parent, but the case will close at the end of the first parent's AWS period if they have not reported a return to work. The case will close even if the second parent still has time left on their AWS period.

For two-parent families, when an AWS parent becomes employed or returns to a job, child care work hours are not adjusted unless the participant states they need additional child care hours. If they ask for more hours, verification is required showing the parent's work schedule to determine the new overlapping hours.

If the other parent's work schedule has changed, work schedules will need to be requested for both parents. If there is more of an overlap, the case will be updated with a higher number of child care hours. If there are fewer overlapping hours, the hours will not be updated because ERDC does not reduce child care hours during the certification period.

AWS automated notices

Two system generated notices will be sent to the participant. A notice is sent when AWS is added to the case explaining the copay waiver period. The second notice is the timely closure notice; it will be sent in the last AWS month.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Click here for examples: Authorized work search (AWS).

Oregon Administrative Rule(s)

461-160-0040 — Dependent Care Costs; Deductions and Coverage
461-170-0010 — Reporting Changes – Overview
461-170-0011 — Changes That Must be Reported

Authorized medical leave (AML)

This applies specifically to the ERDC program but can also affect SNAP benefits.

When a caretaker leaves work for a temporary period of time for medical reasons, they may be eligible to continue to use child care benefits. This is called authorized medical leave (AML).

SNAP When a copay is waived due to AML on a corresponding ERDC case, the child care deduction will need to be addressed with the participant. The child care deduction should reflect the actual amount the participant pays.

Click here for Expenses and deductions.

TANF This does not apply to the TANF program.

ERDC

Medical and maternity leave

Medical leave coding (AML) can be used when an individual reports they are not working due to a medical condition or maternity leave.

Maternity leave may be authorized for up to three months without medical documentation. If additional complications occur that require the participant to remain on leave, documentation is required.

Medical leave requires verification of medical situations by a qualified medical professional. This must include:

- Diagnosis
- Prognosis, and
- Expected period of time off work.

Income received during medical leave

Income is still counted during medical leave.

However, families have a waived copay during this period automatically applied by the ONE system. Remind the parent of the reporting requirements; they must report when they return to work and if their income exceeds the ongoing and exit income limit.

AML can be extended if medical leave goes beyond the anticipated time period. Additional verification will be required; maternity leave extending beyond three months must be verified.

Medical leave beyond the end certification date

Medical leave date can be approved up to three months beyond the end certification date.

If the individual has not returned to work by the third month after the end certification date, the case will automatically close with a system-generated close notice.

Extending AML

If the individual reports they are unable to return to work, ODHS|OHA will request verification and extend medical leave if it is received. Medical leave cannot be extended more than three months beyond the

certification period.

If the individual does not respond to the RFI, no action is taken. The case will automatically close at the end of the AML period.

Two parents and medical leave

The same process applies to a one-parent and two-parent family. However, the system will end benefits once the first parent's expiration date occurs.

Returning to work after AML

When the individual reports they are returning to work, the parent's previous income prior to medical leave will be used to re-establish their copay amount. If their income has reduced ongoing beyond medical leave, verification is needed to process a lower copay amount. If their income has increased above the ongoing and exit income limits, the case should be closed with timely notice.

Job loss after AML

When the individual contacts ODHS|OHA to report they are cleared to work but have lost their job, the participant may qualify for authorized work search (AWS). ODHS|OHA will determine if there is good cause for the job loss, add the information about job loss into the system. The AWS period will auto close the case after three months and send a timely notice.

Click here for Authorized work search (AWS).

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Click here for examples: Authorized medical leave (AML).

Oregon Administrative Rule(s)

461-160-0040 — Dependent Care Costs; Deduction and Coverage
461-170-0010 — Reporting Changes – Overview
461-170-0011 — Changes That Must be Reported

Authorized military transition (AMT)

This applies specifically to the ERDC program but can affect SNAP benefits.

AMT stands for '"Authorized Military Transition." The intent of AMT is to allow child care usage (at the same level) for the purpose of family transition activities, work search, medical appointments and other activities needed for the caretaker returning from a military war zone to transition to civilian life. This allows the children to maintain

a routine and continuity of care during the six-month transition. The family does not need to identify what the transition activities are: it is based on the needs of the individual.

SNAP When a copay is waived due to AMT on a corresponding ERDC case, the child care deduction will need to be addressed with the participant. The child care deduction should reflect the actual amount paid by the participant.

Click here for Expenses and deductions.

TANF This does not apply to the TANF program.

ERDC Child care can continue for up to six months to allow a transition period for a family that includes a caretaker who is a discharged U.S. military member returning from active duty in a military war zone. Active duty means they are in the military full time. If a military member returns home and is still in active duty or a member of a National Guard or a U.S. Armed Forces Reserve unit (not discharged), there is no need for a transition period. The case will remain the same.

AMT begins the month after the participant returns home. If they do not report within 10 days, the six-month count still starts the month after they have returned home; however, the waiver will begin the month after the change is reported. AMT ends before six months if the military member returns to active duty.

The waiver ends after the six-month period, and the case remains open through the end of the certification if the military member becomes employed; however, if the military member does not find employment, the AMT period will automatically close the case at the end of six months.

Income is not adjusted during the AMT period unless it is less than the amount received prior to AMT; in that case, verification is required.

Employment after AMT

If the military member finds employment, ODHS|OHA will only adjust the income if it is less than the amount prior to AMT; verification will be needed. The child care hours may be increased if they need more hours; verification of hours will be needed.

AMT is not removed when new employment is reported prior to the end of the six-month transition; AMT allows the copay to continue to be waived for a full six months. The case is tracked to remove the AMT code at the end of six months.

A reapplication is needed if the end of the six-month transition occurs the last month of the certification or if AMT extends beyond the end certification date.

If there are months remaining in the certification, AMT will end after six months; this allows ERDC to continue through the end of the certification.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Click here for examples: Authorized military transition (AMT).

Oregon Administrative Rule(s)

461-160-0040 — Dependent Care Costs; Deduction and Coverage
461-170-0010 — Reporting Changes – Overview
461-170-0011 — Changes That Must be Reported

Required notices

A decision notice is a written notice sent to the benefit group describing the action taken on an application or the benefits.

A decision notice must be sent when approval, denial, reduction, suspension or closure of benefits (including retroactive medical) have been determined and when a request for benefits has been withdrawn. Decision notices are also often required when ODHS|OHA is taking action on an application or has received a request for benefits on an ongoing change, e.g., when ODHS|OHA needs to request more information or pend. The action taken on a case will determine what type of notice must be sent to the individual.

ODHS|OHA may take any of the following actions:

- Amend a decision notice with another decision notice or a contested case notice
- Amend a contested case notice
- Delay a reduction or closure of benefits as a result of an individual's request for hearing, or
- Extend the effective date on a decision notice or contested case notice.

When ODHS|OHA amends a decision notice with another decision notice, the date of the amended notice restarts the individual's deadlines to request a hearing or continuing benefits, or both. When a contested case notice extends an effective date or delays a reduction or closure, the date of the amended notice restarts the individual's timeline to request continuing benefits. When an individual has a pending hearing request or is receiving continuing benefits, and ODHS|OHA amends a notice under this section, the individual does not need to re-file the hearing request or renew the request for continuing benefits.

Notices must contain certain information. Standard, preprinted information consists of the hearing rights and procedures around hearings. The part that is not standard consists of the action ODHS|OHA intends to take, the effective date of that action, the reason for the action and the date of the notice. The notice can be computer-generated or completed by ODHS|OHA staff and sent manually.

There are three types of decision notices that can be given to individuals. They are:

- Basic decision notice. This notice is mailed no later than the planned date of action on the case and does not give the individual the right to continuation of benefits pending a hearing. The notice period is the month in which the notice is mailed.

- Continuing benefit decision notice. This notice is mailed in time to be received by the date benefits are, or would be, received. It gives information on the benefit group's right to continuing benefits. The notice period is the budget month from which information is used to initiate the decision notice.
- Timely continuing benefit decision notice. This notice contains information on the benefit group's right to continuing benefits. The notice period is the month in which the timely mailing requirement ends.
  - For actions that take effect on the first day of the following month, this notice must be mailed no later than the first business day following the 15th day of the month before the effective date of the action.
  - For actions that take effect no earlier than the last day of the current month, this notice must be mailed no later than the first business day following 15th day of the current month.
  - Timely notices mailed after the first business day following the 15th and the last day of the current month must have an effective date no earlier than the last day of the next month.

Note: Additional processing time is needed for individuals that require an alternate format.

A decision notice must do all of the following:

- Except for mass changes, specify the action ODHS|OHA intends to take, the effective date of the action, the date the notice is mailed and the reason for the action.
- Provide the name and phone number of the ODHS|OHA staff person or office to contact for additional information.
- Inform the individual of their right to a hearing before an impartial person. This includes the following:
  - Specifying the method and time frame for requesting a hearing;
  - Informing the individual of their right to a pre-hearing conference with staff representing ODHS|OHA
  - Informing the individual of their right to representation (including legal counsel)
  - Informing the individual about availability of free legal help, and
  - Informing the individual of their right to have witnesses testify on their behalf.
- Cite the Oregon Administrative Rule (OAR) that supports the action being taken on the case.

Continuing benefit decision notices and timely continuing benefit decision notices must also inform individuals of their right to continuing benefits. Individuals are entitled to a continuation of benefits if they request a hearing by the later of the following:

- Within 10 days of the mailing of the notice, or
- On or before the effective date of the action. (If the deadline falls on a weekend or holiday, extend the deadline to the next working day.)

  Any benefits paid while awaiting the hearing's final order are considered an overpayment if the decision is in favor of ODHS|OHA's action, except for hearings on overpayment recovery issues.

No notice is needed in the following scenarios:

- Everyone in the benefit group is deceased, or
- A hearing is dismissed or upholds ODHS|OHA's decision and a notice was sent before the individual requested the hearing.

Click here for ODHS/OHA Production Calendar, which provides deadlines for timely notice.

A Notice of Expiration is automatically sent to the filing group when a case is going to expire. It includes the following information:

- The date the certification or benefit period ends, and
- The consequences of failure to apply for renewal.

SNAP A decision notice must also state under what circumstances benefits will be continued pending a hearing.

A continuing benefit decision notice and a decision notice must also state the individual's household will incur a liability for any overissued benefits if benefits are continued pending a hearing, and the hearing decision is adverse to the individual.

For SNAP, no notice is needed in the following scenarios:

- Everyone in the benefit group is deceased;
- A hearing upholds ODHSIOHA's decision, and a notice was sent before the participant requested the hearing;
- The filing group has moved out of Oregon;
- In CRS cases, when mail has been returned with no forwarding address and the individual's whereabouts are unknown;
- There is a mass change;
- A drug or alcohol treatment center is disqualified by FNS as a retailer or an authorized representative or loses its state certification;
- An adult foster care home loses its state license;
- A residential care facility is disqualified as an authorized representative or loses its state certification;
- A participant is notified of benefits changing month to month at application (usually given on the *Notice of Income and Benefit Calculation* (DHS 7294));
- Individual applied on a joint application for SNAP and cash benefits, when the receipt of a new public assistance grant reduces SNAP (because the individual received prior notice of this when they signed the *Your Rights and Responsibilities (DHS 0415R) or Rights and Responsibilities (SDS 0539R)*;
- An ongoing participant reapplies for SNAP during the certification period (e.g. checks the food benefit box on the application when applying for medical benefits);
- A group was previously notified they would receive a restoration of benefits over a period of time, and the restoration payments end at the end of that time;
- Benefits are reduced when the SNAP certification period is extended following receipt of verification requested during expedited service.

TANF No additional program-specific information.

ERDC No additional program-specific information.

REF No additional program-specific information.

MSP ONE will automatically generate all needed notices and correspondence, including hearing rights when an MSP TOA is approved, denied, a reduction occurs or at the end of a benefit period.

A manual notice is needed for Client Buy In (CBI). Workers should send an SDS 540M whenever CBI is authorized in ONE or approved on a legacy case.

If the individual's whereabouts are unknown, end benefits by sending a basic decision notice to their last known address.

A basic decision notice is required at the end of the specified period if the benefit group was informed in a prior notice at the time benefits began that they would receive benefits only for a specific period of time.

A mass-change notice is automatically sent when applicable. If benefits are reduced or closed to reflect cost-of-living adjustments or another mass change under a program operated by a federal agency or a mass change to payments in a program operated by ODHS|OHA:

- Instead of specifying the action ODHS|OHA intends to take and the effective date of the action, the decision notice may state all of the following:
  - The general nature of the change,
  - Examples of how the change affects an individual's benefits, and
  - The month in which the change will take place.
- The decision notice must also state the individual's right to continue receiving benefits.

No additional decision notice is required if:

(a) The individual was sent a basic decision notice of eligibility and a simultaneous continuing benefit decision notice to reduce or end the program due to a change in the individual's circumstances between the date of application and the date of the eligibility determination, or

(b) The individual completes an MSC 0457D form or ONE-121 to reduce or end benefits or when the individual withdraws an application.

OSIPM ONE will automatically generate all needed notices and correspondence, including hearing rights with the exception of Medical Related Payments.

Refer to Medical Related Payments manual notices.

If the individual's whereabouts are unknown, end benefits by sending a basic decision notice to their last known address.

A basic decision notice is sent to terminate, suspend or reduce benefits in each of the following situations:

- The individual has been admitted or committed to an institution.
- The individual has been placed in skilled nursing care, intermediate care, or long-term hospitalization.

- The individual is placed in official custody or a correctional facility.

A basic decision notice is required at the end of the specified period if the benefit group was informed in a prior notice at the time benefits began that they would receive benefits only for a specific period of time.

A mass-change notice is automatically sent when applicable. If benefits are reduced or closed to reflect cost-of-living adjustments or another mass change under a program operated by a federal agency or a mass change to payments in a program operated by ODHSIOHA:

- Instead of specifying the action ODHSIOHA intends to take and the effective date of the action, the decision notice may state all of the following:
  - The general nature of the change,
  - Examples of how the change affects an individual's benefits, and
  - The month in which the change will take place.
- The decision notice must also state the individual's right to continue receiving benefits.

No additional decision notice is required if:

(a) The individual was sent a continuing benefit decision notice to decrease their liability for an allowable deduction, if that decision notice specified when the deduction would no longer apply, or

(b) The individual was sent a basic decision notice of eligibility and a simultaneous continuing benefit decision notice to reduce or end the program due to a change in the individual's circumstances between the date of application and the date of the eligibility determination, or

(c) The individual completes an MSC 0457D form or ONE-121 to reduce or end benefits or when the individual withdraws an application.

HSD A basic decision notice is sent whenever an application for HSD medical program benefits is approved or denied. A timely continuing benefit decision notice is sent whenever HSD medical program benefits are reduced or closed with the following exceptions.

A basic decision notice in sent in the following situations:

- For a beneficiary who becomes an inmate of a public institution or a correctional facility,
- For a beneficiary who has been placed in skilled nursing care, intermediate care, or long-term hospitalization,
- When individual ceases to be an Oregon resident and is eligible for benefits in the other state,
- When a request to withdraw or end benefits is made by a beneficiary, another adult member of the EDG or the authorized representative and the request includes a written signature or a recorded verbal signature,
- When an individual who is not a recipient of any Medicaid/CHIP benefits makes a request to withdraw an application for benefits, or
- When returned postal mail is received without a forwarding address and the beneficiary's whereabouts are unknown.

No decision notice is required in the following situations:

- The only individual in the EDG dies, or
- A hearing was requested after a notice was received and either the hearing request is dismissed or a final order is issued.

Click here for Returned mail.

Oregon Administrative Rule(s)

461-175-0010 — What a Decision Notice Must Include
461-175-0050 — Notice Period
461-175-0200 — Notice Situations; General Information
461-175-0210 — Notice Situation; Moved or Whereabouts Unknown
461-175-0250 — Notice Situation; Mass Changes
461-170-0010 — Reporting Changes – Overview
461-170-0011 — Changes That Must be Reported
410-200-0120 — Notices

Other resources

Manual Notices *includes screenshots: Covers situations where manual notices are needed

Correspondence *includes screenshots: Covers how to access notices and how to generate manual correspondence

Correspondence Inventory: Excel spreadsheet with comprehensive listing of correspondences in the system.

Withdraw/Discontinue Program (457D) QRG: Discusses the Withdraw/Discontinue case action for all programs (including TA-DVS). Describes the difference between Withdraw and Discontinue and the different steps needed, along with timely processing of the 457D.

Case closures and transitions between programs

Cases may close for any variety of reasons, such as a filing group earning more than the income limits for a specific program, or no longer meeting non-financial requirements. Some case closures may result in transitions between programs rather than complete closure of all public assistance; this occurs most often between the TANF and ERDC programs and between medical programs.

SNAP Families receiving SNAP benefits are often eligible to receive a special reporting system when their TANF case closes under certain circumstances, called Transitional Benefit Reporting.

Click here for Transitional Benefit Reporting System (TBA/TBS).

TANF Employment payments

Employment Payments (EP) are a cash benefit made to families who's TANF closed with paid employment. Payments are made available the three months following TANF closure. The following

amounts will be issued to the family.

1st month	=	$100
2nd month	=	$75
3rd month	=	$50

For an individual to be eligible for EP the following must be true.

- Have obtained unsubsidized paid employment and reported in a timely manner.
- Meet TANF residency requirements
- Remain at or below 350 percent Federal Poverty Limit, and
- Be JOBS-eligible or volunteer and closed TANF due to one of the following:
  - Have become ineligible for the Pre-TANF, SFPSS or TANF programs due to income above the applicable countable income limit
  - Voluntarily closed TANF to avoid accruing time toward the TANF time limit, or
  - Voluntarily closed TANF to be eligible for TBA.

The ONE system automatically determines EP eligibility whenever TANF is closing with earned income.

Whenever new employment/income or change in current employment/income is reported, the family coach or eligibility worker must add an employment and income record into the ONE system. Reminder, updated employment/income could affect eligibility for other programs including, SNAP, JPI, and Medical programs. The following employment/income details are required for ONE to accurately determine eligibility.

- Employment start date
- How many hours the participant is scheduled to work per week
- The participant's hourly rate of pay
- The date of the participant's first paycheck
- Actual/Anticipated income in initial month when pay is received
- Actual/Anticipated hours to be worked in initial month when pay is received

If the worker does not have answers to all mandatory questions, or the participant does not know, this will generate a missing information notice. The worker will be able to add specific details to the notices as needed.

There are times when the household's income may not put them over the TANF exit limit. If the family chooses to close TANF in order to save TANF months or receive TBA, the worker will need to withdraw their TANF in ONE, selecting the appropriate withdrawal reason. ONE will then determine EP eligibility.

Ending EP

EP will automatically end after the third month payment and whenever a change record is created for the following reasons (allowing for timely notice):

- At any time during the three months the participant reports a job loss

- When the participant is approved for REF, Pre-TANF, SFPSS or TANF program benefits

When ONE approves EP, the approval notice also serves as the closure notice. No further action is needed by the worker.

Other resources

TANF Transitions *includes screenshots: Explains the requirements for timely reporting of details about new or changed income for ONE to reduce, close and transition TANF cases accurately

TANF to ERDC transition

When a TANF participant has gone over income, they may be eligible for ERDC if they have a child care need. Participants who have been receiving child care support services while on TANF assistance (JCCB) may not know the process for requesting ERDC. The individual should be contacted right away to discuss child care and their ERDC eligibility.

An application is required when an ERDC request is made prior to TANF closing. Applicants can apply and sign online, by using the 415f or 7476, or through a verbal signature and application. Eligibility workers can also collect the application information orally and submit it into the worker portal. Eligibility will need to be cleared by completing the application process, verifying and narrating all ERDC eligibility requirements, and completing an interview in person or by phone. A participant may request ERDC and establish a date of request by:

- Phone call, written request or office visit
- A completed and returned TANF 6E Application for ERDC; Conversion from TANF (a computer-generated notice) or
- Any other method that results in enough information to determine a child care need.

Verification of hours and income are still required when TANF participants are transitioning to ERDC, using proof of representative income.

- New employment verification may include a first paycheck from a new job (if representative of the future), an employer statement or a phone call to the employer by staff determining eligibility.
- Child support pass through income should be end dated and a new income record added, which will update the type of payment from pass through to money. when transitioning a family from TANF to ERDC. The system will not count the child support on the ERDC case if this is not updated correctly.

  Click here for Child support programs.
- Child care hours may change when transitioning from TANF child care to ERDC. This is because TANF work hours are averaged, while ERDC allows child care for the highest number of verified hours.

When a participant is already receiving TANF child care (JCCB), an email will need to be sent to the Direct Pay Unit to ensure billing has been updated for the individual's new eligibility.

Click here for Direct Pay Unit (DPU).

Reduced copay (RCP) for TANF-ERDC transition cases

When an ERDC case is opened, the individual's copay is calculated by the system based on the EDG size and countable income. When a TANF case is transitioned to ERDC in ONE, the computer will bypass the usual copay calculation and enter a $0 copay amount for the three months of reduced copay eligibility.

Eligibility for the reduced copay depends on three factors:

- The family meets all ERDC eligibility criteria and is approved.
- The family has transitioned off TANF due to employment.
  and
- The family has requested ERDC within 90 days of closure of TANF.

If the applicant requests ERDC within 90 days of TANF closure, their number of months to receive the reduced copay is dependent on the date of request (DOR).

There are no restrictions on how many times a participant may access the reduced copay after transitioning from TANF.

The reduced copay ends after the third month of receipt or in the following circumstances:

- When the participant requests TANF benefits, or
- When the participant becomes ineligible for ERDC.

Other resources

TANF Transitions *includes screenshots: Explains the requirements for timely reporting of details about new or changed income for ONE to reduce, close and transition TANF cases accurately.

ERDC to TANF transition

When an ERDC participant loses their employment, they may apply for TANF. The applicant should be asked whether they would like to apply for TANF or if they would like to pursue authorized work search (AWS).

No closure notice is necessary if the individual applies for and is determined eligible for TANF benefits.

In most cases, individuals will not have both a TANF and ERDC case in the same month. However, this can apply in the initial month of benefits, such as when a child care billing form has been issued for ERDC and an individual applies for and is found eligible for TANF in the same month.

Click here for Concurrent and other benefits.

It is also important that the individual understands their child care hours will be determined based on their JOBS plan activities.

Click here for Working with families.
Click here for Support service payments.

ERDC TANF to ERDC transition

When a TANF participant has gone over income, they may be eligible for ERDC if they have a child care need. Participants who have been receiving child care support services while on TANF assistance (JCCB) may not know the process for requesting ERDC. The individual should be contacted right away to discuss child care and their ERDC eligibility.

An application is required when an ERDC request is made prior to TANF closing. Applicants can apply and sign online, by using the 415f or 7476, or through a verbal signature and application. Eligibility workers can also collect the application information orally and submit it into the worker portal. Eligibility will need to be cleared by completing the application process, verifying and narrating all ERDC eligibility requirements, and completing an interview in person or by phone

- Phone call, written request or office visit
- A completed and returned TANF 6E Application for ERDC; Conversion from TANF (a computer-generated notice), or
- Any other method that results in enough information to determine a child care need.

Verification of hours and income are required when TANF participants are transitioning to ERDC.

- New employment verification may include a first paycheck from a new job (if representative of the future), an employer statement, or phone call by staff to the employer.
- Child support income should be updated from CSP/PSP to SUP when transitioning a family from TANF to ERDC. The system will not count the child support on the ERDC case if this is not updated correctly.

  Click here for Child support programs.
- Child care hours may change when transitioning from TANF child care to ERDC. This is because TANF work hours are averaged, while ERDC allows child care for the highest number of verified hours.

When a participant is already receiving TANF child care (JCCB), an email will need to be sent to the Direct Pay Unit to ensure billing has been updated for the individual's new eligibility.

Click here for Direct Pay Unit (DPU).

Reduced copay (RCP) for TANF-ERDC transition cases

When an ERDC case is opened, the individual's copay requirement is waived ($0) for up to three months in which a copay would apply. ONE will bypass the usual copay calculation and waivethe copay amount for the three months of eligibility.

Eligibility for the waived copay depends on three factors:

- The family meets all ERDC eligibility criteria and is approved.
- The family has transitioned off TANF due to employment.
  and

- The family has requested ERDC within 90 days of closure of TANF.

If the applicant requests ERDC within 90 days of TANF closure, their number of months to receive the waived copay is dependent on the date of request (DOR).

There are no restrictions on how many times a participant may access the reduced copay after transitioning from TANF.

The waived copay ends after the third month of receipt or in the following circumstances:

- When the participant requests TANF benefits, or
- When the participant becomes ineligible for ERDC.

The employment payments and waived copay are both the approval and closure notice in one. Workers will need to send the notices up front and no other notice is needed for the three-month periods. If waived copay ends prior to the fourth month, timely reduction notice is still needed.

The employment payment notice can be located on NOTM under CMEP123.

The reduced copay notice can be located on NOTM under CMRCP01.

ERDC to TANF transition

When an ERDC participant loses their employment, they may apply for TANF. The applicant should be asked whether they would like to apply for TANF or if they would like to pursue authorized work search (AWS).

No closure notice is necessary if the individual applies for and is determined eligible for TANF benefits.

In most cases, individuals will not have both a TANF and ERDC case in the same month. However, this can apply in the initial month of benefits, such as when a child care billing form has been issued for ERDC and an individual applies for and is found eligible for TANF in the same month.

Click here for Concurrent and other benefits.

It is also important that the individual understands their child care hours will be determined based on their JOBS plan activities.

Click here for Working with families.
Click here for Support service payments.

REF An individual who becomes pregnant is required to apply for TANF in the month before the due date falls.

Click here for Pregnancy.

MSP MSP to MAGI transition

When an existing MSP individual becomes pregnant or becomes parent/caretaker relative, redetermine medical benefit eligibility for MAGI medical programs.

OSIPM OSIPM to MAGI transition

When a child receiving OSIPM is no longer eligible for SSI, the following actions should be taken:

- Rerun eligibility to see if the child is eligible for MAGI or CHIP. If the child is not eligible for MAGI/CHIP, leave the OSIPM case open with the current coding until the end of the 12-month continuous eligibility period.
- Make sure ongoing OSIPM eligibility is evaluated, including whether or not a referral to PMDDT is warranted.

When an individual between the age of 18–64 years old loses OSIPM eligibility, medical benefit eligibility should be redetermined to see if the individual is eligible for MAGI medical programs.

HSD When an individual receiving MAGI benefits becomes ineligible due to circumstance changes, they must be evaluated for non-MAGI benefits. During this period when eligibility is being determined for the individual, the existing benefits should continue without any break. This is to ensure continuous benefits for medical when the determination is not completed.

Oregon Administrative Rule(s)

461-135-0506 — Transitional Benefit Alternative (TBA) in the SNAP Program
461-180-0081 — Effective Dates; Cases Receiving Transitional Benefit Alternative (TBA)
461-160-0040 — Dependent Care Costs; Deduction and Coverage
461-135-1270 — Specific Requirements; Employment Payments
461-180-0050 — Effective Dates; Suspending or Closing Benefits and JOBS and REP Support Service Payments

Other resources

Program Request Withdrawal-Discontinue *includes screenshots: Discusses the Withdraw/Discontinue case action. Describes the difference between ithdraw and Discontinue and the different steps needed to conduct either

Non-MAGI Evaluation for Current MAGI Recipients *includes screenshots: Outlines the process for individuals who are no longer eligible for MAGI medical and have been flagged with a Non-MAGI APD indicator

Chapter 3:
Processes and procedures

Section 2: Verification

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Verification

Introduction

Individuals must provide verification to ODHS|OHA when it is requested.

All requests for verification must be made in writing, and the participant must be given at least 10 days to provide the requested verification. At initial application and renewal, the Request for Information (RFI) or Notice of Pending Status (DHS 0210) is used. When changes in income are reported that require verification, the RFI or Notice of Information or Verification Needed (DHS 0210a) is used.

Verification may be received in a variety of ways. Verification may be:

- A document that is uploaded into the electronic file,
- Information received via a telephone conversation,
- A document viewed during a home visit, or
- Information verified through electronic sources such as DHR screens and online systems and, in some instances, can include the Federal Data Service Hub (FDSH), an interface within ONE.

When verification is not uploaded in the file or available electronically, or when self-attestation is accepted, the worker must carefully narrate the information received in the case notes. If staff determine the individual doesn't have, and can't get, verification due to a hardship, the verification value "no verification due to hardship" can be used. This should be a rare circumstance and a case note needs to be entered to substantiate the reason it's being used.

Other resources

Agency Pend: Describes the process of addressing an Agency Pend

Re-indexing a Document to a Different Case *includes screenshots: Describes the process for re-indexing a document to a different case using screenshots and visual aids.

For most situations, third party verification is the preferred source. When verification is received from a third party, the third party must have direct knowledge of the information and cannot be a member of the filing group. In certain situations,staff must have an MSC 3010 Authorization for Disclosure, Sharing and Use of Individual Information form signed by the individual or their authorized representative before requesting verification from a third party. We should not request documentation if we can verify the information electronically or if the rules allow for self-attestation.

If ODHS|OHA is unable to verify information electronically or from a third party, ODHS|OHA will accept, on a case-by-case basis, self-attestation to verify all eligibility criteria except citizenship and immigration status under the following circumstances:

- Documentation does not exist at the time of the eligibility determination, or
- Documentation is not reasonably available at the time of the eligibility determination, such as in the case of homelessness, domestic violence or natural disaster.

The following factors must be verified at initial application, when changes occur, whenever information is questionable or, for some programs, at redetermination:

- Identity
- SSN or application for an SSN
- Citizenship
- Non-citizen status verified through SAVE
  - Staff may not ask applicants or recipients to verify their citizenship solely on the basis of the individual's ethnicity or ability to communicate in English. If an individual identifies themselves as a non-citizen on the application, non-citizen status must be verified.

    Note: For medical programs, when required, the non-citizen status is verified via the Verify Lawful Presence (VLP) interface in ONE. Data from both the SAVE webservice and the VLP interface is from the Department of Homeland Security and should be the same. In rare instances, if VLP does not verify the non-citizen status, staff will need to go to SAVE to complete the verification process
- Financial eligibility factors (income, expenses, resources)
- Pregnancy, if it is an eligibility requirement. The individual must turn in verification of the pregnancy (as well as the estimated due date — this must be documented for TANF, but the participant's statement is acceptable for SNAP) if there are no other eligible children in the home. If there are other dependent children in the home, the individual's statement that the pregnancy was determined by one of the following is adequate for verification:
  - Medical practitioner
  - Health department
  - Clinic
  - Crisis pregnancy center
  - Similar facility, or
  - Verification of time on TANF in another state or from a Tribal program.

Sometimes verification can be waived in certain circumstances.

Click here for Expedited service and priority processing.

Oregon Administrative Rule(s)

461-115-0610 — Verification; General
461-115-0700 — Required Verification; GA, OSIP, OSIPM, and QMB
461-115-0704 — Required Verification of Citizenship and Noncitizen Status; OSIP, OSIPM, and QMB
410-200-0230 — Verification

Income verification

ODHS|OHA must gather information regarding an applicant's anticipated representative income. If available, ODHS|OHA must use the information it receives from an electronic source such as the Work Number, IEVS or other

recognized sources of income verification to verify eligibility without requiring additional documentation. When additional documentation is needed, this can be provided via paystubs, an award letter, an employer letter, a phone call to the employer (which must be clearly explained in case notes including the person spoken to, position and phone number) or other valid means.

Verification received from an employer, other than pay stubs, should include the following:

- Name of employee
- Position
- Hourly wage
- Number of hours worked per week (can be a range, e.g. 10–15 hours), and
- Date of first paycheck.

Some individuals are paid under the table or do odd jobs that do not generate pay stubs or income verification (e.g., picking up soda cans to recycle, selling plasma, etc.). These may also be considered marginal income. The applicant should be interviewed regarding the type and amount of income they receive. This should be narrated, including the reason why verification is not available.

Applicants may have the ability to get verification even if they receive only marginal income. For example, an applicant who is working for the same person in the neighborhood each week doing odd jobs may be able to get a statement from the neighbor to verify how much they are earning. In this case, verification must be requested.

Some acceptable forms of verification for income include:

- Pay stubs
- Pay envelope
- Employee's W-2 form
- Wage tax receipts
- Income tax return – state and federal
- Self-employment bookkeeping records
- Employer's wage record
- Wage/hour records on terminal
- Statement from employer
- Employment service office
- Occupation tax agency
- Local wage tax agency
- State income tax bureau
- Employer's records of attached wages
- SSA award letter
- Benefit payment check
- Unemployment compensation award letter

- Pension award notice
- Divorce or separation decrees
- Court order
- Contribution check
- Veterans Administration award notice
- Correspondence on benefits
- Income tax record – state and federal
- Support agreement
- Correspondence on support payments
- Rental agreement or lease
- Income-producing contract
- Terminal screens (EWC9 screen, the Work Number, BEIN, TPQY, etc.)
- SAIF (worker's compensation, MVAF)
- Union records
- Veterans' Administration letter, form 3288, local service officer, etc.
- Lawyer's records
- Probation office record
- Statement of person making contribution
- Canceled checks of person making contribution
- Receipts for contribution
- Financial aid statements
- Rental receipts of tenant, roomer or boarder
- Statement of person providing in-kind income
- Insurance company records
- Lodge, club or fraternal organization records
- Railroad retirement board records
- United Mine Workers of America union (black lung benefits)
- State Data Exchange (SDX) microfiche
- Bureau of Indian Affairs
- Local armed services, or
- Federal Data Services Hub (FDSH)

For information regarding how to count income received, click here for Treatment of specific assets.

SNAP Terminated income

Workers are not required to verify terminated income for SNAP.

If the income was from a job, it can be difficult for the applicant to obtain proof. In most cases, it is acceptable merely to talk with the applicant and get information verbally regarding why the job ended, date last worked, and the date and amount of last paycheck.

If the work was seasonal or temporary, the applicant's statements are used and narrated. Good cause for job separation may need to be addressed.

If the termination of income is questionable, workers may contact the employer to verify the last day of work and date of the final paycheck. However, many employers are reluctant to state an employee has been fired or give any reason for termination.

Reduced work hours

In most cases, a reported drop in employment hours must be verified before income can be reduced on a case. Although the participant is responsible for obtaining proof, the worker can get verification by talking with the employer. The exception for this is for jobs in which seasonal fluctuations or similar

circumstances explain the drop in hours (e.g., for retail sales or tourist employment, or a cut in hours one month due to illness). For these cases when the work situation is generally known in the community, it is acceptable for the worker to narrate the reduction in work hours without pursuing verification.

For individuals identified as ABAWD, verification is required for reduction in work hours if they are not working at least 20 hours per week.

Click here for SNAP employment services.
Click here for Income changes.

TANF Terminated income

Verification is required for terminated income if the income is received in the initial month. If it was received prior to the initial month, verification is not required because this is not counted in the certification period.

Reduced work hours

In most cases, a drop in employment hours must be verified before income can be reduced on a case. Although the participant is responsible for obtaining proof, the worker can get verification by talking with the employer.

Click here for Income changes.

ERDC New employment

For new employment, acceptable verification includes the first paycheck from a new job (if hours are representative of the future) or, when no pay has yet been received, an employer statement including expected hours, pay dates and rate of pay. If verified by phone, the conversation should be narrated, including hours, pay dates, rate of pay, name of person who verified the information, and employer

name and phone number. Additional verification may be needed and requested if income is variable or questionable, or if the income or job changes between the date of request and interview.

Terminated income

Verification is required for terminated income if the income is received in the initial month. If it was received prior to the initial month, verification is not required because this is not counted in the certification period.

Reduced work hours

A reported drop in employment hours must be verified before income can be reduced on a case. Although the participant is responsible for obtaining proof, the worker can get verification by talking with the employer.

Verification is not required if the applicant is not requesting a lower copay amount.

Click here for Income changes.

REF

Terminated income

Verification is required for terminated income for REF if the income is received in the initial month. If it was received prior to the initial month, verification is not required because this is not counted in the certification period.

Reduced work hours

In most cases, a drop in employment hours must be verified before income can be reduced on a case. Although the participant is responsible to obtain proof, the worker can get verification by talking with the employer.

Click here for Income changes.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Other resources

Employer Verification Calls: Describes three potential scenarios for employer verification calls and provides talking points and key questions for each different situation.

Resource verification

If required for program eligibility determination, the following list are examples of acceptable resource verification.

- Bank books
- Bank statements

- Stock certificates
- Bond certificates
- Mortgage
- Notes
- Securities
- Credit union statements
- Savings and loan statements
- Deed
- Sales agreement
- Life estate agreement
- Articles of agreement
- Real estate tax receipts
- School tax receipts
- Income tax return
- Will
- Life insurance policy
- Burial arrangement contract
- Stock brokers
- Credit union records
- Judgment and lien records
- Credit applications
- Credit account applications
- Courthouse records
- Tax records
- Title search
- Utility company records
- NADA bluebook
- Kelley Blue Book
- Written value assessment from local business (e.g., auto, boat)
- Statement from insurance company indicating cash value of policy, or
- Statement showing current value of burial plot.

SNAP Only non-categorically eligible need groups have to meet the resource limit.

TANF This does not apply to the TANF program.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM ODHSIOHA must use the Asset Verification System when a resource or transfer of assets (see OAR 461-140-0210 to 461-140-0300) evaluation is necessary to determine eligibility. Consent to use the Asset Verification System is required and a condition of eligibility. If resource information is not available or not returned through the Asset Verification System, or differs from self-attested information, resource documentation may be requested directly from the individual.

If the reported or self-attested value of liquid resources is less than $400, additional verification is not needed unless it is questionable or differs from what is available electronically. Please note that this only applies to liquid resources; it does not mean that verification of all other types of resources is not needed. Declaration of resources on the application is required and necessary to determine when verification is necessary. Additionally, the location and account numbers of bank accounts and other resources is necessary for the estate administration process.

HSD This does not apply to HSD medical programs.

Citizenship status

Staff may not ask applicants or recipients to verify their citizenship solely based on the individual's ethnicity or ability to communicate in English. Individuals who attest to being a U.S. citizen or U.S. national and who are applying for benefits must have their attestation verified. Individuals who are non-citizens and who are applying for benefits may need to have their non-citizen status verified. The requirement for who needs to have their non-citizen status verified varies by program. Individuals who do not have a status cannot be required to provide verification but may be eligible for benefits.

For all programs except medical, individuals identified as non-citizens on the application must have their non-citizen status verified if benefits are being requested for that person

For all programs except medical, non-citizen status must be verified through SAVE. If verification is not available through SAVE, additional verification may be used as listed below.

For medical programs, non-citizen status is verified via the Verify Lawful Presence (VLP) interface in ONE. Data from both the SAVE webservice and the VLP interface is from the Department of Homeland Security and should be the same. In instances, when VLP does not verify the individual's attestation of their immigration status, staff can go to SAVE to complete the verification process (ONE will issue a Request for Information (RFI) when VLP does not verify the attestation).

For all programs except medical, the following items may be used to verify citizenship or non-citizen status:

- Documents or other records generally available from the individual:
  - Naturalization papers
  - Permanent visas
  - Birth certificates or hospital birth records

- Refugee registration cards
- U.S. passport
- U.S. Citizenship and Immigration Services ID card
- "Noncitizen" registration cards/reentry permits
- Certificate of citizenship
- Military service papers, or
- Indian census records.

- Verification information from other sources:
  - U.S. State Department records
  - U.S. Citizenship and Immigration Services records
  - Baptismal or other religious record (only if place and date of birth is shown), or
  - Family Bible

For all medical programs:

- For those individuals in ONE, the system will automatically check for citizenship/identity verification using the interface with the Social Security Administration. If these items are not verified, ONE will issue a Request for Information (RFI).
- For those individuals who are not in ONE, before requesting documentation, check the Medicaid or CHIP applicant or recipient's citizenship field on Person/Alias Update. If the person's citizenship field already has an "A" and you have no reason to doubt the "A" is accurate, narrate the citizenship documentation has already been verified.
- In the event documentation has to be requested to verify an individual's citizenship, check the Medical Program Citizenship and Identity Documentation Hierarchical List for documents that are required to be submitted.
- Applicants, beneficiaries or individuals authorized to act on their behalf shall make a declaration of U.S. citizenship, U.S. national or non-citizen status at the time of initial determination of eligibility when a report of change of non-citizen status is received by ODHS|OHA. Self-attested information shall be verified via the federal data services hub (FDSH) or by electronic verification source available to ODHS|OHA. The following are exempted from this verification requirement:
  - Individuals receiving SSI
  - Individuals entitled to or enrolled in any type of Medicare
  - Individuals receiving Social Security Disability Income (SSDI)
  - Individuals receiving foster care assistance
  - Newborns of an individual who was receiving any type of Medicaid at the time of the newborns birth
  - Individuals whose citizen status was previously documented by ODHS|OHA. ODHS|OHA may not re-verify or require re-verification of citizenship at a renewal of eligibility or subsequent application following a break in coverage
  - Adults who attest to having an immigration status that is a non-qualified non-citizen status or an

individual of any age who does not have a status.

Reasonable opportunity period

- ONE will attempt to verify citizenship or immigration information for applicants who are U.S. citizens or non-citizen whose status is subject to the immigration verification requirements.
- If the system is unable to verify the individual's self-attestation, benefits are approved based on their self-attestation and an RFI is sent. The RFI allows 95 days for the applicant to resolve the discrepancy regarding their U.S. citizenship or immigration status.

Work quarters for non-citizens

ODHS|OHA staff may verify 40 qualifying work quarters for non-citizens by accessing the Social Security Administration's (SSA) Quarters of Coverage History System (QCHS), verifying work income and calculating the appropriate quarters using SSA's methodology, or a combination of both.

Click here for Non-citizens.

Oregon Administrative Rule(s)

461-115-0610 — Verification; General
461-115-0704 — Required Verification of Citizenship and Noncitizen Status; OSIP, OSIPM, and QMB
410-200-0230 — Verification

Other verification sources

The following categories may require verification for eligibility or only when the information is questionable, depending on the program.

Age/relationship

Most documents that can be used to verify age can also be used to verify relationship. The following items can be used as appropriate to verify these eligibility factors.

- Documents or other records generally available from the individual:
  - Birth certificate
  - Baptismal certificate
  - Confirmation papers or other religious records
  - Military service papers
  - Immigration papers
  - Naturalization papers
  - Hospital birth records
  - Adoption papers or record
  - Passport
  - Voter registration card

- Family records (Bible, birthday books, genealogy, newspaper birth announcements, etc.)
- Marriage license
- Driver's license
- Oregon Liquor Control Commission (OLCC) card
- Employee ID card
- Life insurance policy
- Support decree
- School records
- Divorce decree
- Certificate of citizenship
- Social Security records

- Verification information from other sources:
  - Social Security records (numident file with a 'P' in the IDN field, BEIN, IEVS screens)
  - State, federal or Indian census record
  - Medical records
  - Statement from person attending birth (e.g., physician, midwife, nurse, relative)
  - Oregon Vital Records or local government records of birth
  - Court records of parentage
  - U.S. Citizenship and Immigration Services records
  - Child Welfare records
  - Child care records
  - Job Training Partnership Act (JTPA) documents

Note: For medical programs, ODHS|OHA can accept self-attestation as verification of age and relationship unless the information is questionable or differs from information available to ODHS|OHA.

Deductible expenses

This applies specifically to SNAP, OSIPM, and MSP.

Click here for Expenses and deductions.

The following items may be used to verify deductible expenses for SNAP (if applicable):

- Rent receipt
- Statement from landlord
- Rent/lease agreement
- Mortgage payment book
- Property tax statements

- Fire insurance/homeowners' policy or billing statement
- Real estate sales agreement
- Receipt/stub for campground fees
- Statement from person with whom individual shares shelter costs
- Statement from HUD
- Utility bills
- Statement from utility company
- Receipt for firewood, propane, fuel oil, kerosene, etc.
- Statement/receipt from landlord for utilities
- Canceled check for utilities
- Statement from collateral contact
- Medical expenses:
  - Billing statements
  - Itemized receipts
  - Medicare care indicating Part B coverage
  - Health insurance policy showing premium
  - Medicine/pill bottles with costs on label
  - Lodging/transportation receipts from obtaining medical treatment or services
  - Receipts for animal food/veterinarian services for seeing eye/hearing dogs and housekeeper monkeys
  - Statement from pharmacy
  - Repayment agreement with physician/hospital
  - Statement from doctor verifying over-the-counter drugs prescribed
  - Bill for visiting nurse, homemaker, home health aide, etc.
  - Bill or receipt for prescribed equipment, sick room equipment and/or medical supplies (includes rental costs)
  - Statement from collateral contact
- Child support:
  - The support must be legally obligated, which can be verified using court order or administrative order.
  - The amount of support actually being paid is verified using canceled checks, evidence of withholding from wages or unemployment compensation, RSS or county payment records, or a statement from the custodial parent for payment of child support.

Establishing paternity

When the mother is absent from the home but information indicates a self-alleged father is in fact the child's father, Division of Child Support (DCS) must first try to find the mother and serve her with legal papers (unless she is

deceased) before establishing paternity. This process may be delayed if the mother cannot readily be located.

An alleged father may not be the caretaker relative of children for TANF purposes. If a man wants to begin the process of establishing paternity, he may complete a Self-Alleged Father form; it is available from the Oregon Department of Justice Division of Child Support and must be submitted to DCS. Paternity must be legally established before the man is added to a TANF case as a caretaker relative.

Remember: A self-alleged father may not be considered a parent for TANF until paternity has been legally established.

Identity

For SNAP, verify the identity of the head of household/primary person in all cases. When an authorized representative makes the application, verify the identity of both the authorized representative and the head of household. Use readily available documents including, but not limited to:

- Driver's license
- Work or school identification card
- Identification for health benefits or another social service program
- Voter registration card
- Wage stubs
- Birth certificate

Picture ID is not required. When no other documents are available, SSP staff should use a collateral contact; obtain the collateral contact from as reliable a source as possible.

For HSD medical programs, OSIPM and MSP, verification of identity is required. ONE will attempt to verify an individual's identity via the Federal Data Services Hub (FDSH). If the system is unable to verify identity, the following documents can be used:

- Driver's license issued by state or territory, either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight or eye color
- School identification card with a photograph of the individual
- U.S. military card or draft record
- Identification card issued by the federal, state or local government with the same information included on driver's licenses
- Military dependent's identification card
- Native American tribal document
- U.S. Coast Guard merchant mariner card
- Department of Motor Vehicles (DMV) data provided on WVIR screen meets the federal guidelines for acceptable documentation for an individual's identity
- Fishing and hunting licenses issued by the State of Oregon
- Three or more corroborating documents such as marriage licenses, divorce decrees, high school diplomas or

employer ID cards to verify the identity of an individual

ODHS|OHA may also accept the finding of identity from a federal or another state agency for the purposes of public assistance, law enforcement, internal revenue or tax bureau, or corrections if the agency has verified and certified the identity of the individual.

If identity cannot be verified by one of the methods above, ODHS|OHA must accept an affidavit signed, under penalty of perjury, by an individual other than the applicant who can reasonably attest to the applicant's identity. Such affidavit must contain the individual's name and other identifying information.

Insurance as a resource

Definitions of insurance terms:

Beneficiary: That individual (or entity) named in the contract to receive the policy proceeds upon the death of the insured.

Burial insurance: Insurance that, by its terms, can only be used to pay the burial expenses of the insured.

Cash surrender value: The amount the insurer will pay upon cancellation of the policy before death (or maturity). This value usually increases with the age of the policy.

Endowment insurance: Endowment policies that pay the policy owner the face value plus dividends after a stated period of time. The face value of the policy is paid to the beneficiary upon the death of the insured if death occurs during the stated time period. This type of policy has a cash surrender value.

Face value or amount: The basic death benefit or maturity amount of the policy specified on its face. This amount may be decreased by loans. The face value does not include dividends or additional amounts payable because of accidental death or other special provisions.

Individual and group policies: Individual policies are issued to a person or family and are paid for entirely by the owner. Group policies are usually issued through an employer or organization and may receive some contribution from the employer. Group insurance is usually term insurance and would not be counted in computing life insurance.

Insured: A person whose life is insured against loss.

Insurer-assurer: The company or association that contracts with the owner.

Limited payment life: Ordinary life insurance on which premiums are paid for a limited number of years (e.g., 20 pay life, 30 pay life). This insurance has a cash surrender value.

Ordinary life (also known as whole life or straight): A contract for which the insured pays premiums during their lifetime and on which the company pays the face amount of the policy to the beneficiary on the death of the insured. This type of insurance has a cash surrender value, usually after the second year. It is the most popular type of life insurance written.

Owner: The individual paying the premium on the policy with the right to change such policy as they may see fit.

Term insurance: A contract of temporary protection. The insured pays relatively small premiums for a limited

number of years, and the company agrees to pay the face amount of the policy only if the insured dies within the time specified in the policy. It is temporary protection and usually has no cash surrender value.

Additional considerations when verifying insurance as a resource:

- The first page of the policy generally states the type of policy, the name of the insured and beneficiary, the face value and the date the policy was issued. This and the cash surrender table within the policy usually provide all the information needed to determine if further verification is necessary.
- Most policies do not have a cash value until they are at least two years old.
- Whether a policy pays dividends is usually stated on the cover sheet of the policy. Accrual of dividends may increase the cash value of the policy. The policy owner has several options for disposition of the dividends. They may be paid to the owner directly, applied to reducing the premium payment, or left to accumulate (plus interest) in the cash value of the policy. The owner usually receives a yearly statement from the company concerning the disposition of dividends.
- If the value of the policy contributes to resource ineligibility, the individual should be advised to consult the insurance agent about options other than canceling/cashing in the policy. Other options may include conversion to term insurance or to a policy of smaller face value.

Pending eviction

Documentation of a pending eviction must be a written statement or a notice that explains the reason(s) for eviction and the date the person is to be evicted. It can be from any of the following individuals:

- Landlord or apartment manager
- Homeowner
- The person with whom the filing group is living in a shared housing situation

Residency

The following may be used to verify residency for all programs.

Note: For ERDC and all medical programs, if an applicant states on the application they intend to reside in Oregon, this is sufficient verification of residency.

Documents or other records generally available from the participant:

- Voter registration card
- Library card
- Utility bills
- Rent receipts, mortgage receipts, lease agreement
- Driver's license
- Piece of mail received at stated address
- Real estate tax receipts
- Renters, homeowners or standard fire insurance policy

- Statement of intent to reside in Oregon
- School registration
- Letter from Oregon employer containing job offer

Verification information from other sources:

- Home visit
- Collateral contact
- Statement from nonrelative landlord
- Religious records

Social Security number

For all programs except ERDC, ONE will attempt to verify the social security number (SSN) via an electronic match with the Social Security Administration. Staff should not require documentation if the SSN has been verified through electronic sources.

The following documents can be accepted as proof of an Oregonian's Social Security number (SSN) or proof they have applied for one:

- Social Security card
- SSB or SSI award letter from SSA or other forms bearing the SSN
- Medicare ID card, if the individual is receiving Medicare off their own record
- Enumeration Request (DHS 0415Z) or equivalent SSA form signed by staff at the SSA office
- A completed form SSA 2853 (paper only), signed by staff at the hospital where a newborn was born. This is acceptable verification that parents have applied for an SSN for their newborn child. Social Security will issue the child's SSN in about 13 weeks. If the SSN does not arrive within 13 weeks, the parent should contact Social Security
- Other documents usually showing a correct SSN, such as wage stubs, unemployment records and federal income tax forms.

Requesting change in child care hours

This applies specifically to the ERDC program.

When additional child care hours are requested due to increased work or school hours, verification is required. If possible, only verification of the increased hours should be requested to avoid unnecessary impacts to other program benefits. This can be done via employer letter or phone call..

Note: If verification does show increased income, the copay is not increased

Click here for Child care hours.

Student child care hours

This applies specifically to the ERDC program.

When child care hours are requested due to schooling, verification of registration and current class schedule are required.

Click here for Child care hours.

Out-of-state verification

Verifying out-of-state benefits is only a requirement if ODHS|OHA has reason to believe an individual currently has open benefits outside Oregon. Reasons it may be appropriate to verify out-of-state benefits include, but are not limited to:

- Applicant presents an out-of-state ID or license, or
- Applicant marks on the application for benefits that they received benefits or resided previously in another state.

Below is a list of central phone numbers or fax numbers staff may use to find out if a person applying for assistance in Oregon has already received benefits in another state or American territory. If the applicant has a different phone number for a specific worker in another state or territory, that number should be used. Policy units should be notified as needed regarding any changes to the numbers on this list.

For verification of duplicate participation or receipt of out-of-state SNAP benefits, click here for the National Directory of Contacts.

For all other programs' verification of assistance, click here for a list of Out of State Contacts.

SNAP Click here for information about verifying counting months from out of state for SNAP.

TANF Verifying time on TANF from another state

When an individual indicates on the application that they received TANF benefits in another state(s) or from a tribal program, the agency must verify how many months the individual received TANF in the other state(s) or program.

If verification is needed, SSP staff should do the following things:

- Pend the adult's benefits for 30 days and open a case for the children if all other TANF eligibility requirements are met, and
- Attempt to verify the out-of-state time by contacting the other state.

If verification of time on TANF from another state or tribe is not received within the 30-day application period, deny the application for the adult for failure to complete the application process. Leave the case open for the children.

When verification is received within the 30-day application time frame:

- If the adult has less than 60 months on TANF: Add the adult and supplement TANF back to the filing date.
- If more than 60 months, the adult's needs would not be added to the grant unless the individual meets one of the hardship extension criteria. The children would continue to receive benefits as

long as all other TANF eligibility requirements were met.

- If more than 60 months and the adult meets one of the hardship extension criteria, add the adult and supplement TANF back to the filing date.

Out-of-state months, once verified, must be added to the Out-of-State Time Limits screen. If verification from the other state identifies months in Indian Country, those months do not count toward the federal or Oregon time limit.

ERDC No additional program-specific information.

REF No additional program-specific information.

MSP No additional program-specific information.

OSIPM No additional program-specific information.

HSD No additional program-specific information.

Oregon Administrative Rule(s)

461-115-0610 — Verification; General

Vital statistics

This section contains addresses of Vital Records offices to contact for information on births, deaths and marriages in the United States. Fees and processes are subject to change without notice.

Many states require a written, signed statement from the individual to release vital records. When ordering records from another state, SSP staff should send a signed release statement from the individual to expedite the request.

Internet sites with vital statistics information include:

- For Oregon information, click here.
- For other states' information, click here or here.

Other resources

Oregon Vital Events Registration System (OVERS)

Quick reference charts

Supplemental Nutrition Assistance Program (SNAP) verification table

Type of asset	Certification		Periodic Report		Report a Change		Recertification/ Renewal**	
	Verify	Accept Client Statement	Verify	Accept Client Statement	Verify	Accept Client Statement	Verify	Accept Client Statement
Countable income	X (See below)		X (See below)		X (See below)		X (See below)	
Medical costs	X (See below)		X (See below)		X (See below)		X (See below)	
Child support deduction	X		Only if the amount paid or the court order changed			We do not request verification but only verified amounts will be considered	Only if the amount paid or the court order changed	
Identification Of Hoh[1]	X		Only if the HoH is changed		Only if the HoH is changed		Only if the HoH is changed	
Identification Of Other HH Members		X		X		X		X
SSN[2]	X		Only of a new member		Only of a new member	X	Only of a new member	
Noncitizen Status	X		Only of a new member		Only of a new member or status changed		Only if status changed or documents expired	
Residency		X		X		X		X
Household Comp		X		X		X		X
Citizenship		X		X		X		X
Work Hours For ABAWD	X			X		X		X
Shelter Cost		X		X		X		X
Utility Allow-ance		X		X		X		X

Type of asset	Certification		Periodic Report		Report a Change		Recertification/ Renewal**	
	Verify	Accept Client Statement	Verify	Accept Client Statement	Verify	Accept Client Statement	Verify	Accept Client Statement
Dependent Care Deduction		X		X		X		X
Disability	X (with the income)		Only of a new member		Only of a new member		X (with the income)	
Student Status		X		X		X		X
Relationship		X		X		X		X
Age		X		X		X		X
Resources		X		X		X		X
Work Status		X		X		X		X
Pregnancy		X		X		X		X
Incapacity		X		X		X		X

***Recertification/Renewal – It the application filing date is prior to the end of the current certification or is within 30 days of the certification period ending, the application is a Recertification/Renewal and follows the verification rules for Recertification/Renewal.

1. Whenever there is a new HoH on the case we need verification of the HoH.
2. Applicants or recipients are to supply the SSN to the department. The department will verify the SSN via SSA.

Countable Income

When processing a Certification

Verify all (non-excluded) countable incomes.

When processing a Periodic Report– verification is only required if at least one of the following are true:

- The total reported for all earned incomes has changed by $125 or more
- The total reported for all unearned incomes has changed by $125 or more
- The total income used in the budget was not more than 130% of FPL for the filing group and the new total income puts the total income over 130% of FPL.
- The income source if a new source, this includes income of a new member.

When processing a Report a Change– verification is only required if the following is true:

- The total income used in the budget was not more than 130% of FPL for the filing group and the new total income puts the total income over 130% of FPL.

When processing a Recertification/Renewal – verification is only required if at least one of the following are true:

- The reported income (each separate source) has changed by $50 or more
- The total countable income used in the budget was not more than 130% of FPL for the filing group and the new total income puts the total countable income over 130% of FPL.
- The income source if a new source, this includes income of a new member.

Medical Costs

When processing a Certification

We require verification if the amount reported is greater than $35 and if they want to claim the expense in the initial determination of eligibility. The applicant gets to choose if we soft pend or hard pend. If they chose to hard pend and do not supply the verification by the due date, eligibility will be determined without allowing the deduction, unless eligible for expedited SNAP (ESNAP). If they chose to soft pend, eligibility will be determined without allowing the unverified deduction, unless eligible for ESNAP. If eligible for ESNAP, the unverified expense will be included in the budget.

When processing a Periodic Report/Report a Change

We do not request information about medical costs on the Periodic Report. If a change is reported to medical expenses anytime outside of intake and renewal, we will not require verification. Please explain to the client if they choose to submit verification, we will take action on that reported change but without verification the new costs will not be considered.

When processing a Recertification/Renewal – verification is only requested if both of the following are true:

- The medical expenses reported to have changed by at least $25; and
- This will result in a change to the SNAP medical deduction. If the Standard Medical Deduction (SMD) is used in the budget and this change will result in the SMD still being used verification is not required.

Note: The information under Certification about hard and soft pending also applies to Recertifications/ Renewals.

SNAP Verification Required; Periodic Reports, Renewals, Report a Change (RAC) Examples

Periodic Reports: When verification is required

If the total income from all earned income or the total income from all unearned income sources has changed by more than $125. The income needs to be verified.

Example 1: Rahul currently has earned income of $1000 per month listed on his Periodic Report from his job at TJ's Market. On the Periodic Report Rahul states his income has decreased to $850 per month and did not provide

verification. This is a change in total earned income of more than $125 per month an RFI will be issued.

Example 2: Shanice currently has social security benefits in the amount of $500 per month and $350 per month from her pension. On the Periodic Report she states she is now receiving a $580 in SSB and $410 from her pension and did not provide verification. This is a change in total unearned income of more than $125 per month an RFI will be issued.

Example 3: Matthew currently has wages in the amount of $500 per month and $350 per month from his pension. On the Periodic Report he states he is now receiving $580 in wages from the same employer and $410 from his pension and did not provide verification. This is a change in total earned income of $80 and change in total unearned income of $60. An RFI will not be issued because neither the total earned, nor total unearned income increased over the $125.

If there is a new income source, which includes income from a new member of the filing group, the income needs to be verified.

Example: Paul and Maria are currently receiving SNAP on a case together. A Periodic Report is received which states their 20-year-old son Daveed has moved home. They list on the report that Daveed is currently working at Burger Farm and did not provide verification of his income. An RFI will be issued for Daveed's newly reported income.

If the total income from all sources in the ONE system was not above 130% of FPL but now goes above 130% of FPL, the income needs to be verified.

Example: Javen is currently receiving SNAP benefits on his own and is working part time at Frank's Frosty earning $800 per month and at O's Tire Factory earning $500. On the Periodic Report he reports he started working more hours at O's Tire Factory with earnings of $600 per month, no verification provided. This new income now places his case above 130% of FPL, so even though the change is not more than $125 the system will generate an RFI for income verification.

Reminder: Entering "Needs Verification" will not override any of the rules in ONE. "Needs Verification" should only be used when information received is questionable. If an individual didn't provide verification the correct selection to use is "Client statement" unless found questionable.

Renewals: When verification is required

Change in Income

ONE will ONLY generate an RFI for a change in income if the source has changed or the amount has changed by more than $50. Adding a new income source for an existing or a new filing group member is also considered a change in the source of income.

Example 1: Jamal submits a renewal with income from his job at Tin Can Garage in the amount of $1000 per month and did not provide verification. The worker sees the income record in ONE is currently verified with pay stubs at $975 per month. The worker adds a new earned income record for same employer of $1000 monthly. Verification is entered as Client statement and the system will not generate the RFI for verification because this change in income is not more than a $50 change. The income of $975 per month will remain as the earned income for the SNAP financial summary because the new income does not have valid verification.

Example 2: Jamal submits a renewal with income from his job at Tin Can Garage in the amount of $1000 per month and did not provide verification. The worker sees the income record in ONE is currently verified at $975 per month from a different employer (Quick Mart) and Jamal is no longer employed there. The worker will end the current income source record and add the new employment information on the Earned Income Source Screen. On the Earned Income Details and Verification screen the worker will enter the income record of $1000 per month, with Client statement as verification. The system will generate the RFI for this newly reported income source.

Note: If the total reported countable income places the filing group over 130% of FPL and no verification is provided, an RFI will be generated even if the change is less than $50.

Change in Medical Expenses

ONE will ONLY generate an RFI for medical expenses which were previously unreported or when the total of allowable medical expenses has changed by more than $25. If the verification does not change the deduction amount an RFI will not be issued.

Example 1: Ingrid currently does not have any medical expenses entered for SNAP in the ONE system. On her renewal, she reports a co-pay in the amount of $20 and did not provide verification. This reported amount is under $35, the system will not generate an RFI.

Example 2: Ingrid currently has a verified medical expense in the ONE system in the amount of $50. When entered in the ONE system, this amount was between $35.01 - $205, the Standard Medical Deduction (SMD) of $170 was applied. On her renewal, she reports this medical expense has gone up to $90 and did not provide verification. The new reported amount is between $35.01 - $205, the system will not generate an RFI. She will continue to get the SMD of $170.

Example 3: Ingrid currently has a verified medical expense in the ONE system in the amount of $210. Since this was higher than the SMD amount, $210 was given to her as a medical deduction in the system. On her renewal, she reports this medical expense has gone up to $250 and she did not provide verification. The system will generate an RFI as the amount of this change is more than $25.

Report a Change (RAC): When verification is required

One will generate an RFI on a case with reported changes in the following situations:

Income is currently entered in ONE and is equal to or under 130% of FPL (Federal Poverty Level) and the new income reported places the case over 130% of FPL.

Example 1: Chantel is on a SNAP case by herself and has earned income verified in the ONE system at $1000 per month from her employment at Toy Barn. She is reporting a change in income and now earns $1500 per month due to increased hours but did not provide verification. The prior income was not over 130% and this newly reported income places her case over 130% of FPL, the system will generate an RFI for income verification.

Example 2: Juan has an approved SNAP case in the ONE system with his 3 children. He is currently working at B's Lumber Yard and has verified earned income of $2750 per month in the ONE system. Juan reports he now receives child support for each of his children in the amount of $500 per month and did not provide verification. The total countable income is now $4250. Since the case was over 130% of FPL before the reported change there will be no RFI issued. The new income is not verified so it will not be used in the SNAP budget and this case will remain BBCE

(Broad Based Categorically Eligible) based on the verified income.

Note: There is no requirement to report when income reaches or goes over 200% of FPL. The requirement is to report if the change puts them over 130% of FPL and they were not over 130% of FPL already.

If a filing group reports an income change that puts the gross income over 200% of FPL, they are not automatically over income for SNAP. The filing group will not be BBCE but might remain eligible. This can happen if the case is ECE (Expanded Categorical Eligibility) or if not subject to the countable income limit (130%) and their adjusted income is under the limit (100%).

Income is currently entered in ONE and is already over 130% of FPL but ends, and there is a new unverified income source reported which is also over the 130% of FPL.

Example: Juan has an approved SNAP case in the ONE system with his 3 children. His job ended at B's Lumber Yard; his income is verified in the ONE system at $2750 per month which is over the 130% of FPL. He reports a new job at Sandy's Mill and reports his new income is $3000 per month and did not provide verification. The worker will end the income from B's Lumber Yard and add the new unverified reported income. The system will generate an RFI for the new income source because the original income was removed bringing the income to under 130% of FPL. The new unverified income brings the case over 130% of FPL so this new income must be verified. The income of $2750 will continue to be used in the SNAP budget month until the verification has been returned and updated in ONE.

Report a Change (RAC) system functionality for SNAP:

1. If the income before the change was less than or equal to 130% of FPL and after the change was also less than 130% of FPL.

   - No RFI and do not use the new income that is not verified in the SNAP budget

2. If the income before the change was more than 130% of FPL and after the change was also more than 130% of FPL

   - No RFI and do not use the new income that is not verified in the SNAP budget

3. If the income before the change was less than or equal to 130% of FPL and after the change was more than 130% of FPL

   - RFI to be generated use the newly reported income in the potential pending EDG

   Note: If an EDG is pending the previously authorized benefit will continue until the RFI is cleared, or SNAP closes for not clearing the RFI.

4. If the income before the change was more than 130% of FPL and after the change was less than or equal to 130% of FPL

   - No RFI and do not use the new income that is not verified in the SNAP budget

Chapter 3:
Processes and procedures

Section 3: Issuance of benefits

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Issuance of benefits

Introduction

Issuing benefits is a separate function from eligibility determination. The security of benefits and the household's circumstances should be considered in determining the appropriate method of issuing benefits. Currently, the program benefits available on EBT cards include SNAP, TANF, Refugee Program, prison release funds, Summer Electronic Benefit Transfer for Children, Low Income Home Energy Assistance Program and Job Participation Incentive (JPI).

The Oregon Trail Card makes benefits available electronically to recipients of cash and SNAP benefits by using a plastic debit card at point-of-sale (POS) devices and most automated teller machines (ATMs – cash only).

For participants 65 and older or who receive Supplemental Security Income (SSI) and live in a cash-out demonstration area (Clackamas, Columbia, Multnomah and Washington counties), SNAP benefits are deposited to a cash account and are available at both POS devices and ATMs.

Alternate methods of issuing benefits:

- Issue cash benefits by check (printed check or direct deposit) to the primary person or the authorized representative, or by vendor payment.
- Issue medical benefits by providing the individual with a medical card.

Electronic benefit transfer

The Oregon Trail Card (EBT) system makes SNAP and CMS-issued TANF benefits and HIPP reimbursements (TANF and HIPP equal cash) available to individuals by using a plastic debit card at point-of-sale (POS) devices and automated teller machines (ATMs). EBT operates through a partnership between Fidelity Information Services (FIS or eFunds/FIS) and ODHS|OHA. ODHS|OHA's EBT computer system is EB (electronic benefits). The system functions through an interface among EB, CI-FIND, CMS and FSMIS on one side, and eFunds/FIS's system on the other.

One advantage of the Oregon Trail Card is benefit availability. Weekends and holidays do not affect when an individual receives their benefits. The individual will know when their benefits are available.

There are two types of accounts available in the system: a cash account and a SNAP account. Cash benefits issued by CMS will be deposited in the cash account. For SNAP cash-out, SNAP benefits will be deposited to the cash account unless participants opt for direct deposit of their SNAP cash benefits. All other SNAP benefits will be deposited in the SNAP account.

SNAP cash-out individuals must be issued their SNAP benefits through the EBT or direct deposit system. On a case-by-case basis, SNAP cash-out individuals who are unable to adjust to the EBT system may receive their benefits by check only if direct deposit is not an option. If, in the professional judgment of the worker and supervisor, the SNAP cash-out individual has a medical or mental health condition (documented or not) that makes it very difficult to adapt to using an EBT card, the individual may be issued their SNAP benefits by check.

New individuals may be issued an Oregon Trail Card and select a personal identification number (PIN) before their

eligibility is determined; generally, the EBT card is issued after the initial screening interview. When the benefits are issued, they will be deposited to the EBT account.

The Oregon Trail Card and PIN together control access to individual accounts. The PIN is a four-digit number known only to the individual. The selection device encrypts the PIN as the numbers are selected. The PIN number is not kept in the system. If an individual forgets their PIN number, they may call eFunds/FIS Customer Service at 888-997-4447 or go online at www.ebtEDGE.com to select or reset their PIN. The individual can also go into the local branch for PIN assistance.

Cash direct deposit is not affected by EBT. Individuals whose cash benefits are directly deposited into a bank account will remain in direct deposit unless changed by a worker. Companion SNAP benefits will be issued by EBT, unless they are for SNAP cash-out individuals who have an alternate method (direct deposit or check).

How does EBT work?

The responsibilities are as follows:

- The individual applies for benefits. ODHS|OHA staff sets up a CMS or SNAP case. The case can be in pending status.
- The EB system creates an EBT case or connects the CMS/SNAP case to an existing EBT case. The EBT case and individual information is sent to eFunds/FIS.
- When ODHS|OHA determines the individual may be eligible for benefits, the branch will issue an EBT card.
- ODHS|OHA's EB system sends the card information to eFunds/FIS.
- The individual selects a PIN for their card.
- Once a worker determines eligibility and the applicant is approved, the case will be issued benefits using CMS and FSMIS.
- Benefit issuances are sent to the eFunds/FIS system. For regular issuance, an overnight process will send the data to eFunds/FIS. For immediate issuance, the data is transmitted to eFunds/FIS online when ODHS|OHA authorizes it.

Setting up the EBT case and changing payees

EBT case creation

EBT cases are created automatically by the EB system when a CMS or SNAP case is added and when a payee is changed on a case. To ensure a single EBT case is created for individuals with companion cases, the cash payee and SNAP head of household need to be the same person.

Changing payees

When the EBT payee is changed, the EB system recognizes benefits need to be issued to the EBT case with the current payee connection. The connection between the EBT case and the previous payee is automatically changed. The EBT Case Detail screen displays the case numbers of the eligibility cases connected to the EBT case. It also displays the payee's status for each eligibility case as "C" (current payee) or "P" (previous payee).

Benefits cannot be transferred from one EBT account to another. If there are any benefits remaining in the previous payee's account, they must be withdrawn by the previous payee or their alternate payee. Balances cannot be transferred between EBT cases.

If an old SNAP case exists in the computer files but no EBT case was created, an ADJ transaction will establish the EBT case.

About EBT alternate payees

Alternate payees are individuals who may be used to obtain and use benefits for the benefit group. During the eligibility interview, a worker can discuss the potential need for an alternate payee. Make sure the individual understands the alternate payee will have access to benefits without the individual giving any further authorization.

Any adult member of the benefit group may appoint an alternate payee. The head of household, primary person or primary contact, or authorized representative may designate an alternative payee by completing the Authorized Representative or Alternate Payee form (MSC 0231). Do not use the form for filing group members. When this form is submitted, ODHS staff must do the following:

For authorized representatives, record the information on the CM or FS record.

For alternate payees:

- Locate the person on CI-FIND. If the person does not have a FIND record, use the Add a Person screen to add the payee, and
- Go to the EBT Case Detail (EBCAS) screen for the individual. Type the alternate payee's SSN or name on the payee line and press {F11} Get a Person to bring in the payee from FIND and press {F9} Save. The benefit access level will automatically default to B (both). If you want to restrict the alternate payee, change the code to C (cash only) or F (food benefits only). Once this code is sent to FIS, it can only be changed by the EBT administrator.

Access to each type of account (cash and SNAP) can be controlled separately. The primary payee chooses which account(s) an alternate payee can access. Benefits spent by an alternate payee will not be replaced.

If the head of household (payee) decides they no longer want an alternate payee outside the filing group to have access to their account(s), the individual will need to contact ODHS|OHA. Designated branch staff may inactivate or cancel the EBT card online. Their card must be inactivated (can be reactivated) or deactivated (canceled and cannot be reactivated).

- To inactivate a card, branch staff use the EBCAS screen to change the Card stat code to IA (inactivate). A card that has been inactivated can be reactivated.

  Note: Inactivating the alternate payee's card, instead of deleting the alternate payee, allows historical payee information to remain on EBCAS without allowing that person's access to the account.

- To cancel a card, authorized card issuance branch staff use the EBCRD screen using one of the permanent card status codes listed in the Help Window for the Crd stat field (e.g., card lost, card damaged). Once a card has been canceled, it cannot be reactivated to be used again.

Participants may temporarily block access by the alternate payee by calling the eFunds/FIS Customer Service

number on the back of their card and having the alternate payee's card status changed to INACTIVE. The individual can also request an alternate payee's card be deactivated/canceled if they need to immediately end an alternate's access.

When ODHS|OHA is notified a person with an EBT card has left the household, it is important to cancel the card. If the card is not cancelled and the alternate payee continues to use it after being removed from the case, ODHS|OHA must restore benefits.

Oregon Administrative Rule(s)

461-165-0035 – Alternate Payees

EBT support

eFunds/FIS provides telephone assistance through separate numbers for individuals, ODHS|OHA staff and retailers. eFunds/FIS Customer Service number is an automated response unit (ARU) available 24 hours a day, seven days a week. You can also reach a person at eFunds/FIS Customer Service 24 hours a day, seven days a week. To speak to a person at eFunds/FIS Customer Service, individuals must stay on the line. This includes individuals who have rotary phones or who need language services other than Spanish or English.

Using the ARU, individuals can check their benefit balance and review their last 10 transactions; or transfer to a customer service representative to report a card lost, stolen or damaged or to request other assistance.

For protection of their benefits, individuals should call eFunds/FIS Customer Service to report a lost/stolen card or a compromised PIN as soon as they discover the loss or suspect someone knows their PIN.

Help for individuals

The individual customer service number is printed on the training pamphlet and on the back of each Oregon Trail Card. The number is 888-997-4447; it is a toll-free call. eFunds/FIS has a variety of bilingual staff. If they do not have someone on staff who speaks the individual's language, they have access to other resources, such as the telephone language interpreter services. As an FYI, ODHS employees may follow the guidance in the Office of Equity & Multicultural Services to request language access assistance. Customers can also visit www.ebtedge.com to access similar information and actions for their Oregon Trail Card.

For issues other than equipment problems, staff should call the OIS Service Desk at 503-945-5623 or 888-457-3375.

Help for retailers

To make SNAP transactions with the EBT card, retailers must be approved by FNS. Retailers that have questions about using the EBT card or need other assistance, such as equipment problems, can call eFunds/FIS at 800-831-5235. They will be requested to enter their store's FNS number or store location ID. If retailers need information about becoming certified to accept Oregon Trail Cards, refer them to FNS at 877-823-4369.

Participant training; EBT

Districts should have a local process to provide Oregon Trail Card training to new individuals and their alternate payees.

The training may include review of the How to Use Your Oregon Trail Card (DHS 0208) individual pamphlet. The DHS 0208 is available through Distribution Services or online at the form server. It is important for staff to go over the pamphlet with the individual to ensure they are familiar with the process. Some individuals may need more individualized training.

Card issuance and PIN selection; EBT

Card issuance involves:

- Providing Oregon Trail Card training to new individuals and their alternate payees
- Issuing original and replacement Oregon Trail Cards to individuals and their alternate payees when allowable
- Helping the individual and alternate payee with the PIN selection process
- Helping the individual and alternate payee use the POS device, the PIN pad and the printed receipt.

The worker who determines cash and SNAP does not issue the Oregon Trail Card to the individual. The separation of responsibility is an important security measure. ODHS|OHA will decide who will issue EBT cards from the office.

The branch person authorized to issue EBT cards must:

- Positively identify the individual
- Log out an EBT card and record it on the individual's EBCRD screen
- Have the individual select a PIN on a POS device
- After the individual has successfully selected the PIN, perform a balance inquiry with the individual to verify the card and PIN are working properly. When the balance inquiry is completed, the system prints a statement for the individual.

During PIN selection, ODHS|OHA will advise the individual to keep their PIN secret and not share it with anyone. In addition, ODHS|OHA will inform the individual of the need to call eFunds/FIS Customer Service as soon as they discover their card is missing or they have compromised their PIN. A PIN is compromised anytime the payee feels someone else may know the number. ODHS|OHA will direct the individual to call the eFunds/FIS customer service number and not a local branch office. When an individual has reported a card lost or stolen, eFunds/FIS Customer Service staff will deactivate the card. This will prevent anyone from using the card to obtain benefits.

If the individual comes into a local branch with their current EBT card that is damaged and the last four digits can be read, the local branch can issue the EBT card out of the office. Follow the procedures above to replace a damaged card.

EBT cards by mail

Some individuals may not be able to come into the office to obtain an Oregon Trail Card for a reason such as medical issues. In addition, with the increased number of applicants and recipients applying for benefits online and the ability to conduct an eligibility interview over the telephone, an individual may need to have the Oregon Trail Card mailed to their home. These cards will be mailed by the branch, not the EBT Replacement Unit.

The card issuer must follow the steps outlined above, except:

- Write "mailed" in place of the individual signature on the Oregon Trail Card Issuance Log (DHS 0248).
- Do not assign a personal identification number (PIN).
- Place the EBT card and How to Use Your Oregon Trail Card brochure (DHS 0208) in an envelope and send to the mailing address of the individual.
- Inform the individual, when they receive the Oregon Trail Card they must call the eFunds/FIS/FIS Help Desk or go online at www.ebtEDGE.com to select a PIN.

The toll-free customer service telephone number and website are printed on the back of the Oregon Trail Card.

Replacing lost, stolen or damaged EBT cards

The following steps may be taken at the branch level:

If the card is lost or stolen on a weekday during business hours:

- An individual may call the toll-free Oregon Trail Card Replacement Line at 1-855-328-6715 to request a replacement card. The Replacement Line is open Monday through Friday from 8:30 a.m. to 4:30 p.m. Replacement cards are sent by mail and typically arrive within five business days.
- Only under certain circumstances can the branch issue out a lost or stolen card. If approved by branch, the card needs to be approved by either a manager or lead.

If the card is lost or stolen on a weekend or outside normal business hours:

- The card may be reported as lost or stolen by calling the toll-free Oregon EBT Customer Service Help Line at 888-997-4447 to cancel the card and protect the remaining benefits. The Help Line is open 24-hours a day, seven days a week.
- The person will then need to make a second call the Oregon Trail Card Replacement Line toll-free at 855-328-6715 to order a replacement card. The Replacement Line is open Mondays through Friday from 8:30 a.m. to 4:30 p.m. Replacement cards are sent by mail and typically arrive within five business days.

Before issuing a replacement, the card issuer must verify the individual's identity and ensure the old card is no longer active. When the individual gets a new card, they can use their old PIN or select a new one.

If someone finds a lost card, it should be returned to the address on the back of the card. The card will then be destroyed. Cards returned to branch offices should be destroyed and logged in the destruction log Cards left in automated teller machines (ATMs) will not be returned to individuals and must be replaced by a branch.

Forgotten or compromised PINs; EBT

Participants have three options to get a new PIN number. They may:

- Bring their Oregon Trail Card to the closest ODHS or OHA office to request a new pin.
- Call the toll-free customer service number at 1-888-997-4447 and ask for their PIN to be changed.
- Go online to www.ebtEDGE.com and change their PIN.

The eFunds/FIS system keeps track of the number of times an incorrect PIN is used during the day. Anytime an individual tries to use the EBT card and enters an incorrect PIN, the transaction is rejected and the number of "PIN fails" increases. If a person fails to enter the correct PIN four times in one calendar day, the card/PIN is locked up. The hold will be released after midnight. If the individual does not know their PIN or cannot wait until the next day, they can select a new PIN through Customer Service or they can go into their local office to select a new PIN. It is not necessary to cancel the EBT card to assign a new PIN. If the individual successfully uses their PIN after fewer than four failures, the PIN fail number resets to 0. It also resets every day at midnight.

If an individual forgets their PIN or believes someone else knows what it is, they should call eFunds/FIS Customer Service to report it. eFunds/FIS Customer Service staff will assist them in selecting a new PIN.

Access to benefits via EBT

Cash benefits

Individuals and their alternate payees may access cash benefits (including SNAP cash-out benefits) in two ways, through POS devices at some retailers displaying the "Oregon Trail Card Accepted Here" sign and at participating ATMs. As retailers sign up to participate in the Oregon Trail Card project, they decide what amount of cash they will allow an individual to withdraw per visit using the POS device. Each store will have their own policy, so the individual should ask how much cash they can get back, and if they can do cash-only withdrawals. Individuals will not be charged for a cash purchase or a purchase with cash back. They have two free POS cash-only withdrawals each month. After the two free withdrawals, there will be an 85-cent charge for each subsequent withdrawal in a calendar month. Retailers can sell individuals money orders at a minimal fee, for all or part of their cash benefits. This would count as a purchase, not one of the two free withdrawals. This option provides a good solution to both the individual and retailers because the individual does not leave the store with large amounts of cash, and the retailer reduces security issues by not being required to keep large amounts of cash on hand.

ATMs

Some individuals choose to use ATMs to access their cash benefits. ODHS|OHA does not charge a fee, but there can be a bank surcharge. Many ATMs have a surcharge and the amounts differ. Most ATMs will accept the Oregon Trail Card.

The following is a partial list of participating ATMs:

- US Bank
- Bank of America
- First Security Bank
- Chetco Federal Credit Union
- Card Capture Services.

There are other participating ATMs with an Oregon Trail Card sign. For others, the only way to know if the ATM accepts the card is by trying.

ATM mis-dispense

If individuals contact ODHS|OHA to report they received the wrong amount from an ATM (a mis-dispense), refer them to eFunds/FIS Customer Service Desk at 888-997-4447. Federal banking laws require a resolution within 30 days, but it sometimes takes as long as 45 days. If the bank finds the ATM out of balance, eFunds/FIS will credit the individual's EBT account. A worker will narrate when an individual calls to report a mis-dispense.

SNAP benefits

Individuals can access their SNAP benefits through POS devices at retailers displaying the Oregon Trail sign. There is no transaction fee when an individual uses their EBT card to purchase food each month. The retailer is responsible for ensuring only allowable food items are purchased from the SNAP account. Most of the store systems will separate the items into food and nonfood automatically. It would just be a second card swipe rather than a separate transaction. With the card swipe, they select the form of payment, i.e., SNAP or cash. The individual will not receive change or cash back on a SNAP transaction. A return of a SNAP purchase results in a credit to the individual's SNAP benefit account.

Individuals can also access their Oregon Trail Card SNAP benefits when no POS device is available by using an off-line voucher system with retailers approved to accept SNAP benefits. This includes nontraditional retailers such as route delivery providers. These retailers, and traditional retailers when their terminals are down, will use an off-line voucher system. However, not all retailers will process voucher transactions when their terminals are down. If they will not, the individual will either have to return when their terminals are back up or go to a different store.

The voucher works much like a credit card transaction. The retailer fills out the voucher, which is then signed by the individual. The retailer compares the signatures on the voucher and the Oregon Trail Card, and then calls for telephone confirmation of benefit availability by eFunds/FIS. The retailer calls the eFunds/FIS Help Desk number. The offline voucher system applies only to purchases from SNAP benefits.

Because elderly and SSI individuals in the cash-out demonstration area receive SNAP benefits in their cash account, they will not be able to use the voucher system.

Retailer issues; EBT

Overcharges

When individuals report a retail store has deducted money from their account in error (i.e., the store said the card did not work and they paid cash or left the groceries, but the amount was deducted):

- Print a copy of the transaction from EBT Financial History
- Give it to the individual, and
- Suggest they take this back to the store for resolution.

If the issue cannot be resolved at this level, have the individual call eFunds/FIS and file a claim with their research department. eFunds/FIS will research the issue and credit the individual's account, if appropriate.

Undercharges

Retailers cannot identify individuals unless the retailer has a voucher with the individual's name. There have been occasions where clerks fill out the voucher and get approval but fail to record the entire card number. It is

appropriate to provide the retailer with this information if the voucher information is available on EBT Financial History.

For POS transactions, the only individual information retailers have is the Oregon Trail Card, or only the last four digits of the card. They may contact branch offices to request help when the individual's account is not deducted because the store made an error or when the system errors. Since the retailer has only the last four digits of the card, the branch will be unable to assist them.

Retailers contacting the branch regarding equipment problems should be referred to the eFunds/FIS Customer Service Desk for retailers at 800-831-5235.

Other retailer information

- Retail stores cannot require identification in addition to the Oregon Trail Card. The card and the PIN are the identification;
- For voucher transactions, the signature on the card reverse, and the voucher signature are the individual identification.

Availability of benefits via EBT

Benefit authorizations are transmitted to eFunds/FIS in one of three ways:

- For an individual's regular monthly benefit, there is the monthly transmission to eFunds/FIS. Benefits issued this way are available by 8 a.m. For SNAP, the benefits are available on the calendar day equal to the last number of the SNAP case number-Social Security number. For CMS and SNAP cash-out, benefits are available on the first of the month. Benefits will be available on these dates regardless of which day of the week it falls. Weekends and holidays do not affect availability of benefits.
- The second method is the daily transmission. For CMS, benefits sent this way are available to the individual by 8 a.m. the calendar day following the benefit authorization, but no earlier than the first of the payment month. For SNAP, once the monthly report has been processed, the benefits are available on the next day or the calendar day equal to the last number of the SNAP case number.
- The third method is immediate issuance. Benefits issued this way are immediately available to the individual. SNAP benefits will be available the same day as issued when an immediate issuance release code such as IA, IX or IJ is used on FSMIS. TANF benefits are available immediately when issuing from the EBT Immediate Cash Issuance screen (EBISS).

EBT benefit aging

Benefits issued through direct deposit (cash and SNAP cash-out) are not affected by the aging process.

Aging process

If an issuance does not have any withdrawals for 12 benefit aging periods, it becomes inactive and the remaining balance is "aged off" and expunged from the state. Benefits that have aged off cannot be restored to the individual.

- eFunds/FIS tracks which issuances have not been accessed by an EBT payee for each aging period. Aging periods for TANF and SNAP are from the 16th of each month through the 15th of the following month. Partial

months are not counted. For example, an issuance available June 3 would not be counted in the aging period beginning May 16 and ending June 15. Instead, because eFunds/FIS does not include partial months, it would first be included in the aging period beginning June 16 and ending July 15.

- eFunds/FIS tracks each benefit issuance, not the total account balance. The system works on a "first-in, first-out" basis. Purchases are deducted from the balance of the oldest issuance first. For individuals who wish to accumulate benefits in their account, making a small purchase each month will only preserve the oldest remaining issuance but not more recent ones.

Individual notification

Notice WCN005R-A: EB12 – Unused Benefits May be Lost – will be sent monthly to all individuals with a balance of $2 or more that has not been accessed for 12 months. Information on this notice will be displayed on the Individual Notice Log – LOGI. The notice is mailed mid-month.

Tracking aged benefits

Information about aged benefits is available in the EB:

- For 90 days after the issuance has been aged off, the aging transaction will display on the individual's EBT Financial History screen (EBFHL) with the Msg-Type "S1014": and the Trans-Type "DEL." The aged off issuance will also display on the individual's EBT Benefit Issuance History screen (EBISH) with the benefit status code "D."
- SNAP issuances that have been aged off will display on page 3 of FSUP. When none of the original SNAP issuance was accessed by the individual, and the original issuance amount is aged off and expunged, the aged issuance displays as canceled. When the aged off issuance is a portion of the original issuance amount, it is displayed as an adjustment.
- Cash issuances that have been aged off will display on WISH. When none of the original cash issuance was accessed by the individual, and the original issuance amount is aged off, the aged issuance displays as canceled. When the aged issuance is a portion of the original issuance amount, it is displayed as an adjustment.

Restoring aged benefits

Benefits will remain in individuals' EBT accounts for 12 months. Once the benefits age off, they are expunged from the account and sent back to FNS; those benefits cannot be restored to the individual.

Using EBT benefits to make voluntary repayments

By completing and signing the Voluntary Agreement to Take Action on Case (MSC 0457D), individuals may choose to make voluntary repayments of part or all of their SNAP or cash account balance. Workers with appropriate RACF authority may reduce, in whole dollar amounts, the available SNAP or cash benefit using the EBT Adjustments/Conversion screen. Cash adjustments will display on the WISH screen.

To avoid an overpayment

The individual's SNAP or cash account balance is reduced on the EBT Adjustments/Conversion screen by entering

the amount of available balance to be reduced to avoid an overpayment. An "N" should be entered in the repayment of overpayment field.

Individuals requesting to remove TANF benefits to prevent an overpayment should be informed that this is not possible. The TANF program has strict accounting and reporting requirements to several agencies, both state and federal. Additionally, once benefits have been issued, individuals have already received a counting month against their TANF time clock. Counting months cannot be removed unless an overpayment has been established, and the individual has paid the grant amount back.

To repay an overpayment

The individual's SNAP or cash account balance is reduced on the EBT Adjustments/Conversion screen by entering the amount of available balance to be reduced to repay an overpayment. An individual may also choose to reduce a cash balance in order to repay a SNAP overpayment. A "Y" should be entered in the repayment of overpayment field. An Overpayment/Over issuance Change Report (MSC 0284A) must be completed and sent to the Overpayment Recovery Unit so the individual's overpayment may be reduced.

Canceling EBT issuances

Individuals may request EBT issuances canceled by completing and signing the Authorization to Cancel Benefits Deposited to an Electronic Benefits Transfer (EBT) Account (DHS 0215). EBT issuances may be canceled on the EBT Benefit Issuance History (EBISH) screen by a worker with the appropriate RACF authority. Only issuances that have not been accessed may be canceled. SNAP issuance cancellations will display on page 3 of FSUP. Cash issuance cancellations will display on WISH.

When the FSMIS and CMS cases close; EBT

The Oregon Trail Card account does not close when a case is closed. This means the individual is entitled to use whatever TANF or SNAP amounts remain in their account. In addition, the individual may still need EBT services from the local office (e.g., they may need to add an alternate payee, get a replacement card, select a new PIN).

When a case is closed, advise the individual to hold on to their card. If they reapply, they may use the same card if they meet all the following conditions:

- The primary payee for the case has not changed.
- They still have the card.
- The card has not had the status changed to anything other than INACTIVE.
- The card is still in good working order. The individual can perform a balance inquiry to make sure the card still works.

If they do not meet any of these conditions, issue a new card to the individual.

When benefits end because a person has died and there are no other persons in the SNAP benefit group, a worker with RACF authority will remove the balance from the SNAP account using the EBADJ (EBT Adjustments/

Conversion) screen. For all other benefits the balance belongs to the individual's survivors. Determine if ODHS|OHA should designate an alternate payee.

When an individual moves out of state; EBT

The Oregon Trail Card can be used to access SNAP and cash benefits in almost all locations in the United States. When an individual leaves the state with benefits remaining, they will need to locate a retailer or ATM that accepts the Oregon Trail Card.

Cash individuals

If the individual does not have an active card or valid PIN and has only cash or SNAP cash-out benefits remaining, use the EBADJ (EBT Adjustment/Conversion) screen to convert the benefits. Issue a special paycheck using special pay reason code 5.

SNAP individuals

If the individual does not have an active card or valid PIN and has SNAP benefits remaining, issue a new card and have the individual select a PIN by phone. The card is to be mailed to the individual. The PIN is not to be mailed to the individual. The individual must remember the PIN they selected. The identity of the individual must be verified to the satisfaction of the card issuer.

Nonstandard living situations; EBT

Some individuals receive their SNAP benefits in nonstandard living situations. Some considerations that may not apply to individuals living independently include:

- The individual may designate an employee of the facility as their alternate payee, or the individual may choose to use their benefits for themselves.
- Facilities may use SNAP benefits through a POS device in the facility, through vouchers or by shopping at the store with cards. How this is done will be decided on a facility-by-facility basis depending on SNAP volume. The facility with a POS device can swipe the Oregon Trail Card and transfer SNAP benefits to the facility's account. Individuals in semi-independent living may shop for themselves and swipe the card at the store. In some instances, facilities with a smaller SNAP volume will use vouchers to transfer SNAP benefits. To have a POS device or use vouchers, the facility must be authorized by FNS as a retailer.
- When the facility accesses SNAP benefits, they should determine a prorated daily amount based on that individual's SNAP benefit, with the facility swiping the card weekly or biweekly based on the cost of meals for the week. Facilities not authorized as a retailer and that must shop with individual cards will need to use SNAP benefits carefully to ensure one-half of the benefits are left in the individual's account should they leave the facility before the 15th .
- The facility should ensure the individual has their card and the amount in their EBT account reflects the full balance the individual is entitled to receive. If the individual is entitled to any part of the EBT funds already deducted, the facility can process a SNAP purchase refund. This will debit the center's daily transactions and credit the individual's SNAP benefit account.

If an applicant is a resident of a Group Living Arrangement or Drug or Alcohol Treatment and Rehabilitation Program, click here for SNAP worker guides.

Group living arrangement as authorized representative

Residents who apply for SNAP through the facility's authorized representative must have eligibility determined as a one-person household unless they live with their child/ren under 22 years old. The facility must:

- Receive and spend the residents' SNAP benefit allotment for food to be prepared and served to the eligible residents, or
- Allow the residents to use any portion of their allotments on their own behalf; and
- Be knowledgeable about the residents' situation, the facility designated authorized representative is responsible to provide accurate information regarding the residents' situation.

The facility is liable for any overpayment resulting from failing to report and/or inaccurately reported information.

Rights of residents acting on their own behalf

When a resident applies and is certified on their own behalf, or designated an authorized representative of their own choice, the resident may:

- Use the SNAP benefits to purchase meals prepared and served by the facility, or
- Use any portion of SNAP benefits to purchase and prepare food for their own consumption

Drug and alcohol treatment and rehabilitation programs

Residents of a facility or treatment center that are participating in a drug and alcohol (D&A) treatment and rehabilitation program, may be eligible for SNAP benefits. To receive benefits the resident applies and is certified in accordance with OAR 461-115-0020, through the use of an authorized representative employed by the facility and designated for that purpose.

Not all facilities meet the requirements for their residents to receive SNAP. The facility must meet the following criteria:

- The drug and alcohol treatment and rehabilitation program is conducted by a private, nonprofit organization or institution, or a publicly operated community mental health center, under part B of title XIX of the Public Health Service Act to receive funds, even if it does not actually receive funding under part B of title XIX. (https://findtreatment.samhsa.gov/); or
- The treatment center or facility is an authorized retailer by FNS (https://www.fns.usda.gov/snap/retailer-locator); and
- Designate an employee to serve as authorized representative on behalf of residents.

Residents of approved facilities:

Residents of approved facilities or treatment centers may voluntarily apply for SNAP through the authorized representative at the facility.

The application process is as follows:

- The authorized rep for the facility must have an in-depth conversation with the resident so that they are knowledgeable about the resident's situation.
- The authorized rep submits the SNAP application on behalf of the resident. The resident must designate and sign the MSC 0231 and DHS 222 (MSC 0231 and DHS 222 embed) appointing the facility designated

employee as authorized representative for SNAP benefits.

- The resident can only apply for SNAP benefits with the assistance of the authorized representative designated by the facility.
- If the resident refuses to designate the facility as an authorized representative and sign the MSC 0231 and DHS 222, they are no longer eligible for SNAP since it is a requirement of the program to designate the facility as their authorized representative. The facility is not able to receive or apply for SNAP benefits for a resident without their knowledge and consent.

- Ensure timely notice or a signed 457D to remove the applicant from any existing SNAP cases and deactivate any cards currently issued to the applicant.
- Each resident is in a separate filing group and there is no need to determine how meals are purchased and prepared;
  - Only the resident and any child/ren under 22 years old also residing in the facility should be on the SNAP case.
  - Spouses and children may reside in the same facility or treatment center. In this circumstance, children under the age of 22 will need to be included in only one parents filing group. The authorized representative will need to discuss and determine with the residents which filing group the children should be included in.
- The AFS 222A (AFS 222A) is required to be updated and submitted monthly reporting the current residents in the facility receiving SNAP. If form is greater than 30 days old a new AFS 222A is required.
  - The DHS 222A (DHS 222A) must be on file at the local branch dated within 30 days.
- On FSMIS, add the facility name on the authorized rep line.
- Request a new EBT card.
  - The card should be issued to the facility as soon as the application/interview is completed.
    - » For instructions on how to designate the card for SNAP/Cash only please contact the SNAP policy unit to get the card updated
  - Do not require the authorized rep to give you an SSN to be added as the alternate payee.
  - The facility is allowed to take 50 percent of the EBT benefits on the first half of the month, and the remaining benefits on the 16th or after. The facility may not access or remove benefits from the resident's EBT card after they leave the facility.

Exit procedures:

The household is allowed sole access of any benefits remaining on the card at the time they left the facility. If the resident leaves before the 16th day of the month the facility must ensure that half of the household's monthly allotment is available to the individual. If the household leaves the facility on or after the 16th day of the month there is no requirement that the facility return any benefits already used.

The following are responsibilities when a resident exits the facilities:

1. The facility:
   (a) If possible, provide a change report form (DHS 853) when the resident exits the facility and advise them to

return the report form within 10 days to report new mailing address or any required changes.

(b) No longer act as an authorized representative for certification or for obtaining or using SNAP benefits.

(c) Notify the branch of the household's departure from the facility and provide a new address if available.

(d) When possible, provide the household with the EBT card.

i. Any EBT cards not returned to the resident must be returned to ODHS|OHA by the end of the month.

(e) When a card is received by the branch from a facility follow destruction of Oregon Trail Card process detailed here.

2. The Branch;

(a) Remove the authorized rep;

(b) Deactivate any returned EBT cards received from a facility and follows the destruction of Oregon Trail Card process detailed here.

(c) Verify the facility has not accessed any benefits after the date the household exited the facility.

(d) Take no additional action on the case during the certification period unless verified information is received or action is required based on the SNAP reporting system requirements.

Facility acting as an authorized representative reporting requirements and responsibilities

- The facility is responsible for reporting required changes.
- The facility is liable for any SNAP overpayments incurred while acting as authorized representative for a resident.

If there is reason to believe that a facility is misusing SNAP benefits and/or EBT cards in its procession contact SNAP Policy with facility and case information. Take no action against the facility, organization or institution before or after submitting report to SNAP policy.

Residents of ineligible facilities:

Residents of an ineligible facility may be eligible for SNAP if meals are separately and they have space to store their food.

If the resident does not purchase and prepare separately from other residents;

- Take action to close the case. Allow for timely closure of the case (10-day notice) unless a Voluntary Agreement to Take Action on Case (MSC 457D) form is submitted. When an MSC 457D is completed the closure can happen without 10-day notice.
- Cancel the EBT card immediately.

Direct deposit

Direct deposit, also called electronic fund transfer (EFT), is an issuance method for cash benefits (including SNAP cash-out). Direct deposit is not affected by EBT. Individuals with a bank checking or savings account may prefer to use direct deposit instead of EBT. There is a fee to withdraw EBT benefits from an ATM, but there is no fee to withdraw money from a personal bank account. Additionally, benefits issued by direct deposit are not subject to the

aging process, such as those issued to EBT accounts.

Individuals whose cash benefits are directly deposited into a bank account will remain in direct deposit unless changed by ODHS|OHA. Companion SNAP benefits will be issued by EBT, except for SNAP cash-out. Benefits direct deposited into bank accounts will not be displayed on EBT screens. Using direct deposit, individuals can have their benefits deposited directly into their checking or savings account. Direct deposit is available for CMS-issued benefits and reimbursement of cost-effective, employer-sponsored health insurance premiums payments (HIPP) and private health insurance (PHI) reimbursements. Special cash payments cannot be made via direct deposit. Direct deposit is also available for FSMIS-issued benefits only for SNAP cash-out individuals.

Benefits are replaced only if some problem with coding the case prevents direct deposit. Once ODHS|OHA transmits the electronic transfer to the individual's bank, credit union or savings and loan account, the benefits are considered the same as a check the individual has cashed.

How to sign up for direct deposit

The sign-up procedure for direct deposit is as follows:

- The branch will give a Request for Direct Deposit — A Safer, Easier Way to Put Your Benefits in Your Bank Account (AFS 7262) and a pre-addressed, postage-paid envelope to any new or ongoing individuals who want to sign up for direct deposit.
- Individuals who want to use direct deposit complete the AFS 7262 or take it to their financial institution.
- The bank, credit union or savings and loan enters the account number and routing number shown on the AFS 7262 and returns the form to the individual.
- The individual then returns the direct deposit authorization to the address on the form using the pre-addressed, postage-paid envelope.
- ODHS contracts with Wells Fargo to disburse payments through direct deposit. When Wells Fargo receives the account information, they send a pre-note to the individual's bank to ensure the account is open, and all information is accurate.
- When the individual's first direct deposit is successfully completed, a computer notice is sent to inform the individual. The notice is recorded in the individual notice file.

Direct deposit check redirects

Individuals receiving their cash benefits via direct deposit may get their benefits redirected, just like other individuals.

For CMS-issued benefits, the benefit redirect is processed using HLD1/HLD2. These checks are redirected to the branch. The hold may be generated by the worker or the system. All holds are listed on HLD2 (accessed via HLD1) and the List of Branch Held Checks report (WCM0120R-A) on ViewDirect.

Removing individuals from direct deposit

The direct deposit authorization becomes invalid when either of the following occurs:

- The direct deposit is rejected (e.g., the individual's account is closed, the payee changed or the CMS/SNAP

case is closed), or

- An individual indicates they no longer want to receive their benefits through direct deposit.

When the individual indicates they no longer want to receive benefits via direct deposit, contact CMU to make the change. When CMU closes the direct deposit record, the system sends a notice to confirm the change in issuance method.

Check registers and assistance summaries

CMS/CASH

Check registers and assistance summaries show the codes for cash payments. The indications of direct deposit issuances are:

- A DD beside the check amount under the heading DD,
  and
- A DD series of check numbers.

The assistance summary will show the electronic deposit as a regular CP with no direct deposit notation.

SNAP

Page 3 of FSUP and the Electronic Deposit Transaction Register report (WEB387X-B) on CA VIEW show the codes for SNAP cash-out benefits issued by direct deposit. The indication of direct deposit issuances is a two-digit release code (REL ATP) starting with a "D" (e.g., DG indicates direct deposit for a monthly batch issuance).

Rejected direct deposit

When an individual has direct deposit D and reports they did not receive a deposit because their bank account closes or their account number changes, the worker needs to take action to issue the monthly benefits.

Below is a summary of what to do:

- Call CMU (503-378-4369). CMU needs to know the individual closed their bank account, or their account number changed. CMU receives a notice when a direct deposit did not go through. It can take six to 10 days for the notice to get to CMU. A call from ODHS|OHA allows CMU to change the direct deposit status so ODHS|OHA does not try to make any further direct deposits to the closed account.
- When the worker is sure ODHS|OHA did not make a direct deposit, issue the individual a check. Use either the special cash pay process online or, if the worker decides the individual needs the money right away, issue the check through the revolving fund. In either case, use code 03 for CMS and code 81 for SNAP cash-out benefits.

This transaction will show on the MCR1 screen for CMS replacements and FSUP page 3 for SNAP cash-out replacements. If the individual wants to continue using direct deposit, they must complete a new Request for Direct Deposit — A Safer, Easier Way to Put Your Benefits in Your Bank Account (AFS 7262) and send it to CMU.

It is unnecessary to do a check replacement or go through the check replacement procedure. Because ODHS|OHA could not make an electronic deposit, the individual needs a check instead of the direct deposit.

Replacement checks for direct deposit benefits

To determine if an individual in direct deposit is entitled to a replacement check for CMS-issued benefits, look at the WCMI or UCMS screen to determine if the case is coded Y in the direct deposit field. The Y will be deleted if the direct deposit cannot be made.

- If direct deposit is not coded Y, check MCR1 to determine if cash payment was issued. If no special cash payment was issued, issue a replacement check. If a special cash payment check was issued but not received, issue a replacement using the check replacement procedure. Otherwise, do not issue replacement benefits.
- If direct deposit is coded Y, but the individual claims no deposit was made, contact CMU.

For SNAP-issued benefits, look at FSUP to see if Y displays in the direct deposit field and FSUP page 3 to determine whether and how the issuance was made.

- If a direct deposit issuance is indicated and BR also displays, check EBISH to see if the issuance was deposited into the EBT account.
- If a direct deposit issuance displays, there is no BR status indicated for that issuance and individual claims no deposit was made, contact CMU (503-378-4369).

JOBS Plus for TANF/SNAP companion cases

TANF participants may be placed in a JOBS Plus assignment up to six months (with a potential for extension) as part of their JOBS activity. JOBS Plus provides an incentive to participants and employers through subsidized employment in the public or private sector where the participant is placed on the employer's payroll and the family's TANF/SNAP benefits are suspended.

It is important for the participant to understand that SNAP benefits are diverted for the entire filing group. Although the case remains open, no issuance is made. If, for example, a minor parent living with her own parents and siblings is placed into a JOBS Plus worksite, no one in the filing group will receive SNAP benefits as long as the job continues.

The following actions should be taken to suspend payment of SNAP for TANF JOBS Plus participants:

- Send the Notice of Entering Job Opportunities and Basic Skills (JOBS) Plus Program (DHS 7874) explaining TANF and SNAP benefits will stop effective the end of the month in which the individual receives their first JOBS Plus paycheck.
- Using an ADJ transaction code, add the PL hold code, PLS HH Type and TANF GNT amount (before JOBS Plus started) to FSMIS effective the first of the month after the individual receives their first JOBS Plus paycheck.
- Extend the recert date (Expr Cert) to the month after the month in which the assignment is scheduled to end.
- Remove SNAP from SRS and convert to CRS.

To ensure TANF or SNAP participants do not incur a net loss of income because of participating in JOBS Plus, ODHS|OHA will mail to the participant a supplemental check for the portion of income that falls below their benefit equivalency.

TANF and SNAP benefits resume the first of the month after the JOBS Plus worksite assignment ends. To restore benefit issuance, remove the PLS HH Type and PL Hold codes. Use prospective eligibility and budgeting for ongoing months. There is no need for the individual to reapply unless the certification period is ending.

Other considerations for JOBS Plus individuals:

- JOBS Plus wages are excluded income.
- If the individual is hired as a direct employee and goes over income for TANF, transfer their SNAP case into TBA.

Legal status of benefit payments

Under Oregon law, cash benefits are not subject to assignment, transfer, garnishment, levy or execution, as long as they can be identified as program payments and are separate from other money in the individual's possession.

- A cash payment accrues to and becomes vested in the individual when issued.
- Except for EBT, consider a benefit issued if the check has been handed to the individual in a branch office or mailed to the individual. Consider a benefit issued and received by the individual when a direct check deposit is made to the individual's bank account.
- For EBT, consider benefits issued and received when an EBT card and personal identification number (PIN) have been issued in person to the individual, or the EBT card and PIN have been received by the individual in the mail, and the benefits have been deposited to the individual's EBT account.
- SNAP benefits in the EBT account remain available for individuals to access as long as the account is active. The EBT system removes them after three calendar months without activity. If there is no activity in 12 months on the account, the balance is expunged/gone.
- Cash benefits, including SNAP cash-out, are unrestricted and do not require accountability for individual expenditures or amounts. SNAP benefits are required by federal law to only be used for allowable food items.

Stores accepting SNAP benefits are required by federal law to restrict the usage to allowable food items.

Oregon Administrative Rule(s)

461-165-0010 — Legal Status of Benefit Payments

Concurrent and duplicate program benefits

Individuals cannot receive benefits of the same type (cash, medical, SNAP) for the same time period from Oregon.

The exceptions to this rule follow:

- An individual receiving TANF for themselves and their children may also receive ERDC for children who are in the household group but cannot be included in the TANF filing group.
- An individual may receive TA-DVS and cash payments from other programs for the same time period.
- A child who is an ERDC benefit group member may also be a member of the following benefit groups:
  - TANF benefit group when living with a non-needy caretaker relative, If the caretaker relative is not the parent

  - An OSIPM-AB benefit group
- SNAP individuals who leave a filing group that includes a person who abused them and enter a domestic violence shelter/safe home may receive SNAP benefits twice that month.
- A QMB individual may also receive medical benefits from OSIPM.
- An individual may receive Emergency Assistance and cash payments from other programs for the same time period.

Individuals cannot receive benefits of the same type (cash, medical, SNAP) for the same time period from Oregon and another state, except as follows:

- Medical benefits may be authorized for an eligible individual if an Oregon provider refuses to bill another state and the individual would not otherwise receive medical care. Accept the individual's statement as verification that a provider will not bill another state for needed medical services.

Applicants for SNAP from another state are not eligible in Oregon if they have already received their SNAP through EBT, even when they are unable to access the benefits. The state they left is responsible for issuing their SNAP benefits by a method they can use here.

If eligible, prorate benefits based on the application filing date unless the applicant is a migrant or seasonal farm worker.

Use the following procedure to determine if the individual received benefits from another state while receiving benefits in Oregon:

- Contact the other state to see if benefits were issued to the individual. See here for the statewide verifications of assistance.
- If benefits were issued, but then returned and canceled, that is proof the individual did not receive benefits from the other state.
- **For all programs except SNAP**, if benefits were issued but not returned and canceled, have the individual sign a statement that they did not receive benefits from the other state. If the other state says the benefit check was cashed, ask them to send a copy of the check to Oregon. Use the replacement check procedures to determine if the signature on the other state's check is the individuals. If it is, the individual is responsible for the overpayment.
- **For SNAP**, do not accept individual statements in any form as verification.

Oregon Administrative Rule(s)

461-165-0030 — Concurrent and Duplicate Program Benefits

Emergency payee; SNAP and TANF

An emergency payee may be appointed for an open SNAP case when all the adults in the filing group are deceased, incarcerated or have left the household with whereabouts unknown. ODHS|OHA will appoint an alternate payee for the adult acting as guardian. ODHS|OHA will issue them an EBT card and have them choose a PIN to access any remaining benefits. ODHS|OHA will send a timely notice to close the SNAP case. The guardian may apply for the children.

An emergency payee for ongoing TANF may be used when the dependent children are abandoned by the caretaker relative for reasons such as the caretaker relative dies or whereabouts are unknown, and there are no other relatives immediately available to be the children's caretaker. An emergency payee:

- May be used for up to two payment months
- Does not have to be related to the dependent child
- May not be used for initial payments.

An emergency payee may be included in the benefit group if all the following are true:

- They meet all eligibility requirements except relationship and cooperation with JOBS
- Their income and resources are counted, and
- There is no other caretaker relative in the benefit group.

When an emergency payee or alternate payee is named and benefits are issued via EBT, issue that person an EBT card; they must also select a PIN.

Payee and case names are changed during the 60-day emergency period. ODHSIOHA should use an authorized representative or alternate payee (if benefits issued via EBT) designated by the individual or a branch when the caretaker relative has not relinquished care, control and supervision of the children.

Oregon Administrative Rule(s)

461-165-0045 — Emergency Payee; TANF

Dual payee: when to use

For OSIPM and REF, a dual-payee check is used for protective payments if the benefit group has shown they are not able to properly manage benefits meant to meet their needs. The dual-payee check is issued in both the name of the individual and the name of the service provider.

TA-DVS checks are issued for shelter, moving costs, property taxes and home repairs as dual-payee or vendor checks. The supervisor or manager must authorize an exception to this policy in advance and only when necessary to prevent putting the individual at risk of harm.

To make sure a JOBS payment is used to meet a specific need, the branch office may write a special cash pay or dual-payee revolving fund check in the name of both the individual and the vendor.

Oregon Administrative Rule(s)

461-135-1230 — Benefits; TA-DVS
461-165-0050 — Dual Payee; When to Use

Prohibition against benefits in amounts less than $10

In the SNAP program, a benefit group is not eligible for benefits in the initial month if the allotment is less than $10. For ongoing months, SNAP benefits are issued as follows:

- An eligible, including categorically eligible, benefit group of one or two persons receives a minimum monthly allotment. See 5530 Income Standard form for current amount.
- An eligible benefit group of three or more persons receives the calculated allotment. A categorically eligible benefit group of three or more persons does not receive an allotment, but the case remains open with zero net allotment.

For TANF and REF, benefits should not be issued if the computed monthly benefit is less than $10. People who do not receive a cash payment because the monthly benefit is less than $10 may still be eligible for medical benefits. The $10 limitation does not apply to:

- Special payments, such as one-time special needs, emergency assistance, supplements or a benefit amount under $10 due to recovery of an overpayment
- Dual-payee payments made in money management cases if the monthly benefit amount is $10 or more (Issue the individual any remaining funds after the dual-payee payments are made.)
- Wage supplements issued to JOBS Plus participants.

Oregon Administrative Rule(s)

461-165-0060 — Minimum Benefit Amount; REF, SNAP, TANF

Immediate and advance issuance

Immediate issuance of benefits should be used for new, reopened and restored cases if the individual is eligible for a benefit and has emergent needs that must be met before a benefit can be issued through the automated computer system, or for SNAP, meets the criteria for expedited service.

Provide immediate issuance of benefits as follows:

- **For cash benefits**, issue by EBT using the EBT Immediate Cash Issue Screen (EBISH), revolving fund check or the special cash pay system.
- **For SNAP, except for SNAP cash-out** individuals who receive a check or direct deposit, issue by FSUP into the EBT account.
- **For SNAP cash-out** individuals who receive benefits by check or direct deposit, issue a revolving fund check (code 80).

Oregon Administrative Rule(s)

461-165-0070 — Immediate Issuance of Benefits

Method of delivery of benefits

Benefits are delivered several ways, depending on the program and individual situation. All mailed benefits should be sent to the individual's address. A rural route box number is acceptable as an individual address.

The following exceptions may apply on a case-by-case basis if directions to the home are included in the case record.

- A post office box number can be used if any of the following is true:
  - There is no mail service to the individual's home.
  - The individual lives in a nonstandard living arrangement.
  - There have been verified cases of benefits being stolen from home mailboxes in the individual's neighborhood.
- Use General Delivery only if it is the individual's sole means of mail receipt.

Oregon Administrative Rule(s)

461-165-0080 — Method for Delivery of Benefits

Alternate methods of delivery of non-EBT benefits

Non-EBT cash benefits should be redirected to the branch office if any of the following is true. The benefit group:

- Is unstable (i.e., moving constantly, and the branch needs to re-establish contact when there has been an unreported change of address)
- Has not cooperated in completing a QC review
- Must be contacted personally to obtain essential information that may affect eligibility or the correct computation of the benefit amount.

Additionally, if a SNAP cash-out individual receives a check for the value of their SNAP benefit because they are unable to adapt to EBT, direct deposit is not an option. If the individual has a history of theft from their mail or lives in an area that has been identified by branch staff or postal inspectors as high-risk for mail loss, they may receive their benefits redirected to a branch.

Issuance date of benefits

For all programs except the EA and SNAP programs:

- Date an authorized cash payment check on the first day of the payment period, or as soon as possible thereafter.
- Mail checks so they can be delivered to the individual on the first day of each month.

Exceptions are:

- Initial month benefits for new/reopened/restored cases
- If the first day of the month falls on Sunday or a holiday, mail the check in time for the individual to receive it on Saturday or the mail day preceding the holiday
- Checks redirected to a branch office may be released any time on the workday preceding a weekend or holiday.

Benefits issued by EBT should be available on the first day of each month, except for the following:

- Initial month benefits for new/reopened/restored
- SNAP benefits sent through staggered issuance.

SNAP benefits issued by EBT (except SNAP cash-out) are staggered based on the last digit of the ONE case number over the first nine calendar days of the month, except for the following:

- The benefits for the initial month of eligibility for a new or re-opened case
- The benefits for the seventh month of the certification period for a case in the semi-annual reporting system.

SNAP benefits issued through the SNAP cash-out are available as follows:

- Benefits are accessed through an EBT account are available on the first day of the month.
- Checks are mailed on the first day of the month.
- Direct deposit funds are available on the third working day of the month.

For SNAP changes that could not be made in time to adjust the monthly allotment, issue a supplement within 10 days of the date the change was reported.

Oregon Administrative Rule(s)

461-165-0100 — Issuance Date of Benefit

Exception to staggered issuance; SNAP

The second month's allotment of SNAP benefits is not subject to staggered issuance if the filing group applies after the 15th of the month and the application is not for a redetermination of eligibility. Once eligibility for SNAP benefits is established for these groups, benefits are issued as follows:

- If the SNAP case is opened by the last day of the initial month of eligibility, the computer will prorate benefits for the initial month and automatically issue benefits for the second month on the first of that month.
  or
- If the case is opened after the initial month of eligibility, the computer will prorate benefits for the initial month and will automatically issue benefits for the second month on the same day if the SNAP benefits are issued using a prior month issuance code.

Federal regulations require individuals who qualify for SNAP and apply after the 15th of the month to have their second month's benefits excluded from staggered issuance. The computer automatically issues the second month's benefits. If the second month's benefits are incorrectly calculated due to a change the branch could not act on, a supplemental payment may be made.

Oregon Administrative Rule(s)

461-165-0105 — Exception to Staggered Issuance; SNAP

Issuing expedited SNAP

To ensure SNAP expedited benefits are received by the seventh calendar day following the date of application, immediate issuance benefits should be authorized on the system by the seventh calendar day after the filing date.

When these benefit groups provide the pended items requiring verification, the second month's benefits should be issued:

- Within seven working days of receipt of the verification, or
- On the first of the month, whichever is later.

Benefits should be issued even if the report has not been received. The last month's report should be used to determine the benefit amount.

Applicants qualifying for expedited SNAP who apply on the first through the 15th of the month and do not supply complete verification are not eligible for the second month's benefits. FSMIS should be coded so the second month's benefits are not automatically issued.

Applicants qualifying for expedited SNAP who apply after the 15th of the month and do not supply complete verification are not eligible for the third month's benefits. When these benefit groups provide the postponed verification, benefits are issued according to regular staggered issuance procedures.

Alternatives to direct money payment

For OSIPM, REF and TANF, the alternative to direct money payment is protective payments when the goal is to ensure the benefits are used to meet basic needs.

For REF and TANF, protective payments may be made whenever individuals demonstrate such an inability to manage funds that ODHS\OHA determines their benefits are not being used in their best interest. Protective payments should be used particularly if mismanagement of funds, caused by repeated interruptions of TANF benefits, poses a threat to the health and safety of children in the household.

Protective payment methods include the following:

- Payments to authorized representatives
- Dual-payee payments
- Vendor payments.

If the branch is paying an individual's benefits by vendor payment, all money left over after the individual's bills are paid are to go to the individual. The branch may not retain leftover money.

For information on payment procedure for individuals in a hospital, see 461-165-0120.

Oregon Administrative Rule(s)

461-165-0110 — Alternatives to Direct Money Payment
461-165-0010 — Legal Status of Benefit Payments
461-165-0120 — Benefits in an Acute Care Hospital

Payment of benefits out of state

For all programs except the SNAP and HSD medical programs, send benefits out of state if individuals are absent from Oregon and they establish their intent to return within 60 days.

If individuals are detained out of state beyond 60 days for medical reasons, continued eligibility is determined, and the individual is required to provide documentation of the need to remain in the other state.

For medical benefits, out-of-state medical expenditures must have prior authorization.

For HSD medical programs, an individual can use their Oregon Medicaid/CHIP benefits in another state as long as they remain eligible and if the provider is willing to bill and is contracted with ODHS|OHA.

Refer out-of-state medical providers to DMAP for approval and copies of Oregon's fee schedule so they can accurately bill for medical services provided to the individual.

Advise people receiving medical assistance who are temporarily leaving Oregon that they will receive only emergency medical coverage while they are out of state. If the individual needs specific information, contact the "out-of-state" coordinator at OMAP.

Individuals who are enrolled with a CCO should contact their respective plan offices for information and/or authorization for out-of-state medical coverage.

In the SNAP program, benefits are not sent out of state.

Oregon Administrative Rule(s)

461-165-0130 — Payment of benefit out of state

Protective payment; general information

For OSIPM, REF and TANF, the alternative to direct money payment is protective payment and is part of case management. Additionally, **for REF and TANF**, protective payment should be discussed as part of case planning decisions around potential disqualifications to reduce the risk of harm to individuals and cannot continue for longer than 24 months.

For OSIPM and REF, use a dual-payee check for protective payments if the benefit group has shown they are not able to properly manage benefits meant to meet their needs. Issue the dual-payee check in both the name of the participant and the name of the service provider.

All protective payment plans should be reviewed monthly for REF and TANF and every six months for OSIPM cases. This review can be part of the redetermination of eligibility.

Protective payment methods include the following

- Payments to authorized representatives
- Dual-payee payments
- Vendor payments (money management).

If a participant's benefits are being vendor paid by ODHS|OHA, all money left over after the participant's bills are paid go directly to the participant.

Oregon Administrative Rule(s)

461-165-0120 — Benefits for a Client in an Acute Care Hospital
461-165-0110 — Alternatives to Direct Money Payment; OSIP, REF, TANF
461-165-0050 — Dual Payee; When to Use; OSIP, REF, TANF

Endorsement of benefits and benefits to survivors

The individual or the individual's payee must endorse checks issued in payment of a benefit. The endorsement on the check must be the same as the name appearing as payee.

The individual can endorse a check with a mark or thumbprint if duly witnessed by two people giving their full names and addresses.

The person with power of attorney may:

- Act as authorized representative or alternate payee
- Endorse and cash the benefit check as in the following example:

  John Doe (Recipient)
  by Richard Jones (Power of Attorney)

For all programs except SNAP, any cash benefit issued to individuals before their death is available to their survivors.

Checks may be endorsed in the name of the deceased beneficiary by the surviving spouse or next of kin, or by the administrator of their estate. Use the following procedure

- Before the next of kin endorses a check, the check must be presented to a branch office.
- Rubber-stamp the endorsement on the check only if it has been determined that the individual died on or after the first day of the period for which the payment was provided.
- The endorsement must show both the name of the deceased beneficiary and the name of the surviving spouse or next of kin, as well as the relationship of the endorser to the beneficiary.
- The person who endorses the check receives the proceeds of the benefit.

For cash benefits in an EBT account (except for SNAP cash-out), an adult survivor is designated as the alternate payee. The payee should be issued an EBT card and PIN to access the balance in the EBT account.

For SNAP, there is no survivor's right to benefits unless the survivor is independently entitled to benefits as a member of the benefit group. When the survivor is not in the benefit group:

- Ask them to return the non-negotiated SNAP cash-out checks to the branch.
- For SNAP benefits issued via EBT, cancel the remaining benefits from the EBT account.

When the only survivor(s) is a child, refer to policy on emergency payees.

Oregon Administrative Rule(s)

461-165-0140 — Endorsement and Survivorship of Benefits

SNAP cash-out project for SSI or seniors

When all members of a SNAP filing group are at least 65 years old or are SSI recipients and reside in Clackamas, Columbia, Multnomah or Washington counties, they receive their SNAP benefits through the "cash-out" program. This is called the SNAP Cash-Out project.

Individuals receiving SNAP Cash-Out must meet the same eligibility criteria as other SNAP participants. To receive their benefits using cash-out, each person in the filing group must be one of the following:

- Individuals living alone who are 65 years of age or older or have been determined eligible to receive SSI benefits under title XVI of the Social Security Act, or
- Individuals living together, all of whom are 65 years of age or older or have been determined eligible to receive SSI benefits under title XVI of the Social Security Act.

The SNAP Cash-Out benefits may be issued in one of three ways:

- EBT – SNAP benefits are issued as cash into an EBT account. These are accessed as cash transactions. For ongoing monthly issuances, these are available on the first day of each month. The staggered mail schedule used for EBT SNAP benefits is not used for EBT benefits in the SNAP Cash-Out project.
- Direct deposit (DD) – SNAP benefits are issued by direct deposit into their private bank or credit union account. For ongoing monthly issuances, these are available on the third bank day of the month.
- Check – SNAP benefits are issued by check and mailed to the individual. For ongoing monthly issuances, these are mailed on the first mail day of the month.

These SNAP Cash-Out benefits are cash benefits and, as such, may be used to purchase food and nonfood items and for cash withdrawals. When an individual's status changes from SNAP Cash-Out individual to a regular SNAP individual, the case manager must explain how this change will affect their benefits.

Cash-Out individuals may be exempted from EBT or direct deposit participation if, in the professional judgment of the case manager and supervisor, the SNAP Cash-Out individual has a medical or psychological condition (documented or not) that makes it very difficult for them to adapt to using an EBT card, and they do not have a bank account for direct deposit.

FSMIS has been modified to support the SNAP Cash-Out project. The computer program will use the case coding to determine if the individual is age 65 or older and/or receiving SSI. The branch cost center is used to determine if the individual lives in the cash-out area. There is no need to change the codes on FSMIS. The REL ATP code will be the same whether benefits are issued as EBT (cash) SNAP Cash-Out or EBT SNAP benefits. The two-character REL ATP code will be the same whether benefits are issued as EBT (cash) SNAP Cash-Out or EBT SNAP benefits. The two-character REL ATP code will start with a "D" if the case is direct deposit or "E" for EBT or Check. FSMIS automatically determines if the individual gets EBT SNAP Cash-Out or EBT SNAP benefits.

To issue using EBT

To use the EBT issuance method, code the case the same as all other SNAP cases. The individual must have an active EBT case and an EBT card. Normal ongoing issuances show up on FSUP page 3 with an EG.

To change a SNAP case from receiving cash-out checks to EBT, type S in the CHG Status field and press {F9} to save on the EBCAS screen.

To issue using direct deposit

To issue benefits using direct deposit, the individual must have an EBT case. The EBT case must have an A-active or S-sent/submitted code in the status field on EBCAS. When there is an active EBT case and an active enrollment record, the direct deposit enrollment flag (DD) on FSUP page 1 will be Y. For normal monthly issuances, the Rel ATP code on FSUP page 3 will be DG.

Enrollment in direct deposit

The individual must complete the Request For Direct Deposit – A Safer, Easier Way to Put Your Benefits in Your Bank Account form (AFS 7262). Send the completed form to the CMU Unit. The direct deposit enrollment record is created (submission code 1) and a pre-note is sent overnight to the bank. The enrollment record becomes active the next day.

Monthly issuances

During monthly processing, the system will check each SNAP Cash-Out case. If there is not a direct deposit account, the benefits will be sent to EBT.

Coding initial/exceptional issuances

To issue initial benefits or any exceptional benefits (supplements, retroactive, etc.) through direct deposit, use D in the left-hand digit of the Rel-ATP. The individual must have a direct deposit enrollment in active status (DD:Y) for you to use the D Rel-Code.

Direct deposit rejected

If the direct deposit could not be made, a notice is sent to ODHS Accounting, which forwards the information to CMU. CMU will contact the field office. The local office must determine the appropriate action. If the individual has an EBT card, they may use it to access their benefits. If the individual cannot use EBT to access their benefits, the local office can cancel the EBT benefit and issue a revolving fund or special paycheck. Use pay reason code 81-FS Cash-Out Replacement

To issue using a check

To issue using a check, the individual's EBT case status must be changed to T on the EBCAS screen. Normal ongoing issuances show up on FSUP page 3 with a CG.

To issue initial benefits or any exceptional benefits (supplements, retroactive, etc.) by check, use C in the left-hand digit of the Rel-ATP. The individual must have a T EBT case status for you to use the C Rel-Code.

Using a T code on EBCAS status cuts the EBT connection to E-Funds, and EBT information will no longer be

available. In order to complete transactions on untouched issuances on EBISH or to view financial EBT transactions completed prior to bypassing EBT, you will need to reconnect to EBT.

Issuance date of SNAP benefits

For ongoing months, SNAP benefits issued by EBT are issued based on the last digit of the case number over the first nine calendar days of the month. Those people receiving SNAP Cash-Out get their benefits on the first of the month.

Oregon Administrative Rule(s)

461-165-0100 — Issuance Date of Benefit

Other resources

Benefit Issuance QRG: Provides an overview of benefit issuance within the ONE system. Including benefit issuance methods per program, guidance on SNAP Cash Out, and direct deposit.

SNAP coupons returned to the branch

With the passage of the Food and Nutrition Act of 2008 (formerly known as the Farm Bill), Congress has de-obligated the old Food Stamp Coupons. Effective June 18, 2009, coupons can no longer be redeemed or returned.

Chapter 3:
Processes and procedures

Section 4: Individual loss and restoration of benefits

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Individual loss and restoration of benefits

Introduction

This section covers how to restore benefits to individuals. For program eligibility, please see other areas of this manual. The office procedures in this section do not apply to APD medical programs. For APD/AAA office procedures, please see the Field Staff Assistance Manual.

Non-negotiated check replacement procedures

Business.Security@dhsoha.state.or.us should be contacted for any questions. There are also the replacement check policy and procedures online at OFS Forgery section on SharePoint – FBPM has Financial Clerk Support.

Original CMS or special cash pay (SPL) check not negotiated process:

- First, the agency uses MCR1, RCIQ or the branch office's check register to verify an original check was issued. Verify the payee name, check number, amount and date of the check.
- The branch has the payee complete an Affidavit Concerning Lost Check (DHS 0138A). The payee must fill out every section, except payment alert number. When the payee signs the form, it must be notarized.
- The branch calls Forgery Services (in the ODHS General Accounting Unit) and gives them the information needed to complete a Request for a Payment Alert and Follow-Up (DHS 0435A) (paper only).
- Payroll assigns a Payment Alert number to be written in the designated area of the DHS 0138A.
- The worker writes the payment alert number on the DHS 0138A and forwards the original to Forgery Services.

The branch can issue a replacement check by computer or by revolving fund (for emergent needs). The procedures are described below:

To replace a check by computer:

- If the individual did not receive the check, wait five mailing days from the date it was issued before issuing a replacement.
- If the check was lost, stolen or destroyed but not endorsed, issue a replacement check without a waiting period.
- If the payee endorsed the check before it was lost, stolen or destroyed, issue a replacement only if the remnants of the check are provided as evidence, or the check was noted by the payee for deposit only.
- • To issue the replacement check, complete an Authorization of Cash Payment (MSC 0437) using pay reason code 03. Refer to the reverse side of the MSC 0437 for more information. The computer will generate a check, and it will be mailed to the payee.

To replace a check by revolving fund (for emergent needs):

- Write the replacement check number on the MSC 0437 (Authorization of Cash Payment) and the DHS 0138A.

When original child care provider check from PP/SA is not negotiated:

- Only DPU may replace child care provider checks issued by PP/SA. Branch offices are not authorized to replace provider checks issued by PP/SA.

There are two reasons why the branch should never replace a provider check issued by PP/SA:

- When a provider has multiple claims paid all on one check, each claim must be manually adjusted to reconcile the payment record.
  and
- If the branch and DPU both replace provider checks, it is very likely there could be duplicate payments on the same claim.

If the provider contacts SSP with a request for a replacement check, SSP will advise the provider to call DPU. The provider must wait at least five mailing days from the date the check was issued before requesting a replacement check.

After receiving a request for a replacement check, DPU will contact Forgery Services and give them the information needed to complete a DHS 0435A (paper only).

DPU will notify the local branch office that the provider will come in to complete the DHS 0138A. The local branch office will obtain the payment alert number from Forgery Services, assist the provider in completing the DHS 0138A, notarize the form and send to General Accounting, Forgery Services. Forgery Services will make a replacement decision and notify DPU; DPU will replace the check and mail it to the provider.

If the provider wants a replacement check right away, DPU will make a determination of emergent need and contact the branch for issuance of payment.

Criteria DPU will use to determine emergent need:

- The payment is at least $100, and
- The provider is in a crisis (in jeopardy of losing housing, utilities or vehicle use). Proof of crisis is required. Documents can be supplied through the branch or faxed to DPU, or
- SSP has made an error causing a financial hardship for the provider by an undue delay in payment through no fault of the provider.

SNAP cash-out checks not negotiated:

Should any SNAP cash-out individuals be unable to adapt to EBT and are instead issued a check, these are the two methods for replacing SNAP cash-out checks:

When the individual needs a replacement right away, use the following procedure:

- The branch completes the top portion of the DHS 0138A using information from FSMIS.
- The branch gives the DHS 0138A to the payee. When the payee signs the form, it must be notarized.
- The branch calls Forgery Services and gives them the information needed to complete a DHS 0435A (paper only).
- Forgery Services assigns a payment alert number to be written in the designated area of the DHS 0138A.
- The branch writes the payment alert number on the DHS 0138A and forwards the original to Forgery

Services.

- The branch types a revolving fund check and codes it “SNAP 81.”
- The payment information is entered on SPL5 as a SNAP load sheet.

If the individual does not need a replacement right away, use the computer, using “RB” release ATP code.

Administrative checks not negotiated:

Have the payee complete a DHS 0138A. After the payee signs the form, it must be notarized.

- Forward the DHS 0138A to Forgery Services.
- Forgery Services will complete the necessary paperwork and issue a replacement check to the payee.

Restoring benefits

Restoration or supplemental payment of benefits should be authorized even if the benefit group is currently ineligible, if a benefit group received fewer benefits than it was entitled to because of any of the following:

- A change that would cause an increase in benefits was reported before the first of the payment month, but too late for the branch to adjust the next payment.
- The branch caused an administrative underpayment. Administrative underpayments include, but are not limited to, the following:
  - Failing to take action on information reported, e.g., not canceling the EBT card of alternate payees who leave the household.
  - Using an incorrect effective date.
  - Denying, closing or reducing benefits in error.
  - Failure to send the individual a required (or appropriate) decision notice when benefits were closed or reduced.
  - Making calculation errors.
- An individual is entitled to a restoration of lost benefits if:
  - The branch was directed to restore benefits in a hearing or a court order decision.
  - ODHS|OHA withheld too much when collecting an overpayment.
- The amount restored is issued in addition to the benefits a currently eligible group is entitled to receive. For SNAP, the branch office must honor reasonable requests by benefit groups to restore benefits in monthly installments.
- A benefit group that moves from the state can still receive any restoration of benefits due it.
- Restoration of benefits is limited to the extent provided in Effective Dates; Restored Benefits (OAR 461-180-0130).

SNAP individuals may only have benefits restored or supplemented when ODHS|OHA made an error that caused the household to get fewer benefits than it was entitled to receive.

If an individual notifies the office that a member of the filing group has left the household, the branch is to cancel

any EBT card the member who left the household may have. If the office fails to cancel the card, this is an administrative error and the benefits used by the person who left must be restored to the filing group.

Oregon Administrative Rule(s)

461-165-0200 — Restoring Benefits

Calculating restored or lost benefits

Calculate the amount of benefits to restore using the following process:

- Determine the effective date the benefit group is eligible for lost benefits. The benefit group is not eligible for restored benefits any month eligibility for those benefits cannot be established. Give the benefit group an opportunity to prove eligibility for questionable months.
- Calculate the correct benefit amount for the months the benefit group was underpaid, closed or denied in error.
- Subtract the amount the benefit group actually received from the amount they should have received.
- Prior to issuing lost retroactive benefits, review overpayment records for any outstanding overpayment balance in the program in which the overpayment occurred. When an overpayment balance exits, reduce the amount of retroactive benefits otherwise payable to the individual by subtracting the amount of the outstanding overpayment balance.

When an overpayment exists, complete the Notice of Restoration of Benefits (DHS 0362) and send a copy to the Overpayment Recovery Unit for the retroactive payment to be credited to the overpayment. This form serves as the individual's notice of restoration of benefits.

Benefits are restored to the group containing the largest number of people who were benefit group members at the time the loss occurred. If the location of this group is unknown, restore benefits to the benefit group containing the primary person at the time the loss occurred. Restorations are limited to the most recent 12-month period for all programs except JPI. JPI may be restored only for the four preceding months.

Click here for Overpayments.

Oregon Administrative Rule(s)

461-165-0210 — Calculating Restored and Supplemental Benefits
461-195-0551 — Methods of Recovering Overpayments
461-180-0130 — Effective Dates; Restored Benefits

Replacing benefits

Lost, stolen or undelivered checks:

Payment alert procedures begin when a payee reports a check was lost, stolen, destroyed or not received and completes an Affidavit Concerning Lost Check (DHS 138A).

A replacement check should be issued if the original check is still outstanding and the payee claims any of the

following:

- The original check was not received. Allow five postal service working days from the date the original check was issued before issuing a replacement.
- The original check was received but not endorsed. Issue a replacement check without a waiting period if the unendorsed check was received and has been lost, stolen or destroyed.
- The original check was received and endorsed but not cashed before it was lost, stolen or destroyed. Issue a replacement check if the check was destroyed and remnants of the check are provided as evidence or if the check was noted by the payee "for deposit only."

A dual-payee check should be replaced only if:

- The individual completes an affidavit that the unendorsed check has been lost, destroyed or stolen, or
- The individual has endorsed the check and the second party completes

A replacement should be issued for an original check (which the payee has reported as lost, stolen, destroyed or not received) processed by the state treasurer for payment only after:

- The Business Security Unit has begun forgery procedures, and
- The individual has completed a forgery packet.

The written report by the Oregon State Police on the handwriting analysis of the check signature is binding on SSP. The payee has the right to prove the analysis incorrect.

Replacement checks cannot be issued in either of the following situations:

- The individual fraudulently cashes a dual-payee check without the second party's signature. The second party can take civil action against the individual to recover the money, but the branch office does not replace the check to the second party.
- A check has been direct deposited to the account specified by the individual.

Negotiated check replacement procedures

Benefits issued via EBT should not be replaced when:

- Benefits are considered to be issued and received because the card and PIN have been issued in person to the individual and the benefits have been deposited to the individual's account
- EBT benefits were issued by a state other than Oregon, they may be redeemed in Oregon.

Benefits issued via EBT are replaced under the following circumstances:

- EBT benefits accessed by the wrong person because ODHS inadvertently switched cards and issued a card and PIN to someone unrelated to that case or failed to cancel an EBT card when removing an alternate payee from a case. When reported by the individual, deactivate the card issued to the wrong individual, issue a card and PIN to the correct individual and replace the amount of lost benefits.

For SNAP, replace the value of food purchased with SNAP program benefits destroyed by a verified household misfortune (e.g., a fire or loss of electricity) or disaster (e.g., a flood or earthquake). The branch must replace the value of food destroyed within 10 calendar days if the filing group:

- Reports the loss of food within 10 days of occurrence
- Submits a signed statement or affidavit attesting to the loss within 10 days of reporting the loss.

When replacing the benefits, do not exceed one month's allotment unless it includes restored benefits that will be replaced up to the full value of the restored benefits.

Issue a timely replacement of the value of the loss within ten days after the filing group reported the loss or within two working days of receiving a signed statement or affidavit.

If the U.S. Department of Agriculture has issued a disaster declaration and the household is otherwise eligible for emergency SNAP benefits, the household cannot receive both disaster benefits and benefits to replace the value of lost food.

Click here for examples: Negotiated check replacement procedures.

Oregon Administrative Rule(s)

461-165-0230 — Replacing SNAP Program Benefits and EBT Cards

Other resources

SNAP Replacement Benefits *includes screenshots: SNAP Replacement benefits are often confused with Disaster SNAP benefits. This QRG clarifies the differences between the two and demonstrates how to issue Replacement Benefits in ONE.

Subsequent action on payment alerts

Business Security/Forgery Services will follow up on all payment alerts and close the check file if the original check is not paid/canceled within 60 days.

If the original check is returned to the branch office or DPU, the branch (DPU, if the check was originally issued by them) will verify whether a replacement check has been issued:

- If a payment alert and replacement have been issued, send the original check to the Business Security/Forgery Services for cancellation.
- If no payment alert or replacement has been issued, attempt to deliver the check to the payee. Send the original check to Business Security/Forgery Services for cancellation if it cannot be delivered to the individual or provider.

Notify Business Security/Forgery Services immediately if:

- The original check is given to the payee after a payment alert has been called in
- A replacement check is issued after the DHS 0138A and the payment alert have been processed stating, "No replacement will be issued"
  or
- Any business calls or writes to the branch about checks returned to them from the Office of the State Treasurer.

Replacement of benefits due to a disaster or household misfortune

SNAP benefits may be replaced when the food purchased with SNAP benefits has been spoiled or destroyed in a disaster or household misfortune (e.g., due to fire, flood or loss of electricity). Please see transmittal SS-IM-19-004 and form DHS 0349D (Affidavit of Loss of Food Purchased with SNAP Benefits Due to a Disaster).

The following should be considered when a household reports a loss and asks for a replacement:

- The filing group must have been receiving SNAP when the misfortune occurred.
- The filing group must report the loss within 10 days of the occurrence either orally or in writing.
- The filing group must submit a signed statement attesting to the loss.
  - The statement must include a detailed list including the cost of food destroyed or lost.
  - The statement must be received by SSP within 10 days of the date the loss was reported to SSP. If the 10th day falls on a weekend or holiday and the statement is received the first workday after the weekend or holiday, SSP will consider the statement received on time.

The disaster's or misfortune's occurrence should be verified, and:

- If the household has not supplied proof of the misfortune when requesting the replacement, ODHS should send a Notice of Information or Verification Needed (DHS 0210A) or verify with a call to a collateral contact.
- Verification must be received within 10 days of the report of the loss to the agency. If the 10th day following the report of loss falls on a weekend or holiday, any verification received on the next workday thereafter will be considered received on time.
- ODHS will not replace the full SNAP allotment for the month. Instead, staff should determine the amount to be replaced. The replacement is only for the value of the food purchased with SNAP benefits and lost due to the misfortune. The replacement cannot exceed a one-month SNAP allotment for the filing group.
- The replacement should be issued no later than the 10th day following the date the loss was reported to the agency or within two days of receiving the items needed to process the request, whichever is later.
- It is important for staff to carefully narrate the situation and decisions to show this is a replacement and not a duplicate issuance. It is important to include in the narration the date of the event, the date of the loss and the date the loss was reported to the agency.
- If the replacement is denied, a denial notice should be issued.

Verification that the misfortune exists can be proof the filing group resides in a power outage area, the national disaster area, flood area, etc. If the spoilage occurred due to a misfortune such as loss of power to the filing group's residence only, the verification may include statements from repair persons or the local utility company.

After determining the cause of the food loss, ODHS should ask the filing group where the food was located when it was spoiled (e.g., cupboard, refrigerator or freezer). Staff should determine if the amount of food spoiled is a reasonable amount based on the situation.

For example, refrigerated food will last about 24 hours without electricity. Food kept in a freezer will last about 48 hours and maybe longer if the freezer is kept closed and it is full. Also, if the disaster happened at the start of the

month, did they just get their SNAP benefits and spend them on a full month's worth of food, or is it the end of the month and they have very little food left from the month?

Once it has been determined food was spoiled or lost due to a valid disaster or misfortune, the replacement should be issued using the ISS transaction code and an IH or EH issuance code. Code the actual dollars being issued (replaced) and the current month's date.

Issuing the Oregon Trail Card when the individual cannot be present

Sometimes an individual or their alternate payee cannot come to the office to get their EBT card or their PIN. Under no circumstances should a PIN ever be released to another person (even if in the same filing group).

Chapter 3:
Processes and procedures

Section 5: Program integrity

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Program integrity

Introduction

Many aspects of ODHS|OHA programs are not covered in basic eligibility and benefit determination. These are a part of a greater entity called "program integrity," which includes such categories as definitions, confidentiality, overpayments, hearings, Direct Pay Unit, Background Check Unit, Job Participation Incentives, quality control, and participant rights and responsibilities. This area of the manual may be updated as needed with program changes.

Other resources

Crisis Response: Covers helpful tips and best practices for managers and workers when crisis situations arise

Confidentiality

ODHS|OHA works with many types of information. It is critical this information is kept confidentially and not shared with outside entities or individuals. This information is kept confidential by permanent and temporary employees, as well as volunteers or contractors of all ODHS|OHA programs who either work at a local office or have access to any ODHS|OHA database, case management software or email access for the state.

The intent of confidentiality policies are as follows:

- To preserve the confidentiality and privacy of individual and family information,
- To work together with partners, other agencies and the individual for the benefit of the individual, and
- To summarize how information about individuals may be used and disclosed, consistent with confidentiality requirements.

Confidentiality is presumed. All information that identifies an individual is considered confidential. ODHS|OHA's expectations are that employees, volunteers and contractors covered by this policy may not release or disclose individual information, except as specifically authorized by the individual in writing, by statute or administrative rule, or as ordered by a court. This means that in responding to questions about an individual, staff must not even identify the person as being served by ODHS|OHA. This policy summarizes the situations in which use and disclosure is permitted.

A signed Authorization for Disclosure, Sharing and Use of Individual Information (MSC 3010)) form from the individual is needed if there is any question regarding whether a release of information is required. The request should honor and respect the choice and dignity of families, not an impediment to providing services.

ODHS|OHA employees who violate ODHS|OHA policies and procedures regarding the safeguarding of information about an individual are subject to disciplinary action up to and including dismissal, as well as legal action by the individual. ODHS|OHA employees who knowingly and willfully violate state and federal law for improper use or disclosure of information about an individual are subject to criminal and civil penalties.

Staff must make reasonable efforts to limit the individual information they are using, requesting or disclosing to the minimum necessary in the particular situation. This requirement does not apply to:

- Disclosures or requests by a health care provider for treatment

- Disclosures made to the individual about their own protected information
- Uses or disclosures authorized by the individual that are within the scope of the authorization, or
- Disclosures required by law.

The minimum necessary standard should be considered at the time the staff member and individual are mutually completing a written Authorization for Use and Disclosure of Individual Information (MSC 3010).

ODHS|OHA staff may submit questions regarding ODHS|OHA Privacy Policies and the MSC 3010 authorization form to DHS.PrivacyHelp@dhsoha.state.or.us . This email address can be found in the Outlook address book. The Privacy Program phone number is 503-945-5780.

The MSC 2090, Notice of Privacy Practices, describes how medical information about applicants and participants may be used and disclosed and how they can get access to this information. The notice is required to be given at the time of application, and is a required posting in all ODHS|AAA offices.

Situations in which a written authorization is not required

There are a number of instances in which federal and state law and rule allow information about an individual to be used and disclosed without written authorization and, as necessary, to administer ODHS|OHA programs (including Title XIX). These include the following situations:

- When the information is health or treatment information (but not HIV or substance abuse treatment information) and is being released for the purposes of treatment, payment or health care operations (The minimum necessary standard applies to releases for purposes of payment or health care operations.)
  - Health care operations include such activities as quality assessment and treatment improvement functions, reviewing the competence of health care providers and auditing functions.
- When the information being released is non-health information necessary to carry out the intent of an assistance or service program connected with or operated by ODHS|OHA or the designated agency. When the information is non-health information and is being released to an ODHS|OHA contractor in order to administer programs.
- When a family member is a relative foster care provider or a homecare worker and information shared relates to care needs. Note: authorization is required to provide any specific information if family member is not care giver.
- When the information being released is about a specific individual and is being released to that individual (This exception means participants have access to their own information without signing an authorization.)
- When the information is non-health information and is being released to an Oregon attorney who represents that individual if both of the following requirements are met:
  - The attorney states they are currently representing the individual and
  - The attorney states the individual has authorized disclosure of the individual's information to the attorney
- When using de-identified information (limited data sets)
- When exchanging non-health, non-treatment information with other governmental or private, nonprofit agencies, if necessary to assist applicants or recipients of public assistance to access and receive other governmental or private, nonprofit services that will benefit or serve the applicant or recipient (This exception

includes instances in which an ODHS|OHA staff member is in a position to advocate for an individual without disclosing health or treatment information. Nevertheless, reasonable efforts must be made to obtain the applicant or recipient's authorization in advance.)

- To report suspected abuse of a child or an adult (elder abuse, or abuse of a person with a mental illness or developmental disability)
  - Substance abuse treatment information may be disclosed to Child Welfare, if necessary, in order to make an initial report of suspected abuse of a child. Any subsequent disclosure of substance abuse information would require a court order or written authorization by the individual.
  - Substance abuse treatment information may not be disclosed without authorization in order to report suspected elder abuse or abuse of a person with a mental illness or developmental disability. If it is necessary to make a report without authorization, the report must be made without revealing a person is in substance abuse treatment or has a substance abuse problem.
  - Mental health records are not required to be part of mandatory reporting for suspected child abuse, elder abuse or abuse of a person with a mental illness or developmental disability. Release of mental health records requires a court order or the individual's written authorization.
- To conduct any investigation, prosecution or criminal or civil proceeding in connection with administering ODHS|OHA programs, or for any legally authorized audit or review by a governmental entity in relation to administering ODHS|OHA programs
- To the extent needed to provide emergency medical treatment (this includes substance abuse treatment or mental health treatment)
- When ODHS|OHA believes in good faith the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the report is to a person reasonably able to prevent or lessen the threat, including the target of the threat (e.g., if ODHS|OHA believes a person to be suicidal, information may be released without authorization to a mental health provider), or
- When ODHS|OHA has a court order signed by a judge.

Click here for a flowchart outlining the exceptions.

Use of information within ODHS|OHA

Information can be shared for the purposes of program use and cross-program use without needing written authorization.

Program use refers to the sharing of individual information within ODHS|OHA programs or the sharing of information between program staff and administrative staff that support or oversee the program, such as the exchange of information between an eligibility worker and the Overpayment Writing Unit. Program use of information is permitted without a written authorization from the individual, but it is subject to the minimum necessary standard.

Cross-program use refers to the sharing of information about a participant with another ODHS|OHA program, such as Child Welfare or Vocational Rehabilitation. The following circumstances would allow sharing of information without an individual's written authorization:

- As needed to determine eligibility and/or to coordinate services or benefits

- The disclosure is intended to benefit the individual or to assist the individual in accessing other services
- For mandatory reporting of child or elder abuse, or
- Self-Sufficiency is a member of the local county multi-disciplinary child abuse team as statutorily defined; the information shared is necessary for the prevention, investigation and treatment of child abuse.

While ODHS|OHA strives to work together with other program areas to better serve individuals, at times ODHS|OHA may be limited by federal and state laws in sharing individual information across programs without a written authorization. Unless sharing information is for a purpose described above, an authorization will generally be required. For other types of information in the absence of written authorization, the permissibility of cross-program use of information (within ODHS|OHA) depends on the intended use of the information.

Disclosure of information outside ODHS|OHA

In general, individual information may not be used or disclosed without individual authorization for purposes other than those related to the administration of ODHS|OHA programs. However, non-health information may be disclosed to other governmental or private nonprofit agencies, if necessary, to assist applicants or recipients of public assistance to access and receive other services that will benefit or serve the applicant or recipient. Reasonable efforts must be made to obtain the applicant's or recipient's authorization in advance; however, ODHS|OHA applications for benefits do inform individuals that ODHS|OHA may verify what is reported. Health and treatment information cannot be shared without a release of information for most programs.

Release of information chart

Entity ODHS|OHA is sharing information with	When a release is not needed	When a release is needed
State and federal agencies	Subject to the minimum necessary standard, participant information may be disclosed without a written authorization to state and federal agencies which administer federally funded programs that provide administrative support or oversight to the ODHS|OHA program whose information is being disclosed. No authorization is required to provide sufficient information to accomplish a referral on behalf of an individual.	Authorization is required if an agency requests any information that does not directly relate to the specific agency program in which the individual is involved.

Substance abuse providers and mental health providers, managed care plans and health providers	No authorization is required to provide sufficient information to accomplish a referral on behalf of an individual; reasonable efforts to obtain an authorization must be made. No authorization is required to provide information necessary for activities related to payment, including billing and collection.	An authorization is required to share information about substance abuse treatment and HIV for purposes of treatment. An authorization is not required to share other information for treatment purposes. An authorization is required to receive or provide information for purposes other than treatment, referral and payment.
Social Security Administration (SSA)	No authorization is required to report suspected fraud or abuse to SSA	All other situations
Medical transportation	No authorization is required to provide sufficient information to accomplish a referral on behalf of an individual or to obtain the appropriate level of care during transportation. No authorization is required to provide information necessary for activities related to payment, including billing and collection.	All other situations
Non-medical transportation	No authorization is required to provide sufficient non-health information to accomplish a referral on behalf of an individual. No authorization is required to provide information necessary for activities related to payment, including billing and collection.	All other situations
Child care providers	No authorization is required to release to the individual's child care provider(s): the program for which the individual is eligible, the amount of the ODHS|OHA child care payment, the individual's copayment amount, or reasons for a delay in payment. **Information should not be shared other than what is specific to the delay**.	All other situations
Housing	No authorization is required to provide non-health information to accomplish a referral on behalf of an individual. No authorization is required to provide information necessary for activities related to payment, including billing and collection	All other situations
Employers	No authorization is required to disclose the minimum necessary information when needed to verify questionable information reported by the individual.	All other situations

Law enforcement	No authorization is required when law enforcement is involved in carrying out public assistance laws, investigating proceedings connected with administering ODHS|OHA's benefit programs or reporting a crime related to abuse. No authorization is required when an ODHS|OHA staff member is disclosing personal knowledge about an individual that does not come from the interaction by the individual with ODHS|OHA.	**For all programs except medical**, ODHS|OHA may release the participant's address, Social Security number and photo (if available) to a law enforcement officer without an authorization if the law enforcement officer makes the request in the course of official duty, supplies the person's name and states the individual: • Is a fugitive felon (someone fleeing to avoid prosecution or custody for a crime, or an attempt to commit a crime that would be classified as a felony or is violating parole or probation), or • For all programs except SNAP, has information necessary for the officer to conduct official duties of the officer and the location or apprehension of the individual is within the officer's official duties. For individuals only in the SNAP program, has information necessary to conduct an official investigation of a fugitive felon or someone violating parole or probation. If domestic violence has been identified in the household, information about a survivor of domestic violence should not be released unless a member of the household is wanted as a fugitive felon or is violating probation or parole. **For all programs**, an authorization is required to provide other participant-specific information to a law enforcement officer. This requirement includes when a law enforcement officer is requesting information about the owner of an EBT card. ODHS|OHA cannot release EBT information regarding the owner of the card to anyone, even an arresting officer. ODHS|OHA may take information from the officer regarding the card, including the number of the card, in order to take the necessary steps internally to correct the situation.
Insurance companies	No situations	All situations

Public and elected officials	Except for Social Security numbers, health, treatment and domestic violence information, no authorization is required to provide the minimum necessary information in response to a staff member in the office of a member of the Oregon Legislature or U.S. Congress who has received a complaint from an individual and the program responding is provided with a copy of the written complaint.	Oral authorization is required if an ODHS|OHA worker is contacted by a staff member in the office of a member of the Oregon Legislature or U.S. Congress who has received only an oral complaint. The ODHS|OHA worker will confirm with the participant that the worker may speak with the staff member regarding the participant. Confirmation from the participant should be documented in the participant's file.
Other interested persons (friends, neighbors, etc.)	If other interested persons are present while the participant is disclosing information about themselves, obtain the participant's verbal consent to continue confidential conversation with that person present. Written authorization is not needed.	An authorization is required if the worker is disclosing any participant-specific information while other interested persons are present.
Research	No situations	Disclosure or review of ODHS|OHA records for research purposes is prohibited unless the designated ODHS|OHA executive manager to approve research requests has authorized the specific person or organization and their research subject. For situations not covered here, contact Central Office.
Foster care and adoption assistance	For all programs except SNAP, no authorization is required to disclose information for purposes directly connected with foster care and adoption assistance under title IV-E of the Social Security Act.	All other situations
Individual request for their own information	No authorization is required to disclose information to the individual themselves.	Not applicable
Guardians	No authorization is required for that subject matter/information over which the guardian has authority. The guardian has the same access to the participant file as the participant in those areas. A guardian with full powers would have access to the entire file.	If unclear, ODHS|OHA may ask to see the order of court appointment.

Legal services (private attorney or Legal Aid)	Individual information, other than health or treatment information, may be disclosed without a written authorization to an Oregon attorney who represents that individual if both of the following requirements are met: • The attorney states they currently are representing the individual, and • The attorney states the individual has authorized disclosure of the individual information to the attorney.	All other situations

Redaction of information disclosed to individuals, representatives and family members

An individual's records are subject to redaction prior to disclosure or access; this means the information is deleted or omitted to better protect individual privacy. Records often include information pertaining to other individuals, so this information must also be redacted. Redaction is first done by copying the original record, blacking out necessary information with permanent black marker and finally creating a new copy of the record so the obsoleted information is no longer accessible.

In most cases, the following information needs to be redacted:

- Names, Social Security numbers, dates of birth, addresses and phone numbers of all third parties (those not included in the filing group)
- Social Security numbers, dates of birth and other personally identifiable information for other individuals on the case, including spouse or partner
- All substance abuse treatment records pertaining to someone other than the individual
- All medical, mental health and Vocational Rehabilitation records pertaining to someone other than the individual
- Any records pertaining to domestic violence
- Information that could cause harm to the individual or to another person.

If information requested is being withheld, ODHS|OHA will indicate the general nature of the document or information withheld.

While parents may have access to personally identifiable information regarding their minor children on their own case, minimum necessary standards should still be considered. Minors age 14 and older have the right to confidential mental health as well as substance abuse treatment.

Individual requests for their own information

ODHS|OHA participants have a right to access their own records, which include mental health or medical information and reports, subject to certain limitations as outlined in 461-105-0060(6) and in the Privacy Rights Policy AS-100-02. If ODHS|OHA denies access because of a good-faith belief that a disclosure could cause harm to

the individual or another person, the decision to deny must be made by a licensed health care professional or other designated staff; ODHS|OHA must make a review of this denial available to the individual. If the individual wishes to have this denial reviewed, the review must be done by a licensed health care professional who was not involved in the original decision.

When an individual, or person or entity to which they have given written authorization, requests access to their own case record, use the DHS 2093, Access to Records Request Form. Except for HIV information, case record information may be requested by the individual and released to the individual by telephone if the individual can verify their identity. If the individual is requesting physical copies of case record information, an ODHS|OHA staff member must be present while the individual or authorized representative has access to original copies of the case record.

An individual does not need to complete a release of information form to access their own records.

In response to individual requests for verification of benefits received, the Supplemental Nutrition Assistance Program (SNAP) Benefit Verification Letter (DHS 0839) or the Notice of Income and Benefit Calculation (DHS 7294) should be used for most purposes. If these options do not meet the need, ODHS|OHA screen prints can be used as an alternative (FSMIS, WISH, etc.). However, ODHS|OHA does not have the authority to and should never print or disclose screens from other agencies, such as the Social Security Administration, Employment Department, SAVE (Systemic Non-citizen Verification for Entitlements program).

All ODHS|OHA screen prints must be redacted as earlier outlined.

Disclosure of individual information to family members

ODHS|OHA is generally required to make the minimum necessary information in the case record available to a family member if the family member is a member of the filing group or is authorized by a member of the filing group. This minimum necessary standard does not allow sharing of personally identifying information (such as Social Security number or date of birth), substance abuse information, medical or mental health records or other sensitive information unless the participant to whom the records pertain has authorized access via a written authorization of release of information.

The primary person (including non-needy caretaker relatives) and filing group members may only have access to information related to the time during which they had that position in the case. If the family member is not in the filing group, there must be a signed authorization before information may be disclosed to the family member. Information regarding domestic violence should not be shared with family members.

Authorization for use and disclosure of information

An individual gives consent to share information to identified entities by completing the Authorization for Disclosure, Sharing and Use of Individual Information (MSC 3010). Ideally, this form is signed by the participant in the presence of ODHS|OHA staff, but this is not required; this can help facilitate discussion and to ensure the participant understands the form before signing. ODHS|OHA staff should also answer any questions the participant has about the form and explain to the participant their rights to request limitations on the disclosure of any of their information.

When approaching a participant to obtain consent, it is important to remember that an individual's ability to give

informed consent will depend on a number of factors, including the benefits and risks of a particular decision. Allowing a worker to talk with a family member about a participant's individual situation would require a different level of informed consent than consenting to a series of cancer treatments, for example. If a person has an established history of non-verbal communication, they may give permission for a worker to talk with another party about non-intrusive information by giving their usual sign of consent. In such cases, the worker must document their explanation to the participant about what information they intend to give and for what purpose. They must also document the non-verbal method the participant used to indicate consent.

There may be barriers to understanding of the release form. These barriers may include physical or mental disabilities, limited English proficiency or literacy challenges. The presence of a barrier to understanding does not necessarily mean the person is incapable of giving informed consent. For an individual who cannot sign their own name, the participant can make a mark such as an "X" or request another person to sign on their behalf. If a person signs on behalf of the participant, the signature should indicate who actually signed, so if participant Mary asks Sue to sign on her behalf, it can be recorded as "Mary, by Sue". There is no need to obtain a witness for the participant signing the release form unless there are other reasons to do so (e.g., the individual is requesting a witness, mental competency issue).

There should only be one record holder per form; each member of a two-adult household would need to sign their own form to consent to disclosure. The form must include the signature of the individual on the form. In situations where a release of information is required, ODHS|OHA may not identify the individual as being a recipient of public assistance until the authorization has been completed.

The release of information must include a specific reason for why the information is being shared; information may not be disclosed beyond the purpose stated on the release of information form. ODHS|OHA should not request unnecessary information about a participant, or more than is needed.

The Authorization for Disclosure, Sharing and Use of Individual Information (MSC 3010) form is valid for one year, unless otherwise specified. It is advisable to limit their duration to the shortest period of time during which the release or exchange of information may occur. The release form should be provided in the appropriate native language or in an alternate format (Braille, large print, etc.) as necessary.

Click here for Alternate formats.

Oral authorization

Except for health, treatment and domestic violence information, an oral authorization from the participant is sufficient to allow oral release of case record information specified by the participant to third parties. An oral authorization to release information to a third party is valid for a period of 30 days unless a shorter time period is given. The oral authorization should be narrated or documented in a case note.

Non-ODHS|OHA authorization forms

The use of a non-ODHS|OHA authorization form is permissible if the authorization contains all of the following information:

- A description of the information to be disclosed that identifies the specific information
- The identity of the person, classification of persons or ODHS|OHA program area authorized to make the

disclosure

- The identity of the person, classification of persons or entity to whom the information may be disclosed
- The purpose of the disclosure
- An expiration date or an expiration event, and
- The dated signature of the individual, the individual's attorney or the individual's personal representative.
  - If the authorization is signed only by the individual's personal representative, a description or explanation of the representative's authority to act for the individual, including copies of any court documents appointing the personal representative, must be provided.

What if the individual refuses to sign the authorization?

An individual does not have to sign the release form and sometimes will refuse to sign a release form. The ODHS|OHA worker should talk through with the participant what specific objections they have to the release and why. It may also help to explain to the individual why it is helpful to ODHS|OHA to receive and share certain information about the individual. If, following that conversation, the individual still does not want to authorize disclosure of their information, The ODHS|OHA worker should explain to the individual that they are then responsible for providing any information that would have otherwise been obtained with the authorization.

Failure to sign an authorization cannot be the basis for denying program services to otherwise eligible applicants. However, if the release of information is necessary to obtain documentation related to eligibility for the program, a denial would be based on the lack of required verification necessary to determine program eligibility and not on the refusal to sign the authorization.

Note: You may conduct business while maintaining participant confidentiality. Relevant information may be shared without identifying the specific individual. For example, "I am working with a woman in her late 80's who was recently diagnosed with terminal cancer. She needs the following type of care. . .". However, if it becomes necessary to identify the participant by name or to provide enough specifically identifying information so that the participant will become known even if the individual's name is not revealed, obtain the participant's permission to disclose the necessary and relevant information.

If verification is needed to ensure compliance with JOBS program activities, click here for Working with families.

Revocations or cancellations of authorizations

A valid revocation should be treated similarly to the situation of an individual who refuses to sign an authorization. A revocation about substance use information may be made orally. For all other information, the request must be in writing. The method and date of the cancellation should be written on the authorization form; the current date should be added if different from the cancellation date. An ODHS|OHA staff member should initial the cancellation entry and scan the authorization form into EDMS or ONE.

Requests to restrict use or disclosure of individual information

An individual has the right to request a restriction on use or disclosure of their information. The Request for Restriction and Use of Disclosures (MSC 2095) is used for this purpose. ODHS|OHA is not obligated to agree to a restriction and may deny a request for restriction, or ODHS|OHA may agree to a restriction more limited than what

the individual requested. (Exception: Certain programs can only use information that is authorized by the individual, such as alcohol and drug programs or vocational rehabilitation participants).

When approving an individual's request for restriction on use and disclosure of their information, caution should be used; there must be adequate safeguards provided to the information in question. If safeguards cannot be provided, the request must be denied. When denying a request, the bottom portion of the MSC 2095 is completed. Certain information, such as substance use or mental health information may only be used and disclosed as authorized by the individual. This means if the individual has asked for disclosure of this type of information to be restricted to a particular entity or person, ODHS|OHA may not deny the restriction and instead must abide by that restriction.

Further disclosure (re-disclosure) of information

Further disclosure is any use or disclosure of information obtained under an information form:

- With any program in ODHS|OHA or entity outside of ODHS|OHA not listed on the authorization form, or
- For any purpose not listed on the authorization form.

Information received by ODHS|OHA that is otherwise confidential or privileged under state or federal law may not be further disclosed to another person or entity unless the individual provides written authorization for disclosure of that information or another exception applies. This requirement means that, prior to further disclosure of information, the applicant or individual must first fill out, sign and date an Authorization for Disclosure, Sharing and Use of Individual Information (MSC 3010) form for that disclosure. For example, ODHS|OHA often obtains copies of an individual's medical records in connection with an eligibility determination or abuse investigation. These medical records obtained from a third party are exempt from redisclosure unless an additional release is obtained.

Suspected child abuse or elder abuse

ODHS|OHA employees are required to comply with the following Oregon laws:

- Child abuse reporting laws
- Elder abuse reporting laws, and
- Mentally ill persons and persons with developmental disabilities reporting laws.

Any questions regarding abuse reporting should be directed to a staff member's management.

When there is suspected abuse, the worker must do all of the following:

- Comply with the abuse reporting laws by making a mandatory report
- Narrate the referral by stating only "Referral made to [agency.]" The abuse itself should never be narrated.

Alcohol and drug (A&D) and mental health information

Pursuant to federal A&D law and state mental health law, an individual has the right to authorize use and disclosure of A&D or mental health treatment information to ODHS|OHA or to a specific program within ODHS|OHA, such as Self-Sufficiency, or to a specific person (name or title).

A&D and mental health treatment information may be used only for the specific purpose listed on the Authorization for Disclosure, Sharing and Use of Individual Information (MSC 3010) form. An individual has the right to informed

consent when filling out the MSC 3010. This means the worker has told the participant they may authorize the use of A&D and mental health information to ODHS|OHA as a whole or may limit disclosure to a specific program such as to Self-Sufficiency Programs.

Some elements of A&D federal law and MH state law regarding use and disclosure of A&D and MH treatment information are stricter than HIPAA. Under HIPAA, the stricter law applies.

Federal A&D law prohibits unauthorized use, disclosure and re-disclosure of A&D treatment information. State mental health law prohibits unauthorized use, disclosure and re-disclosure of mental health information. These laws:

- Give an individual the right to restrict to what entity or person and for what purpose treatment information may be used or disclosed.
- Require the individual's right to limit use and disclosure of A&D and mental health information be communicated to the individual.
- Prohibit re-disclosure of A&D and mental health treatment information without the specific authorization of the individual.
- Allow an individual to authorize use and disclosure of information by filling out and signing a release (such as the Authorization for Disclosure, Sharing and Use of Individual Information MSC 3010 form) that includes the:
  - Name of the person or program making the disclosure
  - Name or title of the individual or organization to which disclosure is to be made
  - Name of the participant
  - Purpose of the disclosure, which must be specific
  - How much and what kind of information is to be disclosed.

Reminder: The purpose of the use and disclosure must be specific to the individual or organization to which the information will be disclosed. If the purpose changes or is no longer applicable to the individual or organization named on the authorization form to receive the information, the participant must complete a new authorization before the information may be disclosed.

Narration of A&D and MH information

The A&D and MH narrative is for information that is:

- From a treatment provider, and
- Related to a participant's A&D or MH diagnosis, prognosis or progress in treatment

However, some A&D and MH information — such as that a participant was referred for treatment, attended a treatment appointment or was referred for a urinalysis (UA) — should still be narrated in the regular narrative.

In addition, individual self-disclosure of A&D- or MH-related information should be narrated in the regular narrative.

Information in the A&D and MH narrative should be limited to the minimum necessary to communicate the individual's challenges.

Secure A&D and MH narrative vs. a restricted A&D and MH narrative

There are two different levels of security within the A&D and MH narrative for TRACS. This means the worker entering the A&D and MH narrative will have to choose a level of security. The two levels of security are the secure A&D and MH narrative and the restricted A&D and MH narrative. OR ACCESS and ONE are limited to one level of security.

Note: Behavioral health services cases will not be housed in ONE.

The secure A&D and MH narrative is used when an individual authorizes their A&D or MH treatment information to be disclosed to an entity such as ODHS|OHA. Authorization is given on the Authorization for Disclosure, Sharing and Use of Individual Information (MSC 3010) form. The secure narrative is viewable by group's assigned access. For example, an A&D and MH narrative viewable by all Self-Sufficiency case managers in District 3 is a secure A&D and MH narrative.

The restricted A&D and MH narrative is used when an individual authorizes their A&D or MH treatment information to be disclosed to only a specific worker or workers in the branch. (Authorization is given on the Authorization for Use and Disclosure of Individual Information (MSC 2010) form. For example, if an individual wants their A&D treatment information to be disclosed to only their Self-Sufficiency family coach, the information must be entered into TRACS as a restricted A&D and MH narrative, which means it will be viewable by only that family coach.

Secure and restricted narratives are to be used for A&D and MH information only.

Sharing information across programs

Section (3)(b) of ODHS Privacy Policy AS-100-03, Use and Disclosure of Participant Information, states that "internal communication within the Department is permitted without individual authorization. . ." with the exception that "alcohol and drug, mental health and vocational rehabilitation record disclosure may be limited to particular program areas named on the authorization form. If such a limitation is noted on the authorization form, disclosure is limited to the parties named."

Information that may be shared between programs within ODHS|OHA without a signed release (not protected by 42 CFR) includes:

- Observations of suspected substance abuse or mental health issues
- Any information ODHS|OHA obtains prior to the diagnosis and/or treatment of an individual that does not originate from the A&D provider. This includes the screening and/or referral for an assessment, including the name of the treatment provider conducting the assessment (even if that provider eventually provides treatment)
- Self-disclosed information about the existence of a substance abuse or mental health issue, including that individual is receiving or has received treatment.

Applicability to mental health records

Disclosure of A&D records is governed by 42 CFR Part 2: Disclosure of Mental Health records are governed by ORS 179.505. Because 42 CFR Part 2 is the more restrictive regulation, and because it is not practical to distinguish the different sharing limitations between these records, the more restrictive analysis applies to both A&D and mental health records.

Cross-program use of A&D and mental health treatment information outside the guidelines listed above will require a signed release of information by the participant.

If A&D or mental health treatment information is used or disclosed more broadly than the participant has authorized on the Authorization for Disclosure, Sharing and Use of Individual Information (MSC 3010) form, the person using the information or making the disclosure may be in violation of federal or state law.

Domestic violence

Click here for the Temporary Assistance for Domestic Violence Survivors (TA-DVS) Eligibility Manual.

Confidentiality is assumed in cases where domestic violence is a factor. Both the Code of Federal Regulations (45 CFR 260.52) and state statute (ORS 411.117) instruct ODHS|OHA to keep information confidential about individuals experiencing domestic violence. Information shared should be limited to the minimum necessary and should not be shared without a signed release. The release should be clear about the specific information to be released, for what purposes and the time frames the release covers.

Information sharing with Child Welfare

Domestic violence information, or information from which domestic violence can be inferred, may be shared by ODHS|OHA with the CW program when there is a common case unless:

- Perpetrator works for CW
  - Protocol: ODHS|OHA staff reports information to their program manager for action, or
- Relatives of perpetrator work for CW
  - Protocol: ODHS|OHA staff reports information to their program manager for action, or
- Perpetrator has a close business relationship with CW, such as a program partner or contracted worker
  - Protocol: ODHS|OHA staff reports information to their program manager for action, or
- When DV survivor affirmatively asks that information not be shared and the information in question does not otherwise trigger a mandatory report
  - Protocol: ODHS|OHA staff discusses with DV survivor the survivor's concerns about sharing and, if needed, consults with their program manager to determine whether information may be shared in a manner that protects the victim but still achieves the purpose for which it is shared.

Access to information in the file

It is critical to be mindful of safety issues for individuals in domestic violence situations. This applies to all ODHS|OHA programs. If there is any likelihood an abuser (family member or friend) may have access to the file, staff should proceed with caution. Branch procedures might include keeping domestic violence/abuse information in a separate file or attached separately so it can be easily removed. This separation would include the safety assessment (if used), the TA-DVS addendum (if used), any safety or case planning documents and any information from domestic violence service providers.

In cases where the alleged abuser is no longer in the household but is requesting information, staff should remember a person is only entitled to see information from the time they were a household member and an

applicant or recipient. If a staff member is required to share the narrative, any references to the abuse, as well as the address of the victim or services accessed, should be removed before providing a copy to the alleged abuser. When printing a narrative, a black felt marker should be used to cross out any references to domestic violence before sharing the narrative.

When it is safe to narrate, an ODHS|OHA staff member should do the following:

- Use the TRACS "DV" narrative type.
- Narrate what you actually see (e.g., Mary came in with a black eye and a broken tooth).
- Describe the survivor's situation. Record the survivor's description of what happened (e.g., Mary said, "My boyfriend got a little drunk and threw a bottle at me."). What is the survivor afraid the abuser is likely to do?
- Narrate any history of abuse, abuser criminal history, other factors that might inform case planning efforts including abuser's access to the victim or to weapons.
- If the survivor identifies the abuser as boyfriend/girlfriend, wife/husband, roommate or family member, ask for the actual name and record it in TRACS. (Though this is not required for eligibility, unless there is question about relationship, it is important to record this information in case the abuser shows up at the office or the survivor reapplies for services.)
- Document both financial and non-financial eligibility information including any TANF or TA-DVS requirements waived due to domestic violence.
- Narrate eligibility decisions and notice sent.
- Narrate payments made on behalf of the survivor.
- Document initial safety planning with the survivor (completion of the Self-Sufficiency Domestic Violence Assistance Agreement (DHS 1543), and
- Document any other information pertinent to working with the individual or to the survivor's safety, such as a child support or good cause determination.

Restricted and secured narrative

ODHS|OHA staff should not narrate domestic violence-related information in the Alcohol and Drug/Mental Health (A&D/ MH) restricted or secure narrative. If safety concerns exist in adding information to the narrative, domestic violence-related information should be kept in the hard file marked "Confidential."

If staff are concerned about abuser access to a file, a narration should not be made. Instead, staff should hand narrate the information and put it in an envelope marked confidential and "Do not disclose."

Use of alternate identities

In some cases, an individual may request use of an alternate identity, or they may be going through a name change to protect their identity or location from an abuser.

ODHS|OHA staff must have permission from Central Office or local management to use an alternate identity on the system. The manager or their designee needs to contact Central Office to authorize release of the procedure to code alternate identities.

When using an alternate identity, eligibility information (e.g., individual identifying information, citizenship,

relationship, Social Security numbers, Oregon residency) should be secured. A file containing the confidential information could be kept in the manager's office, put in a separate folder marked "confidential," kept in the hard file in an envelope marked "do not disclose" or otherwise protected. Check with your manager or DV point person to determine the process used in your branch.

Safety tools in the Child Support Program

There are two ways to address potential safety concerns and confidentiality in the Child Support Program. If a participant indicates it is not safe to pursue child support, we can grant good cause. DCS will take no actions to pursue paternity establishment, medical support or child support. If the participant wants to pursue support but would like to protect information during pursuit, there is an additional tool. A participant may request nondisclosure based on "claim of risk," which protects not only the participant's resident address but personal identifying information such as where the individual works, their Social Security number, their driver's license number and where the child attends school. These options are explained in the Client Safety Packet on Good Cause Version A (DHS 8660).

Address Confidentiality Program (ACP) through Department of Justice, Crime Victim and Survivor Services Division

What the ACP does:

- The ACP enables survivors of domestic violence, sexual assault, stalking or human trafficking to keep their physical address confidential.
- The ACP program participants are provided a substitute address to use instead of their actual address.
- The ACP receives participant mail and provides mail forwarding services. and
- Participants may use the address for::
  - Delivery of first class, certified, or registered mail
  - Obtain an Oregon driver's license or ID card
  - Receiving or paying child support
  - Apply for marriage licenses with their substitute address
  - Enrolling dependents in public school

For more information about how ACP is used see the DOJ ACP Frequently Asked Questions website.

When approved for the ACP:

Each participant receives a laminated identification card. It will have the participant's name with their participant number.

PO Box 1108 ACP 0999-19
Salem OR 97308

That address will serve participants across the state. It is best practice to view the ACP identification card or confirm the ACP number with the participate to ensure accuracy of the ACP number. The PO box is used as the applicants physical and mailing address.

We can email or call to verify ACP enrollment at acp@doj.state.or.us or via phone at 503-373-1323. This is also helpful if the survivor does not know their participant number.

What should ODHS|OHA staff do when an individual presents them with the ACP identification card or provides an ACP address?

- In ONE, choose 'Yes' to "Participating in Address Confidentiality Program" and input the ACP number. All ACP participates will prepopulate Salem as their city and Marion as their county.
- Add a case note indicating that the ACP card was viewed or number was confirmed with the participant or DOJ , when the agency is able to do so.
- For managed care (CCO) enrollment, an exception needs to be requested for out-of-area enrollment, due to the Salem (Marion County) address. Send an email to CES DMAP at CES.DMAP@dhsoha.state.or.us with participants' names, case number and prime numbers for all individuals, County (and zip code if known) of physical residence and the managed care (CCO) plan the individual chose, along with the reason why the exception is needed. DMAP CES has been made aware of the need for an exception for ACP participants.
- For SNAP Cash-out payments an exception needs to be requested for anyone living in cash-out county but using the ACP address. Send an email to SNAP.Policy@dhsoha.state.or.us requesting Cash-out be manually updated for this case. Include in the email the participants name, case number and preferred issuance method (direct deposit or case EBT)
- For child care payments issued through the Direct Pay Unit system where care is provided by someone using the ACP PO Box, the maximum payment rates will default to Region A.

People selected for the program have completed safety planning with a local domestic violence service provider or district attorney-based victims' assistance program.

For further information about the program, go to DOJ Address Confidentiality Program.

To apply for the program, the survivor should be referred to your local domestic violence and sexual assault service provider or the local crime victims' assistance program through your local district attorney. The survivor will work with an application assistant who can help them decide if the program is appropriate for them.

Other resources

Address Confidentiality Program (ACP) and Do No Disclose (DND) Address Coding: *includes screenshots: Includes guidance on when to use Address Confidentiality Program (ACP) and Do Not Disclose (DND) and provides address coding options for Oregonians who have safety concerns and meet the criteria for ACP and DND

Client Enrollment Services (CES) & Client Services Unit (CSU): OHP Client Services Unit is the customer service center for all OHP/Medicaid recipients who assist with general questions about OHP medical and refer to Coordinated Care Organizations (CCO) as needed. OHP Client Services Unit (CSU) and Client Enrollment Services (CES) are partners within member services, which manages all member CCO enrollment/disenrollment requests.

Other ways to protect information in domestic violence cases

There are several options available for survivors to protect their address from being used in public records including voter's registration, driver's license and court proceedings. Survivors should be referred to the individual agencies

to learn more information or to the local domestic violence service provider who may help the survivor plan around these options. Legal aid has information about confidentiality protections for survivor of domestic violence, sexual assault and stalking; go to https://www.doj.state.or.us/crime-victims/.

HIV/AIDS

According to Oregon Revised Statutes 433.045(3), in no instance may an ODHS|OHA employee reveal to any person or agency that an individual is HIV positive (a person who is HIV positive has been exposed to the AIDS virus) without written authorization by the participant. On the Authorization for Use and Disclosure of Individual Information (MSC 2010) form, the authorization must specifically identify HIV test results in Section B and be initialed in the correct box below Section B.

Information on an individual's HIV status may not be included in the case record unless necessary to determine eligibility. Workers must judge whether a report containing information about HIV is needed to determine eligibility. If not, the information must be destroyed. If HIV information is needed for eligibility determination, the report should be retained but marked with a notation that the information cannot be released to any person or agency.

Do not enter HIV status information into any shared communication system.

When you receive a subpoena

If you receive a subpoena of any type, do not ignore it under any circumstances. Anytime a worker is served with a subpoena requesting confidential individual information, the worker should immediately notify their supervisor. Central Office may be contacted for technical assistance and to access help from the Department of Justice.

A subpoena is not a court order. A subpoena is a legal document issued by a court or an attorney. It is a writ or order directed to a person and may require the attendance of that person to testify as a witness or may require that person to produce papers, documents, etc. ODHS|OHA must comply with a court order to provide testimony or documents unless ODHS|OHA is able to persuade a judge to amend or rescind the order. In response to a subpoena, ODHS|OHA must file written objections within the specified timeframe or appear to present objections in court (or convince the attorney to drop the subpoena), but a subpoena alone does not require testimony or release of documents. None of the subpoenas can compel release of confidential or privileged information; only a court order can compel such action. If the time period to object to a subpoena is not waived, there must either be a court order or a valid written authorization from the individual for ODHS|OHA to release documents or provide testimony.

There are many kinds of subpoenas. How you respond to a subpoena will depend on what the subpoena is directing you to do:

- Discovery subpoenas do not require the worker to appear before a judge. In these cases, the worker has 14 days (or less if the date for production is earlier) to serve the party issuing the subpoena with written objections to it:
  - Once the written objections are served, the attorney who issued the subpoena has the burden of going to court to obtain a court order compelling the worker to produce the file. The attorney must give the worker notice of the attorney's intent to go to court and, at that time, the worker will follow the instruction for addressing the judge.
- If the case record or worker is subpoenaed to appear before a judge, you should advise the court that the

subpoena requests ODHS|OHA to produce confidential and privileged information and testify to or release individual information in the judicial proceeding if at least one of the following is true:

- The proceedings are directly connected with administering an ODHS|OHA program (except that release of information about substance abuse treatment and mental health still requires an authorization).
  or
- The individual has given a current and valid written authorization for release of specific information sought that covers both the purpose of the proceeding and those present in court.
  or
- A judge directs you to provide the information.

If there is no valid participant authorization and the proceeding is not about ODHS|OHA programs, take a copy of the records requested and appear as directed by the subpoena. Give the presiding judge a copy of the state statutes that relate to the confidentiality of participant records.(ORS 192.502(8), 410.150, 411.300, 411.320, 411.335, as well as ORS 179.505 (behavioral health), ORS 411.117 (domestic violence), ORS 412.074 (TANF), ORS 124.085, 124.090, 430.763, 441.650 and 441.671 (abuse investigation), ORS 433.045 (HIV), 42 CFR 431.300 to 431.307 (Medicaid), 42 CFR Part 2 and 42 CFR 2.64 (A&D), and 45 CFR part 164.512(e) (HIPAA)).

Note: If there are other specific federal or state confidentiality statutes applicable to the program, please provide that information to the court.

These statutes provide an explanation of the laws governing confidentiality of individual information and let the judge know we can provide the information if the judge orders us to do so. Testify only to the extent the judge orders you to testify.

If a case record or a worker is subpoenaed and the subpoena directs the record or worker to provide documents or appear in a deposition or an attorney's office or in an administrative hearing where a judge will not be present, you are recommended to respond to the subpoena by refusing to turn over the information on the basis of the confidentiality statutes and do the following:

- Look at the date you are asked to appear or provide documents. If the subpoena gives ODHS|OHA less than five working days to comply, contact the ODHS|OHA Central Office subpoena liaison immediately and fax a copy of the subpoena to them at 503-373-7032. You should also check the individual file to see if the individual has signed an authorization to release information to the attorney; fax any releases that may apply. Note that a release in the file may not cover the scope or purpose of the request. If time permits, contact the attorney or agency that issued the subpoena. Explain that ORS 410.150, ORS 411.300, ORS 411.320, and ORS 411.335 prohibit ODHS|OHA from disclosing individual information without the individual's written release. Ask that the subpoena be withdrawn and for brief written confirmation that ODHS|OHA is not required to comply with the command of the subpoena.
- If necessary, the state Attorney General's Office will be contacted or the worker advised to call the AAA legal counsel. The rules of evidence and statutes concerning privilege may not be binding in a non-judicial proceeding such as administrative hearings, grand jury proceedings or depositions.
- If you cannot reach the attorney or the attorney is not willing to withdraw the subpoena, immediately contact the ODHS|OHA Central Office subpoena liaison and fax a copy of the subpoena and any related authorizations to share information to the liaison at 503-373-7032.

- ODHS|OHA may file written objections or seek to quash the subpoena, especially if only documents are requested. If only documents are requested, do not provide them in the absence of a court order or valid written individual authorization or specific direction from the Attorney General's Office (AG) contact or confidentiality analyst.
- If a subpoena for your testimony is not quashed, the person subpoenaed should appear as directed by ODHS|OHA's AG contact or the subpoena liaison. You would bring any documents directed; however, actual testimony or release of documents at this hearing would still require a court order or valid, written authorization.
- If the worker or the case record is subpoenaed for a grand jury and the proceedings are not directly connected to administering ODHS|OHA's programs, or the individual has not given written authorization for the release of specific information, immediately contact the subpoena liaison. Fax a copy of the subpoena to them at 503-373-7032.

Click here for flowcharts outlining the procedures for various subpoena scenarios.

Verification

In every situation in which information is shared with or without an authorization and inside or outside of ODHS|OHA, staff, volunteers and contractors are required to take reasonable steps to verify the identity of the individual receiving the information. The only exception is if the ODHS|OHA workforce member fulfilling the request already knows the person or has already verified identity.

When releasing information to an individual's attorney without an Authorization for Use and Disclosure of Individual Information (MSC 2010) form, staff must verify the individual is an attorney. Instructions for how to do this are a http://intranet.ODHS.state.or.us/caf.

If the person is not known to the ODHS|OHA staff member fulfilling the request, take one of the following reasonable precautions to verify the individual with whom staff is communicating is that same attorney:

- Ask to see an identification badge or driver's license when the request is made in person.
- Conference call in another ODHS|OHA employee who knows the attorney, will recognize the attorney's voice and can verify identity.
- Ask for a phone number at the same location you can call back that will confirm you are communicating with a law firm or legal services.
- Receive an email from the attorney's email address that will serve to verify the attorney is the person on the phone.
- Confirm the fax number or address to which you will send the documents is that of the attorney. You can confirm the fax number on the Oregon State Bar website: http://www.osbar.org/members/start.asp.
- Receive a fax from the attorney's fax number to verify the attorney is the person on the phone.
- Use another reasonable approach.

Forms

- MSC 2090, ODHS/OHA Notice of Privacy Practices

- MSC 2093, Request for Access to Records
- MSC 2094, Request for Amendment of Health Record
- MSC 2095, Request for Restriction of Use and Disclosures
- MSC 2096, Request for Accounting of Disclosures of Health Records
- MSC 2097, Disclosures of Protected Health Information (PHI)
- MSC 3010, Authorization for Disclosure, Sharing and Use of Individual Information

References

ODHS Policy

- ODHS-100-001, General Privacy
- ODHS-100-002, Individual Privacy: Permissible and Prohibited Use and Disclosure of Information
- ODHS-100-003, Uses and Disclosures of Individual Information
- ODHS-100-004, Minimum Necessary Information for Releasing Personally Identifiable Information

Oregon Administrative Rule(s)

- 407-014-0000, Definitions
- 407-014-0020, Uses and Disclosures of Client or Participant Protected Information
- 407-014-0030, Client Privacy Rights
- 407-014-0040, Minimum Necessary Standards
- 461-105-0060, Release of Information to the Client
- 461-105-0070, Client Authorization for Release of Client Information to Third Party
- 461-105-0100,Release of Client Information to Law Enforcement Officers
- 461-105-0110, Release of Client Information to Service Providers and Legal Bodies
- 461-105-0120, Release of Information on Child Support and Paternity Cases
- 461-105-0130, Disclosure of Client Information

Oregon Revised Statutes

- 124.050 through 124.095, Elder Abuse
- 179.505, Disclosure of written accounts by health care services provider for persons receiving publicly funded mental health services, alcohol and drug treatment, developmental disability services and public health services.
- 410.150, Use of files; confidentiality; privileged communications
- 411.117, Requirements when applicants or recipients victims of domestic violence; identification
- 411.320, Disclosure and use of records limited; contents as privileged communication; exceptions
- 412.074, Use and custody of records of temporary assistance for needy families program; rules
- 412.094, Public officials to cooperate in locating and furnishing information concerning parents of children receiving or applying to receive public assistance and in prosecuting nonsupport cases; use of information

restricted

- 419B.005–419B.045, Reporting of child abuse
- 430.735–430.765, Abuse reporting for persons with mental or developmental disabilities
- 441.460 through 441.680, Nursing facility resident abuse

Federal Law

- 7 CFR 272.1
- 42 CFR Part 2
- 45 CFR Part 164.522164.528

Oregon Administrative Rule(s)

461-105-0130 — Disclosure of Client Information
461-105-0110 — Release of Client Information to Service Providers and Legal Bodies
461-105-0070 — Client Authorization for Release of Client Information to Third Party

Overpayments

Click here for Personal injury liens.

An overpayment is defined as a benefit or service received by or on behalf of an individual, or a payment made by ODHS|OHA on behalf of an individual, that exceeds the amount for which the individual is eligible. It can also be defined as:

- A payment made by ODHS|OHA and designated for a specific purpose; the payment is spent by a person on an expense not approved by ODHS|OHA and not considered a basic living expense.
  - Basic living expenses are limited to the need of the individual at the time the payment was designated for shelter, utilities, household supplies (other than food, and personal incidentals the individual could not meet with other immediately available resources. Payment amounts are limited to 200 percent of the payment standard for the benefit group.
- A misappropriated payment is when a person cashes and retains the proceeds of a check from ODHS|OHA on which that person is not the payee and the check has not been lawfully endorsed or assigned to the person.
- A benefit or service is provided for a need when that person is compensated by another source for the same need and the person fails to reimburse ODHS|OHA when required by law.
- A cash benefit received by an individual in the General Assistance (GA) or SFPSS programs for each month for which the individual receives a retroactive Supplemental Security Income (SSI) lump-sum payment;

Effective April 21,2021 for Medical Assistance the Department:

- Shall not establish an administrative error overpayment
- Shall not establish a client error overpayment unless an individual received unreduced liability or unreduced benefits pending a contested case hearing decision or other final order favorable to the Department
- May establish a fraud overpayment when a court determines the individual made a false or misleading statement or misrepresented, concealed, or withheld a fact for the purpose of establishing or maintaining

eligibility

ODHS|OHA provides overpayment identification and collection services to the extent possible based on the following expectations:

- ODHS|OHA has a responsibility to ensure that state and federal funds are appropriately expended and to identify where funds have been misapplied.
- Individuals receiving services or payments have a responsibility to provide timely and accurate information to assist ODHS|OHA in appropriate distribution of services and funds.
- ODHS|OHA will hold claimants accountable for repayment of overpayments.
- When overpayment recovery is necessary, the process must be clear and fair to all parties to maintain public trust.

Other resources

Submit an Overpayment *includes screenshots: This QRG discussed the Benefit Recovery functionality and provides steps to submit and overpayment and review the Potential Discrepancy Referral screen.

Identifying potential overpayments

Identifying who is responsible for the overpayment is an important part of the process. Overpayment situations are often complicated. E.g.,, payment for a service goes to a provider while the participant receives benefits from the service. The overpayment process provides the basis for determining:

- When an overpayment occurs
- Who is responsible for the overpayment error
- The type of overpayment (overpayment categories)
- The amount of the overpayment
- Who is liable for repaying the overpayment, and
- Appropriate actions, including collection.

Overpayments may be discovered from the following sources:

- Information from the individual or provider
- Discrepancies identified by agency staff
- Public complaints
- Information received from an employer or co-worker
- Information supplied by the Fraud Investigation Unit
- Information received from community partners
- Employment Department quarterly wage reports, and
- Other sources of information.

Establishing overpayments in the initial month

ODHS|OHA may establish an overpayment for the initial month of eligibility under circumstances including but not limited to the following:

- The filing group, ineligible student or authorized representative withheld information.
- The filing group, ineligible student or authorized representative provided inaccurate information.
- ODHS|OHA failed to use income reported as received or anticipated in determining the benefits of the filing group.
  or
- The error was due to an error in computation or processing by ODHS|OHA.

For medical assistance ODHS/OHA may establish a fraud overpayment for the budget month when a court determines the individual made a false or misleading statement or misrepresented, concealed, or withheld a fact for the purpose of establishing or maintaining eligibility.

When anticipated income was reported for the initial month of eligibility, and it is later determined that income from another source was not reported but should have been, treat the reported and unreported income as follows in computing the overpayment:

- For anticipated income that was not reported, use the actual amount of income received in computing the overpayment.
- For prospective income that was properly anticipated, continue to use the original anticipated amount, rather than the amount the individual actually received, in computing the overpayment. Use this method whenever the anticipated amount was properly determined, even if the actual amount the individual eventually received was different from the anticipated amount.

Establishing overpayments in months of ongoing eligibility

When an overpayment is caused by reported or unreported changes as required per Changes That Must Be Reported (OAR 461-170-0011), the overpayment start date is determined as follows:

For cases in CRS:

Administrative error overpayments: When the change is reported as required per OAR 461-170-0011, allow 10 days to report the change, 10 days to take action and the notice period per Notice Period (OAR 461-175-0050).

An individual's error and fraud overpayments: When the change is not reported as required per OAR 461-170-0011, allow 10 days to report the change and the notice period per OAR 461-175-0050 only. This applies to administrative error, an individual's error and fraud overpayments.

For cases in SRS:

For SRS the overpayment start date is the same for reported or unreported changes Per OAR 461-170-0011, required changes must be reported by the 10th day of the month following the month of occurrence. The overpayment begins the month after the required change is due. This allows for the required notice period per OAR 461-175-0050. This applies to administrative error, an individual's error and fraud overpayments.

Establishing overpayments when prospective budgeting was used

It is not an overpayment when prospective budgeting is used to calculate income and the actual income is different unless:

- ODHS|OHA failed to use income reported
- ODHS|OHA miscalculated the income
- The filing group, ineligible student or authorized representative failed to make a required change report
- The filing group, ineligible student or authorized representative provided inaccurate information,
  or
- The filing group, ineligible student or authorized representative withheld information.

Continuation of benefits pending a hearing

When benefits issued incorrectly are continued unreduced pending a hearing and the hearing decision supports ODHS|OHA, the additional benefits beyond the initial notice period are an overpayment. This overpayment is considered an individual's error. Calculate from the date of the proposed action to the date benefits are reduced or closed as a result of the hearing decision.

In all programs except OSIPM, when an individual disputes a disqualification and benefits are continued, do not establish an overpayment for the continued benefits unless an overpayment exists for a reason other than the disqualification.

The disqualification will be applied when ODHS|OHA is upheld.

For OSIPM, if the hearing concerns a proposed action to reduce, suspend or end benefits due to an overpayment that has already been reported via DHS 0284, add the additional overpayment amount via DHS 0284A. If the hearing concerns a proposed action to reduce, suspend or end benefits and no overpayment has yet been completed, report the entire overpaid amount via DHS 0284.

Overpayment categories

AE "administrative error" overpayment is a result of an error made by ODHS|OHA. Examples include:

- ODHS|OHA fails to reduce, suspend or end benefits after timely reporting by the filing group, ineligible student or authorized representative of a change covered under Changes That Must Be Reported (OAR 461-170-0011 or OAR 410-200-0235) and the reported change requires ODHS|OHA to reduce, suspend or end benefits.
- ODHS|OHA fails to use the correct benefit standard.
- ODHS|OHA fails to compute or process a payment correctly based on accurate information timely provided by the filing group, ineligible student or authorized representative.
- In the SFPSS program, ODHS|OHA fails to require an individual to complete an interim assistance agreement.
  or
- ODHS|OHA commits a procedural error that was no fault of the filing group, ineligible student or authorized representative. For example, a case is opened as JOBS Plus, but SNAP benefits continue to be issued.

CE "client error" overpayment is caused by a misunderstanding or unintended error on the part of the individual, ineligible student or authorized representative, such as unintentionally providing incomplete information or not

reporting a change, even if the information was available to ODHS|OHA. Examples include:

- An overpayment caused by the failure of a filing group, ineligible student, or authorized representative to declare or report information or a change in circumstances as required under Changes That Must Be Reported (OAR 461-170-0011), including information available to ODHS|OHA that affects the individual's eligibility to receive benefits or the amount of benefits
- An individual's unreduced liability or receipt of unreduced benefits pending a contested case hearing decision or other final order favorable to ODHS|OHA
- An individual's failure to return a benefit known by the individual to exceed the correct amount
- An individual's use of a JOBS or SFPSS program support payment for other than the intended purpose
- A payment for child care when the individual was not engaged in an activity that made the individual eligible for child care, such as an activity of the JOBS program
  or
- A payment for child care when the individual was not eligible for child care benefits.

FR "fraud" occurs when an overpayment is determined by the Investigation Unit to be an intentional program violation (see Intentional Program Violation Defined, OAR 461-195-0601, and Intentional Program Violations; Establishment and Appeal, OAR 461-195-0601) or is substantiated through a criminal prosecution.

PE "provider error" overpayment:

- **In the SNAP program,** a provider error overpayment is an overpayment made to a drug or alcohol treatment center or residential care facility that acted as an individual's authorized representative.
- **In the child care programs,** a provider error overpayment is a payment made by ODHS|OHA on behalf of an individual to a child care provider when:
  - Paid to an ineligible provider or
  - The payment exceeds the amount for which a provider is eligible, or
  - Paid to a provider who does not submit attendance logs upon request.

PF "possible fraud" overpayment occurs when an individual or provider is suspected of intentionally causing an overpayment to occur in order to receive or increase payments or benefits they are not eligible to receive.

PI "provider intentional" overpayment occurs when there is clear and convincing evidence the provider intended to mislead, misrepresent, conceal or withhold facts.

Provider intentional overpayment occurs when the provider intentionally does any of the following:

- Bills ODHS|OHA for more care than actually provided, including duplicate billings
- Collects payment directly from an individual after ODHS|OHA's payment for the services has been garnished or after overpayment recovery action have reduced the amount paid
- Fails to comply with the agreements of the Child Care Provider Listing (DHS 7494) form, including failing to list required individuals for the record check, or
- Establishes eligibility for payment for another person.

Note: When an overpayment is caused by both an administrative and participant error in the same month, ODHS|OHA determines the primary cause of the overpayment and assigns as either an administrative or "client error" overpayment.

Overpayment thresholds

ODHS|OHA establishes an overpayment when the following thresholds are exceeded:

AE overpayments concerning:

- Cash and child care programs, when the amount is greater than $200
- SNAP open case, when the amount is greater than $100
- SNAP closed case, when the amount is greater than $200
- Medical programs, do not establish AE overpayments.

CE overpayments in:

- Cash and child care programs, when the amount is greater than $200
- SNAP open case, when the amount is greater than $100
- SNAP closed case when the amount is greater than $200

PE overpayments in:

- Cash, adult care and child care programs when the amount is greater than $200
- SNAP open case, when the amount is greater than $100
- SNAP closed case when the amount is greater than $200.

PF overpayments:

Refer all overpayments to the Overpayment Writing Unit, regardless of program or amount. An overpayment writer needs to evaluate and complete all instances of possible fraud overpayments.

There are **no overpayment thresholds** in the following situations:

- **In the SNAP program,** if the overpayment was identified in a quality control review
- **In all programs,** if the overpayment was caused by an individual's receipt of continuing benefits in a contested case
- **In all programs,** if the overpayment was caused by possible fraud by an individual or provider
- **In the REF, SFPSS and TANF programs** for an overpayment caused by the individual using or accessing cash benefits in any EBT transaction in a:
  - Liquor store: This includes retail establishments that primarily or exclusively sell beer or wine.
  - Casino, gambling casino or gaming establishment.
  - Retail establishment that provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment. This includes adult video stores that exclusively or primarily sell or feature adult-oriented videos or movies.

- Marijuana dispensary.

The amount of the overpayment is the amount of cash benefits used or accessed in the EBT transaction.

Verification and overpayment claims establishment timelines

ODHS|OHA staff should seek verification of potential income or eligibility discrepancies, when necessary, within 30 working days of first identifying them. Additional steps may need to be taken before discovering if an overpayment of benefits has actually occurred. If ODHS|OHA staff or investigator is unable to obtain satisfactory verification, the overpayment writer may average the income from the WAGE screen or quarterly earnings report.

The date of discovery of an overpayment is defined as the date on which an overpayment of benefits, the specific dollar amount and time period are all confirmed. This is typically achieved once all evidence, eligibility verifications, earnings and household composition factors have been confirmed, and the appropriate benefit level has been calculated.

The goal is to complete the overpayment within 90 days following the calendar quarter in which the overpayment was discovered. For SNAP benefits, 90 percent of the overpayments should be written within this time frame.

Responsibility for completing overpayments and referral process

When ODHS|OHA employees receive information indicating a potential overpayment exists, they immediately report the information to the appropriate worker. The case is reviewed by the worker to determine if a discrepancy exists resulting in an overpayment. The worker is responsible for referring potential overpayments that exceed the overpayment threshold guidelines to the Overpayment Writing Unit. Narrate the referral. If a potential overpayment does not meet the threshold, do not submit a referral and narrate the reason for not referring. Overpayment writers from the Office of Payment Accuracy (OPAR), Overpayment Writing Unit (OWU) complete all cash, medical, SNAP and child care (both individual and provider) overpayments. Referrals to Office of Payment Accuracy and Recovery (OPAR) for benefit recovery occurs through ONE for SNAP and TANF programs. ONE supports overpayment referral and recoupment for SNAP and TANF. If an individual is determined to have received extra payments in the past, a worker can either decide to refer or not to refer it to PIPS (Payment system for OPAR) for claim creation. Other programs that need an overpayment referral follow the process below:

- Complete the applicable Overpayment Referral form for the affected program (MSC 0284F or SDS 0284R). Indicate on the referral form the approximate dates of the potential overpayment and describe the cause. It is important that the cause of the potential overpayment be specific and clear. List sources of income and the persons receiving it. If the overpayment was caused by earned income, list the employer and the name of the person on the case who was working.
- Attach the documentation you have gathered. It is not a requirement for ODHS|OHA staff to obtain supporting documents, such as verification of earnings, etc. This preparatory work is completed by an overpayment referral specialist in OPAR.
- Submit the referral form to OPAR using one of the following methods:
  - Email to OVERPAYMENT REFERRALS at OVERPAYMENT.REFERRALS@dhsoha.state.or.us (preferred method)
  - Fax to 503-378-3872.

- Mail to OPAR OVP Referrals, PO Box 14150, Salem OR 97309.
- Submit directly to your local overpayment writer if there is no preparatory work that needs to be done or supporting documentation that needs to be obtained. For example, income cases where no hard copy verification needs to be obtained from an outside employer or agency, such as:
  - » APD home care worker income (HINQ);
  - » Unemployment (ECLM);
  - » The work number (please note on the referral form if income is on the work number).

Other resources

Submit an Overpayment QRG

When a QC review results in an overpayment, the referral will be sent to OWU by staff in the QC Unit. This does not apply to overpayments resulting from other types of reviews, such as those conducted by the Program Accuracy Team, manager reviews or peer reviews.

Calculating overpayments

The overpayment is calculated by determining the amount the individual received or the payment made by ODHS|OHA on behalf of the individual that exceeds the amount for which the individual was eligible. For medical programs, the overpayment amount includes any capitation payments made to a coordinated care organization (CCO) or fee-for-service claims paid for medical, dental, or vision services.

The overpayment starts with the first incorrect payment or program benefit following receipt or possession of income, property, resources or another change in circumstances that caused the overpayment. It ends with the payment in which benefits are corrected or ended.

Benefits paid during a required notice period are included in the calculation of the overpayment when:

- The filing group, ineligible student or authorized representative failed to report a change within the reporting time frame under Changes That Must Be Reported (OAR 461-170-0011), and
- Sufficient time existed for ODHS|OHA to adjust the benefits to prevent the overpayment if the filing group, ineligible student or authorized representative had reported the change at any time within the reporting time frame.

When an overpayment is caused by both an administrative and the individual's error in the same month, ODHS|OHA determines the primary cause of the overpayment and assigns as either an administrative or the individual's error overpayment.

Income general information

Assign unreported income to the applicable budget month without averaging the unreported income, except:

- An individual's earned income reported quarterly from the Employment Department is considered received by the individual in equal amounts during the months identified in the report.
  - **In the ERDC, REF, SNAP and TANF programs,** an individual's actual self-employment income is annualized retrospectively to calculate the overpayment.

- **In the HSD medical programs,** if actual income is not available for the month in which overpayment occurred, an individual's actual self-employment income received during the year when an overpayment occurred is annualized to calculate an overpayment.

When benefits were calculated using prospective budgeting and the actual income differs from the amount determined under OAR 461-150-0020(2), use the actual income to calculate the overpayment when:

- The filing group, ineligible student or authorized representative failed to report a change
- The filing group, ineligible student or authorized representative provided inaccurate information, or
- The filing group, ineligible student or authorized representative withheld information.

When prospective income was reported correctly, but ODHS|OHA miscalculated the income or failed to use income reported, ODHS|OHA should use the actual income only if it results in a lesser overpayment amount for the individual.

When using anticipated income for medical assistance and the actual income differs from the amount determined under OAR 410-200-0310 or 461-150-0050, the Department uses the actual income to determine the amount of the overpayment when a medical assistance fraud overpayment (see OAR 461-195-0501) is established.

Earned income overpayments

Reported earned income:

Compute total countable earned income on a month-to-month basis, allowing all earned income deductions following policy in effect at the time of the overpayment. (see OARs 461-145-0930, 461-160-0160, 461-160-0430, 461-160-0550, and 461-160-0552).

Unreported and under-reported earned income

Compute total countable earned income on a month-to-month basis, unless the individual had good cause for not reporting or under-reporting the earned income, allowing earned income deductions (see OARs 461-160-0160, 461-160-0190, 461-160-0430, 461-160-0550, and 461-160-0552) as follows:

- **In OSIPM, MSP and REFM,** allow the earned income deduction.
- **In REF and TANF,** do not allow the earned income deductions unless good cause exists.
- **In SNAP,** do not allow the earned income deduction on the portion of the income not reported or under-reported.

Note: For purposes of this section good cause means circumstances beyond the individual's reasonable control that caused the individual to be unable to report income timely and accurately.

Unearned income overpayments

Compute unearned income on a month-by-month basis if it is:

- **For cash, SNAP or child care programs,** less than the monthly benefit amount. Remember, there may not be a medical program overpayment if this is the only income source.
- **For cash, SNAP or child care programs,** equal to or more than the monthly benefit amount for cash, SNAP

or child care programs. OWU may also add medical unless the individual was eligible for another medical program with the same benefit level.

Child support, including cash medical support

When support is retained:

- **In the TANF program,** the amount of support (other than cash medical support) the Department of Justice retains as a current reimbursement each month is added to other income to determine eligibility. When an individual is not eligible for TANF program benefits, the overpayment is offset by the support the Department of Justice retains as a current reimbursement.
- **In the medical programs,** the amount of the cash medical support ODHS|OHA retains each month is excluded income and not used to determine eligibility for medical program benefits. When an individual has incurred a medical program overpayment, the overpayment is offset by the amount of the cash medical support ODHS|OHA retains during each month of the overpayment.
- **In the REF and TANF programs,** when an individual directly receives support used to determine eligibility or calculate benefits, the overpayment is:
  - If still eligible for REF or TANF program benefits, the amount of support the individual received directly, or
  - If no longer eligible for REF or TANF program benefits, the amount of program benefits the individual received.
- **In the SNAP program,** exclude child support payments the group receives that must be assigned to ODHS|OHA to maintain TANF eligibility, even if the group fails to turn the payments over to ODHS|OHA, per OAR 461-145-0080.

Credits against overpayments

Allow appropriate credits against the amount of benefits paid in error. Document credits allowed in the narrative portion of the Overpayment/ Overissuance Report form (MSC 0284) or the Overpayment/Overissuance Change Report form (MSC 0284A). Allowable credits are:

- **In all programs,** for underpayments or adjustments
- **In REF and TANF,** an individual's verified payment for medical services made during the period covered by the overpayment, in an amount not to exceed the ODHS|OHA fee schedule for the service (Do not allow a credit for an elective procedure unless it was prior authorized by ODHS|OHA.)
- In TANF months where there was no eligibility, child support payments made on behalf of the individual that are retained by the state and applied to reimburse assistance paid (Only the amount up to the monthly legally obligated support is allowed.)
- **For SFPSS and TANF,** earned income overpayments occurring on or after April 1, 2009: Allow a credit for Post-TANF only if:
  - The individual reported in a timely manner
  - The individual met Post-TANF eligibility per Specific Requirements; Post-TANF (OAR 461-135-1250), including verification of the minimum number of work hours, and
  - The individual has received less than 12 months of Post-TANF program benefits. An individual cannot

receive a Post-TANF payment and a credit in the same month.

- **In medical programs,** cash medical support ODHS|OHA retained during each month of the overpayment.
- **In SNAP,** if the overpayment was caused by unreported earned income allow a credit for the following (when verified only).
- Paid child care costs, to the extent they would have been deductible under Dependent Care Costs; Deduction and Coverage (OAR 461-160-0040) and Income Deductions; SNAP (OAR 461-160-0430).

Overpayments caused by failure to reimburse ODHS|OHA

When an overpayment occurs because an individual fails to reimburse ODHS|OHA despite a legal requirement to do so, the overpayment may be limited. This is true when the overpayment is for benefits or services, including cash medical support provided for a need for which that individual was already compensated by another source. These overpayments are limited to the lesser of the following:

When an overpayment occurs due to the failure of an individual to reimburse ODHS|OHA, when required by law to do so, for benefits or services (including cash medical support) provided for a need for which that individual is compensated by another source, the overpayment is limited to the lesser of the following:

- The amount of the payment from ODHS|OHA
- Cash medical support, or
- The amount by which the total of all payments exceeds the amount payable for such a need under ODHS|OHA's rules.

Continuation of benefits pending a hearing

When benefits issued incorrectly are continued unreduced pending a hearing and the hearing decision supports ODHS|OHA, the additional benefits beyond the initial notice period are an overpayment. The overpayment is considered the individual's error. Calculate from the date of the proposed action to the date benefits are reduced or closed as a result of the hearing decision.

In all programs except OSIPM, when the individual disputes a disqualification and benefits are continued, do not establish an overpayment for the continued benefits unless an overpayment exists for a reason other than the disqualification.

If the hearing concerns a proposed action to reduce, suspend or end benefits due to an overpayment that has already been reported, add the additional overpayment amount via the Overpayment/Overissuance Change Report form (MSC 0284A). If the overpayment has not been completed, report the entire overpaid amount via the MSC 0284.

When the individual's liability is unreduced pending the outcome of a contested case hearing about that liability, the overpayment is the difference between the liability amount determined in the final order and the amount, if any, the individual has repaid.

Overpayment notification

The Overpayment Writing Unit (OWU) completes the overpayment calculation, enters the overpayment in the overpayment system and sends the overpayment notice to the individual or provider. Overpayment benefit

calculation worksheets are also included to explain how the overpayment was calculated. The notice includes hearing rights (see Hearing Requests (OAR 461-025-0310) and Contested Case Hearing (OAR 410-200-0145) and recovery information (see Methods of Recovering Overpayments (OAR 461- 195-0551).

When notice is required in an alternate format, including special accommodations due to a disability, it is noted on the MSC 0284. OWU Central Office will have the alternate format notice generated.

If any overpayment notice is returned by the Postal Service as "undeliverable," the Overpayment Recovery Unit (ORU) will attempt to locate the person's current address and resend the notice.

Non-citizen overpayment liability

Click here for Non-citizens.

Reporting changes in individual-liable overpayments

When changes occur in an individual-liable overpayment, the information needs to be reported to either the Overpayment Writing Unit (OWU) or the Overpayment Recovery Unit (ORU) within the Office of Payment Accuracy and Recovery as follows:

Report to the Overpayment Writing Unit (OWU) when:

- The original amount of the overpayment needs to be adjusted
- The reason for the overpayment needs to be changed
- An allowable credit not deducted previously needs to be applied against the overpayment balance, or
- The adjustment is due to a hearing.

The change information will be entered on the Overpayment/Overissuance Change Report form (MSC 284A) and processed by OWU.

Submit an Overpayment/Overissuance Change Report form (MSC 284A) to the Overpayment Recovery Unit (ORU) when:

- ODHS|OHA recovered on an overpayment that is later determined to not be an overpayment
  - When recovery occurred by reduction of cash benefits and a reimbursement is needed, attach a completed Authorization of Cash Payment form (MSC 0437) to the MSC 0284A and ORU will process the reimbursement and issue a check or add the benefits to the EBT card.
- TANF overpayment recovery is being restored to the individual because they requested unreduced benefits pending a hearing decision on the overpayment or the EOP (TANF overpayment recovery from earned income deduction)
- **For all programs except SNAP,** when a benefit check (that the individual was eligible to receive) is canceled to recover an overpayment and no check is reissued, report the amount of the check and the amount the overpayment is to be reduced on the Use an Overpayment/Overissuance Change Report (MSC 284A).

Do not submit an MSC 284A when an overpayment is recovered from:

- Payment by cash when a General Receipt Book (DHS 0029) (paper only) is issued (The DHS 0029 will be used to adjust the overpayment balance)

- For cash benefits, when benefit reduction is coded except as required above (The computer adjusts the balance(s)
- For TANF, disallowance of earned income deduction coded EOP on UCMS (The computer adjusts the balance).

Overpayment recovery

Collecting overpayments

Collection action is initiated by sending liable persons (see Liability for Overpayments, OAR 461-195-0541) notice of overpayment and demand. The demand includes a due date and options for repayment. The Overpayment Recovery Unit (ORU) will allow 10 working days before taking any recovery action. Individuals requesting continuation of benefits must make the request within 10 days of the notice date to delay benefit reduction. When the request is made within this time frame, no recovery action is taken until a hearing decision is reached.

To recover child care provider overpayments from an inactive child care provider (see Definitions and Categories of Overpayments, OAR 461-195-0501) refer to ODHS|OHA's Account Receivables Unit.

In addition to judicial process, ODHS|OHA may recover an overpayment (see OAR 461-195-0501) through an agreed repayment plan, reduction in benefits, voluntary payment from the individual or authorized representative (see Authorized Representatives; General, OAR 461-115-0090), and offset of the debt.

Liable persons receive 30, 60 and 90 day notices requesting them to contact ORU to set up a payment plan. Involuntary recovery may begin 90 days from the date of the initial notice if the individual has not requested a hearing or agreed to an acceptable payment plan.

All correspondence received from a bankruptcy court on an individual's or former participant's bankruptcy must be forwarded to ORU.

ODHS|OHA reduces current benefits to collect an overpayment only as follows:

- **For OSIPM,** ODHS|OHA may recover an overpayment by reducing cash medical related payments by the lesser of the following:
  - The total overpayment amount
  - The total benefit amount, or
  - Ten percent of the individual's total benefit requirement at the standard of need.
- **In the REF, SFPSS and TANF programs:**
  - Allow only half of the 50 percent earned income deduction described in Earned Income Deduction; REF, REFM, and TANF (OAR 461-160-0160)
  - Reduce the benefit payment by 10 percent of the total benefit requirement of the benefit group (see Benefit Group, OAR 461-110-0750) at the appropriate program payment standard. The reduced benefit payment after such reduction, when combined with all other income (before allowing the 50 percent earned income deduction), may not be less than 90 percent of the benefit group's adjusted income payment standard for a family with no income. In the TANF program, the cooperation incentive (see TANF Cooperation Incentive Payment, OAR 461-135-0210) is not included in the calculations prescribed by this paragraph.

Recovery by a reduction in benefits will end when benefits are:

- Suspended or ended
- Converted to medical only, where there is no financial eligibility, or
- **For TANF,** under $10. The case will remain open with a zero monthly benefit. No overpayment recovery credit will be allowed for the amount of money the benefit group did not receive because it was under the $10 limit. In such cases, the recovery resource code must be on UCMS so that overpayment records will not show a reduction of the overpayment balance(s).

The benefit group may voluntarily repay cash program overpayments using cash benefits over and above any mandatory benefit reduction. When benefits are used as repayment, ODHS|OHA will complete a Voluntary Agreement to Take Action on Case (MSC 0457D) form and an Overpayment/Overissuance Change Report (MSC 0284A) form. The EBT card issuer must adjust the EBT account accordingly. The individual and worker must sign the MSC 0457D or the MSC 0284A for the dollar amount. Send completed forms to ORU.

In the SNAP program, ODHS|OHA collects an overpayment from a liable member of a filing group participating in the SNAP program by reducing the food benefits allotment of the benefit group each month as follows:

- For an overpayment caused by an individual's error (see Definitions and Categories of Overpayments, OAR 461-195-0501) or administrative error, 10 percent of the group's monthly allotment or $10 a month, whichever is greater.
- For an overpayment caused by an IPV (see Intentional Program Violation Defined, OAR 461-195-0601), 20 percent of the group's monthly entitlement or $20 a month, whichever is greater.

In the child care programs:

- ODHS|OHA may not recover an overpayment through reduction of the individual's child care program benefits.
- When a child care program provider is liable for a child care overpayment (see Definitions and Categories of Overpayments, OAR 461-195-0501) ODHS|OHA may recover the child care overpayment by reducing up to 100 percent any future child care payment for which the provider bills ODHS|OHA.
- Voluntary agreement occurs to reduce benefits above any mandatory benefit reduction.
- The benefit group may voluntarily request to repay their existing overpayment with unused EBT benefits in the following programs:
  - SNAP benefits can be applied toward SNAP overpayments.
  - TANF benefits can be applied toward TANF or ERDC overpayments.

ODHS|OHA may recover above any mandatory reduction only if the individual signs a Voluntary Agreement to Take Action on Case (MSC 0457D or ONE-121) form. The form must indicate the program and the amount of the benefit reduction to be applied toward the existing overpayment. Staff should refer individuals directly to ORU for these voluntary requests. ORU will explain to individuals the available benefits that can be applied toward the existing overpayment; ensure the MSC 0457D or ONE-121 is completed and signed; adjust the EBT account accordingly; apply the requested amount to the overpayment balance; and narrate the action taken.

ODHS|OHA may recover an overpayment by offset as follows:

- Using the collection services provided by the Department of Revenue and any other state or federal agency to

collect a liquidated claim established by:

- A court judgment
- A confession of judgment
- A document signed or acknowledged by the debtor that acknowledges the debt, such as:
  - ODHS|OHA-designated form to acknowledge an IPV (see Agreement to Intentional Program Violation, Temporary Assistance to Needy Families (TANF – cash for families), Supplemental Nutrition Assistance Program (SNAP – food benefits) Waiver of Right to Hearings (MSC 0649C), Agreement to Waive Child Care Provider Hearing for Intentional Program Violation (MSC 0649CP))
  - A plea-bargain agreement
  - Any other document acknowledging the overpayment.
- A written notification of overpayment from ODHS|OHA to the debtor, advising the debtor of the basis and amount of the overpayment and the right to request a hearing, if the debtor has exhausted their rights of administrative appeal
- A written communication from the debtor acknowledging the debt.
  - A voluntary agreement to reduce benefits, participation in a voluntary payment plan or a mandatory reduction, does not prevent or preclude recovery from other sources, such as state income tax refund offset.

- Through use of a warrant authorized by ORS 411.703. Upon issuance of the warrant, ODHS|OHA may issue a notice of garnishment in accordance with ORS 18.854 (Notices of garnishment generally)
- The amount of any retroactive payment or restoration of lost benefits otherwise payable to the individual, when the retroactive payment corrects a prior underpayment of benefits in the program in which the overpayment occurred
- In the SNAP program, by offsetting the full amount of the overpayment against restored benefits owed to the benefit group or to another benefit group a liable member of the overpaid group has joined.

The retroactive payment amount is credited to the overpayment by the following method:

- Contact ORU to determine the outstanding overpayment balance.
- Complete a Notice of Restoration of Benefits (DHS 0362).
- Issue to the individual only the portion of the retroactive payment that exceeds the overpayment balance.
- Send a copy of the completed Provider Overpayment/Over-Issuance Report (MSC 0284P) to ORU for the retroactive payment to be credited to the overpayment.

A confession of judgment is used in the case of the individual's error (see Definitions and Categories of Overpayments, OAR 461-195-0501) in overpayment. ODHS|OHA may not file a confession of judgment while the individual receives public assistance or medical assistance and may file one only if the individual has refused to agree to or has defaulted on a repayment plan.

When individuals are found by a court to be guilty of fraud, the court may order restitution. ODHS|OHA will initiate recovery actions for the full amount of the overpayment even if the court did not order restitution or the amount of the restitution ordered is less than the full overpayment amount.

ODHS|OHA may not take collection action against a filing group while a member of the filing group is working under a JOBS Plus agreement.

Receipting direct overpayment reimbursements

The local branch must transmit all money it collects to ODHS|OHA Receipting Unit via DHS 0029 (DHS General Receipt Book) (paper only) system. For direct reimbursements via check, cash or money order, enter the following receipt codes (for additional receipting codes, see the Business Integrity Manual, now titled Field Business Procedures Manual):

- 745 for administrative error overpayments in the SNAP program
- 746 for an individual's error in the SNAP program
- 747 for IPV in the SNAP program
- 231 for all TANF overpayment recoveries that have an Overpayment/Overissuance Report MSC 0284 form
- 232 for all ERDC reimbursements with appropriate MSC 0284 forms processed
- 216 for Medical overpayment recoveries that have an MSC 0284.

Do not use these codes when benefits are reimbursed to prevent an overpayment; use code 216.

Note: Make sure all checks or money orders are made out to the Overpayment Recovery Unit.

Compromise of overpayment claims

For overpayments in Child Care, SNAP, Medical and TANF programs, the Overpayment Recovery Unit (ORU) will consider requests for a compromise on the unsatisfied balance. When an individual or former participant has questions regarding recovery of their overpayment claim, including compromising, refer them to a recovery specialist at ORU at (503) 373-7772 in Salem or toll-free 800-273-0548.

ODHS|OHA may consider a request to compromise an overpayment claim only if the estimated administration and collection costs necessary to collect the account in full likely exceed the current balance of the overpayment. The following limitations apply to the compromise of an overpayment claim:

- The authority of ODHS|OHA to compromise may be limited by federal or state law.
- ODHS|OHA may compromise a claim only after it is liquidated (see OAR 461-195-0501).
- ODHS|OHA may compromise a claim only if the requester has made a good faith effort to repay the overpayment;
- ODHS|OHA may not compromise:
  - A fraud overpayment (see Definitions and Categories of Overpayments, OAR 461-195-0501) claim
  - Any overpayment claim, unless 36 months have passed since the requester initially was notified of the overpayment
  - An overpayment claim if the debtor has the ability to repay the overpayment in full within 36 months of the request date
  - An overpayment claim for less than 75 percent of the total amount of the claim
  - An overpayment claim if the debtor is a member, currently or in the previous 12 months, of a filing

group or HSD medical program household group that received benefits under the program in which the overpayment occurred

- A child care provider overpayment claim if the provider, currently or in the previous 12 months, received a direct provider payment for child care.

ODHS|OHA may allow a compromised claim to be paid in installments over a period not to exceed 90 days.

During the 12 months following the date of the compromise agreement, ODHS|OHA reserves the right to collect the original unmitigated claim through benefit reduction under Methods of Recovery Overpayments (OAR 461-195-0551).

Referrals to the Investigations Unit

Role of the investigator

The investigator conducts investigations as needed to support branch operations in case management. Results of these investigations are reported to ODHS|OHA and/or OWU and can result in eligibility determinations, overpayments, intentional program violations and/or referral to a district attorney for criminal prosecution.

Protocol for appropriate referrals to the Investigation Unit

Do not disclose to an individual that a case will be or was referred to an ODHS|OHA investigator, or the status of an investigation.

Do not narrate or add a case note that an investigator referral was made.

The following are examples of referrals that are appropriate for the ODHS|OHA investigator:

- Individuals/providers receiving duplicate benefits using different names and SSNs
- Individuals receiving cash, medical or SNAP benefits simultaneously from more than one state or in more than one filing group in Oregon
- Individuals failing to report receipt of earned or unearned income
- Under-reported earned or unearned income
- False report of nonreceipt of benefit and receipt of duplicate benefit
- Not reporting assets (e.g., real property, boats, recreational vehicles, livestock, etc.)
- Unreported liquid or easily converted assets (e.g., cash, bank accounts, bonds, stock, etc.)
- Unreported marriage
- Unreported self-employment
- Unreported property settlement
- Presentation of forged documents by an individual
- An individual's receipt of assistance for nonexistent children or children no longer in the household
- "Absent" parent in the household
- False presentation of child care expenses including falsified or forged documents, care not provided, a fictitious provider, etc.

- Presentation of false claims for OHP benefits including unreported and under- reported income, false claim of residency, unreported assets/resources, false financial groups, etc

Do not refer routine eligibility matters such as:

- Routine home visits on new, reopened or ongoing cases
- Separate financial group verification
- In-state motor vehicle license checks
- Vital statistics checks
- School attendance verification
- Citizenship verification
- Determining value of assets.

Do not ask the ODHS|OHA investigator to investigate sale of drugs or income from illegal activities. These are police matters.

Reporting the result of an investigation

Upon completion of an investigation, the ODHS|OHA investigator will send a written report (enclosing any documented evidence obtained) to ODHS|OHA the overpayment referral originated and DPU with a copy to the ORU overpayment writer and/or the IPV Team, if appropriate.

If a case is referred to a district attorney for consideration of prosecution, ODHS|OHA the overpayment referral originated and DPU will be notified in writing and will receive a copy of the report to the district attorney when the case has reached its disposition.

If the investigator has documented evidence of an IPV and has decided not to refer the case for prosecution, the investigator will refer the case to the IPV Team for IPV processing.

The IPV Team will notify claimants that they can avoid an IPV hearing by signing an Agreement to Intentional Program Violation, Temporary Assistance to Needy Families (TANF – Cash for families), Supplemental Nutrition Assistance Program (SNAP – food benefits) Waiver of Right to Hearing (MSC 0649C). If the claimant signs the MSC 0649C, they waive all rights to an IPV hearing for the offense and accept the disqualification period (unless the waiver is set aside by an ALJ or court because the waiver was signed under duress). OWU will initiate collection and disqualification. OWU will notify DPU of the IPV.

When claimants choose not to sign an MSC 0649C, and the IPV Team has documented evidence to support IPV, an IPV hearing will be initiated by the IPV Team. The hearing is scheduled and the claimant and branch/DPU office's designated contact person is notified of the time and place of the hearing.

When the final hearing order is received by the IPV Team, and the claimant is found to have committed an IPV, the case is referred to OWU for initiation of disqualification penalties and collection of the overpayment.

IPV disqualification periods

This section does not apply to HSD medical programs.

IPV (intentional program violation) person disqualification periods:

1st DQ	=	12 months
2nd DQ	=	24 months
3rd DQ	=	permanently

Additionally, effective October 1996:

For SNAP, when an IPV is established against any person found guilty of:

- Trading SNAP benefits for firearms, ammunition or explosives, the person will be disqualified from SNAP benefits permanently starting with the first DQ
- Trading SNAP benefits for controlled substances, the person will be disqualified from SNAP benefits for 24 months with the first DQ and permanently for the second DQ
- Trafficking (buyer or seller) in SNAP benefits of $500 or more, the person is permanently disqualified from SNAP benefits.

A person is disqualified for a 10-year period from receiving benefits in the program in which the person committed fraud if the person:

In the TANF Program:

- Is convicted in state or federal court of having made a fraudulent statement or representation with respect to the place of residence of the individual in order to receive assistance simultaneously from two or more states under programs funded under title IV or XIX of the Social Security Act, or
- Is found in an IPV hearing or admits, in a written waiver of the right to an IPV hearing, to having made a fraudulent statement or representation with respect to the identity or place of residence of the individual in order to receive benefits simultaneously from two or more states.

In the SNAP Program:

- Is found to have made a fraudulent statement or representation regarding the identification of place of residence of an individual in order to receive multiple benefits from one or more states simultaneously under programs funded under the Food Stamp Act of 1997 and Nutrition Act of 2008 through:
  - A state or federal court conviction
  - An IPV hearing, or
  - A written waiver of the right to an IPV hearing. SNAP IPVs established in another state or established in the Food Distribution Program on Indian reservations continue in effect in Oregon.

For ERDC, an individual is not subject to an IPV disqualification but is still required to repay overpayment amounts.

- A child care provider who has incurred an overpayment established as an IPV claim between April 1, 2001, and Sept. 30, 2005, is permanently disqualified to receive payments.
- A child care provider who has incurred an overpayment in the Child Care Program established as an IPV after Sept. 30, 2005, is disqualified:
  - For six months and until the full amount of the overpayment is paid, or

- Permanently, if the Child Care Program manager finds it in the best public interest.

Forms

Use an ODHS General Receipt Book (DHS 0029) (paper only) to receipt monies received directly from the individuals or providers.

Use a SNAP Benefits Computation (DHS 0221) or the SNAP Calc, (or PC facsimile) to compute SNAP overpayments.

Use an Overpayment/Overissuance Report (MSC 0284) to compute and record all overpayments, except provider overpayments.

Note: DHS 0284 forms that are marked CE (client error) or PF (possible fraud) are screened for possible referral to the Investigation Unit.

For OSIPM and MSP, use a Notice of Overpayment and Planned Action Form (MSC 284S). Complete notice and attach it and all overpayment calculation sheets to the MSC 0284.

Use an Overpayment Referral Form (MSC 0284R) for all APD/AAA benefits to refer potential participant caused overpayments to the Overpayment Writing Unit.

Use an Overpayment/Overissuance Change Report (MSC 0284A) to adjust the amount of an overpayment already reported. Do not use this form to submit a new overpayment or to increase an overpayment if the reason to increase is different from the reason for the original overpayment. Submit to OWU within three days of completion.

Use Form CO 01ST to notify an individual or former participant of an overpayment and their hearings rights. Show the computation of the overpayment on the TANF Calc used to compute the overpayment.

Use a Notice of Overpayment and Planned Action for Provider Overpayments (MSC 0284BP) to notify providers of overpayments.

Use a Daycare Overpayment Worksheet (MSC 0284DC) to compute all child care overpayments. Additionally, for child care overpayments, indicate on the Overpayment/ Overissuance Report form (MSC 0284) in which ERDC program the overpayment occurred. Complete and attach an MSC 0284DC. Send the completed forms to OWU within three days of completion.

Use a Self-Sufficiency Overpayment Referral (MSC 0284F) to refer potential participant-caused overpayments to the Overpayment Writing Unit.

When the overpayment is calculated using the TANF calculation program, be sure to include an explanation of the calculation.

For medical programs, use a Notice of Medical Overpayment and Planned Action (MSC 0284M) to notify an individual or former participant of a medical program overpayment and their hearing rights. Show the computation of the overpayment on medical overpayment calculation worksheets. Attach a copy of the participant notice and the calculation sheets to the MSC 0284.

Use a Provider Overpayment/Over-Issuance Report (MSC 0284P) to record a claim for a provider overpayment.

Use a Notice of Restoration of lost Benefits (DHS 0362) when benefits are restored to an individual who has been

underpaid. Send a copy to ORU when restored benefits need to be applied to an overpayment.

Use an OPAR Fraud Investigation Unit Investigation Referral (MSC 0371) to refer a case for investigation to the Investigation Unit.

Use an Authorization of Cash Payment (MSC 0437) to authorize and issue a payment.

Use a Voluntary Agreement to Take Action on Case (MSC 0457D or ONE-121) when an individual is authorizing ODHS|OHA to take action on their case.

Use an Agreement to Intentional Program Violation, Temporary Assistance to Needy Families (TANF – cash for families), Supplemental Nutrition Assistance Program (SNAP – food benefits) Waiver of Right to Hearing (MSC 0649C) when the individual agrees they intentionally violated an eligibility requirement or withheld information.

Use a Verification of Earnings (MSC 0851) when verification of actual gross income is requested directly from an individual's employer.

SNAP

In the SNAP program, overpayments include the trading of a controlled substance (as defined in section 102 of the Controlled Substances Act in 21 U.S.C.802) as the buying or selling of SNAP program benefits for cash or consideration other than eligible food; or the exchange for SNAP program benefits of firearms, ammunition, explosives or controlled substances.

Overpayment liability

In the SNAP program, the following individuals are liable for repayment of an overpayment or a claim that results from the trading of a controlled substance (see Definitions and Categories of Overpayments, OAR 461-195-0501(6)):

- The primary person (see Definitions; SNAP, OAR 461-001-0015) of any age, an ineligible student in the household and all adults who were members of or required to be in the filing group (see Filing Group; SNAP, OAR 461-110-0370) when excess benefits were issued
- A sponsor of a non-citizen household member if the sponsor is at fault, for payments prior to Nov.21, 2000
- A drug or alcohol treatment center or residential care facility that acted as the authorized representative of the individual.

No member of a financial group (see Financial Group, OAR 461-110-0530) is liable for an overpayment caused by a change the group was not required to report.

An emancipated minor is an adult under state law and therefore liable.

Overcollection of SNAP overpayments

If money was collected in error or if the overpayment claim is over-collected, ORU will reimburse the individual the over-collected amount including over-collected benefit reductions.

TANF

In the REF, SFPSS and TANF programs, overpayments include the full amount of cash benefits when the cash benefits were used or accessed in Oregon, outside Oregon or on Tribal lands at a:

- Liquor store, including retail establishments that exclusively or primarily sell beer or wine
- Casino, gambling casino or gaming establishment
- Retail establishment that provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment, including adult video stores that exclusively or primarily sell or feature adult-oriented videos or movies
- Marijuana dispensaries.

These restrictions also apply to using or accessing TANF cash benefits from a private bank account.

In the TANF program, an overpayment includes a payment for child care made by ODHS|OHA to or on behalf of an individual that:

- Is paid to an ineligible provider
- Exceeds the amount for which a provider is eligible
- Is paid when the individual was not engaged in an activity that made the individual eligible for child care, such as completing activities for the JOBS program, or
- Is paid when the individual was not eligible for child care benefits.

It is not an individual overpayment in the Child Care Program when an individual would otherwise be eligible for a child care payment and provides inaccurate information due to an aspect of a documented disability of the individual.

It may not be a provider overpayment in the Child Care Program when the total paid to two or more providers exceeds the monthly limit ODHS|OHA may pay on behalf of the individual unless:

- Two or more providers were paid at the full-time rate, or
- One of the providers is under contract with ODHS|OHA to provide child care.

Cash benefits include JOBS program support payments, including child care support service payments.

Overpayment liability

In the TANF program, the following individuals are liable for repayment of an overpayment:

- Each individual in the filing group or required to be in the filing group and the payee when the overpayment was incurred, except an individual who did not reside with and did not know they were included in the filing group
- A caretaker relative (see Definitions for Chapter 461, OAR 461-001-0000) and their spouse (see OAR 461-001-0000) who were not part of, but resided with, the filing group when the overpayment was incurred
- A parent (see OAR 461-001-0000) or caretaker relative of a child (see OAR 461-001-0000) in the benefit group (see Benefit Group, OAR 461-110-0750) and the spouse of the parent or caretaker relative if the parent, caretaker relative or spouse was a member of or resided with the filing group when the overpayment was incurred
- An individual determined liable for an overpayment remains liable when the individual becomes a member of a new filing group

- An authorized representative (see Authorized Representatives; General, OAR 461-115-0090) when the authorized representative gave incorrect or incomplete information or withheld information resulting in the overpayment.

ERDC In the ERDC program, an overpayment includes a payment for child care made by ODHS|OHA to or on behalf of an individual that:

- Is paid to an ineligible provider
- Exceeds the amount for which a provider is eligible
- Is paid when the individual was not engaged in an activity that made the individual eligible for child care, such as working or attending school, or
- Is paid when the individual was not eligible for child care benefits.

It is not an individual overpayment in the child care program when an individual would otherwise be eligible for a child care payment and provides inaccurate information due to an aspect of a documented disability of the individual.

It may not be a provider overpayment in the child care program when the total paid to two or more providers exceeds the monthly limit ODHS|OHA may pay on behalf of the individual unless:

- Two or more providers were paid at the full-time rate, or
- One of the providers is under contract with ODHS|OHA to provide child care.

Liability for Child Care Program overpayments

An overpayment caused by administrative error is collectible as follows:

- The provider is liable for a provider overpayment made on behalf of the individual eligible for child care payments.
- Each adult in the filing group or required to be in the filing group is liable for an overpayment if the individual was not eligible for the payment. This is referred to as the individual-liable overpayment.

Each adult in the filing group or required to be in the filing group is liable for an individual overpayment, and a provider is liable for an overpayment caused by the provider. The individual and provider are jointly liable for an overpayment caused by both. In situations where there is joint liability, the amount of the overpayment cannot exceed the total benefit amount. In the case of an alleged provider overpayment, a provider's failure to provide adequate records of care creates a rebuttable presumption that the care was not provided.

An adult who cosigned an application with a minor provider applicant is liable for an overpayment incurred by the minor provider.

Use this general rule of thumb in figuring out who is liable for the overpayment:

- If the provider provided the child care service and the individual is not eligible, it is the individual's overpayment.
- If the provider did not provide the service or was not eligible and the individual is eligible, it is a provider overpayment.

- If both the provider and individual were not eligible, it is a joint liability overpayment.

The following questions should be used to determine who is liable for a child care overpayment:

- Were the individual and/or child eligible for child care services?
  This means the individual and/or child were:
  - Engaged in an activity that made the individual eligible for child care, and
  - Eligible for child care benefits

    YES – Go to next step. **NO** – Write OVP for the individual or administrative error.
- Is the provider eligible for approved listing status?

  YES – Go to next step. **NO** – Write OVP for provider.
- Did the provider on the billing form provide the child care services?

  YES – Go to next step. **NO** – Write OVP for provider.
- Was the child in provider's care the same number of hours as billed?

  YES – Go to next step. **NO** – Write OVP for provider.
- Was child care billed at correct rate?

  YES – Go to next step. **NO** – Write OVP for provider.
- Did ODHS|OHA data entry make the correct payment?

  YES – Go to next step. **NO** – Write OVP as administrative error for provider.
- Is there evidence the parent and provider collaborated to receive a payment for which they were not eligible (other than parent signature on billing form)?
  - This means the parent was not eligible for the service and the provider was not eligible to provide or did not provide the child care.

    YES – Write OVP for both provider and parent. **NO** – Does an OVP really exist?

REF In the REF, SFPSS and TANF programs, overpayments include the full amount of cash benefits when the cash benefits were used or accessed in Oregon, outside Oregon or on Tribal lands at a:

- Liquor store, including retail establishments that exclusively or primarily sell beer or wine
- Casino, gambling casino or gaming establishment
- Retail establishment that provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment, including adult video stores that exclusively or primarily sell or feature adult-oriented videos or movies
- Marijuana dispensary.

These restrictions also apply to using or accessing TANF cash benefits from a private bank account.

Overpayment liability

In the REF program, the following individuals are liable for repayment of an overpayment:

- Each individual in the filing group or required to be in the filing group and the payee when the

overpayment was incurred, except an individual who did not reside with and did not know they were was included in the filing group

- A caretaker relative (see OAR 461-001-0000) and their spouse (see OAR 461-001-0000) who were not part of, but resided with, the filing group when the overpayment was incurred;
- A parent (see Definitions for Chapter 461, OAR 461-001-0000) or caretaker relative of a child (see OAR 461-001-0000) in the benefit group (see Benefit Group, OAR 461-110-0750) and the spouse of the parent or caretaker relative if the parent, caretaker relative or spouse was a member of or resided with the filing group when the overpayment was incurred
- An individual determined liable for an overpayment and who remains liable when the individual becomes a member of a new filing group
- An authorized representative (see OAR 461-115-0090) when the authorized representative gave incorrect or incomplete information or withheld information resulting in the overpayment.

MSP Overpayment liability

In MSPs, the following persons are liable for repayment of an overpayment:

- Each individual in the filing group or required to be in the filing group and the payee when the overpayment was incurred, except an individual who:
  - Was a child or dependent child at the time of the overpayment; or did not reside with and did not know they were included in the filing group
  - A caretaker relative and their spouse who were not part of but resided with the filing group when the overpayment was incurred
  - A parent or caretaker relative of a child in the filing group and the spouse of the parent or caretaker relative if the parent, caretaker relative, or spouse was a member of or resided with the filing group when the overpayment was incurred
  - An authorized representative when the authorized representative knowingly gave incorrect or incomplete information or intentionally withheld information that resulted in the overpayment
- A sponsor of a non-citizen household member if the sponsor is at fault
- A drug or alcohol treatment center or residential care facility that acted as the participant's authorized representative.

In all programs, both a non-citizen and the sponsor of the non-citizen are liable for an overpayment incurred if the overpayment results from the failure of the sponsor to provide correct information (see 461-145-0820 to 461-145-0840). If the sponsor had good cause (see 461-195-0521(5)) for withholding the information, the sponsor is not liable for the overpayment.

Change in the payee/benefit group or program

ODHS|OHA will continue to recover the overpayment from the benefit group in which the overpayment occurred, even if there is a change in the payee. If any member of the overpaid benefit group is eligible for and included in another group, recovery will be made from that group's benefits, but only if the recovery is limited to the amount of overpayment incurred when the member actually resided in the household of

or was a member of the overpaid benefit group.

OSIPM

Overpayment liability

For OSIPM, the following persons are liable for repayment of an overpayment:

- Each individual in the filing group or required to be in the filing group and the payee when the overpayment was incurred, except an individual who:
  - Was a child or dependent child at the time of the overpayment; or who did not reside with and did not know they were included in the filing group
  - A caretaker relative and their spouse who were not part of but resided with the filing group when the overpayment was incurred
  - A parent or caretaker relative of a child in the filing group and the spouse of the parent or caretaker relative if the parent, caretaker relative or spouse was a member of or resided with the filing group when the overpayment was incurred
  - An authorized representative when the authorized representative knowingly gave incorrect or incomplete information or intentionally withheld information that resulted in the overpayment.
- A sponsor of a non-citizen household member if the sponsor is at fault
- A drug or alcohol treatment center or residential care facility that acted as the participant's authorized representative.

Note: Remember, no member of a financial group is liable for an overpayment caused by a change the group was not required to report.

Note: An emancipated minor is an adult under state law and, therefore, liable. For example, a benefit group consists of an 18-year-old with his 17-year-old wife. The wife became emancipated when she got married and is therefore equally liable for an overpayment as the 18-year-old husband.

In all programs, both a non-citizen and the sponsor of the non-citizen are liable for an overpayment incurred if the overpayment results from the failure of the sponsor to provide correct information (see 461-145-0820 to 461-145-0840). If the sponsor had good cause (see 461-195-0521(5)) for withholding the information, the sponsor is not liable for the overpayment.

Change in the payee/benefit group or program

ODHS|OHA will continue to recover the overpayment from the benefit group in which the overpayment occurred, even if there is a change in the payee. If any member of the overpaid benefit group is eligible for and included in another group, recovery will be made from that group's benefits, but only if the recovery is limited to the amount of overpayment incurred when the member actually resided in the household of, or was a member of, the overpaid benefit group.

Provider overpayments

Provider caused overpayments are calculated by an ODHS|OHA employee and reported to the Provider and Consumer Services Unit. These are provider payments received by adult foster care providers,

community-based care providers, etc. The Provider and Consumer Services Unit will work out a reasonable repayment plan with the provider and a recoupment will occur (similar to a garnishment).

HSD For the **HSD medical programs**, the following persons are liable for repayment of an overpayment:

- Each individual who was in or was required to be in the HSD medical program household group except an individual who:
  - Was a child or dependent child at the time of the overpayment, or
  - Did not reside with and did not know they were included in the HSD medical program household group
- A caretaker relative and their spouse who were not part of but resided with the HSD medical program household group when the overpayment was incurred
- A parent or caretaker relative of a child in the HSD medical program household group and the spouse of the parent or caretaker relative if the parent, caretaker relative or spouse was a member of or resided with the HSD medical program household group when the overpayment was incurred
- An authorized representative when the authorized representative knowingly gave incorrect or incomplete information or intentionally withheld information that resulted in the overpayment.

Oregon Administrative Rule(s)

461-195-0501 — Definitions and Categories of Overpayments
461-195-0521 — Calculation of Overpayments
461-195-0541 — Liability for Overpayments
461-165-0180 — Eligibility of Child Care Providers
461-165-0210 — Calculating Restored and Supplemental Benefits
461-175-0290 — Notice Situation; Overpayment Repayment
461-195-0551 — Methods of Recovery Overpayments
461-180-0130 — Effective Dates: Restored Benefits
461-195-0561 — Compromise of an Overpayment Claim

Hearings

A hearing is a formal proceeding about individual benefits when the individual has filed a hearing request and disputed a decision made by ODHS|OHA staff. The hearings process provides a "second look" to ensure the benefit or overpayment decisions are correct. Hearings are also held to resolve other issues (see hearings guide). Administrative Law judges from the Office of Administrative Hearings (OAH) preside over each hearing, and ODHS|OHA's position in the hearing is explained by an ODHS|OHA representative, usually a Compliance Specialist (Hearing Rep). When an individual requests a hearing, they are then referred to as the "Claimant". ODHS|OHA staff continue to work as appropriate with an individual who has requested a hearing.

All hearing requests must be submitted to ODHS|OHA within 24 hours of the date the consumer requested a hearing.

For more information, click here for Hearings guide.

Oregon Administrative Rule(s)

461-025-0300 – Contested Case Hearings
461-025-0301 – Lay Representation in Contested Case Hearings
461-025-0310 – Hearing Requests
461-025-0315 – Expedited Hearings
461-025-0316 – Intentional Program Violation (IPV) Hearings; SNAP Program
461-025-0350 – Withdrawals of Hearing Requests

Direct Pay Unit (DPU)

This is specific to child care providers. For adult community and home care providers, refer to LTC.

The Direct Pay Unit is responsible for issuing payments to approved child care providers as well as to employers contracting with ODHS|OHA for the Jobs Plus program. It is a closed facility, meaning it is not accessible by the public, and operates a phone line Monday through Friday 8:30am-4:30pm which can be accessed by the public or ODHS|OHA staff by dialing 1-800-699-9074.

SNAP This does not apply to the SNAP program.

TANF JOBS Plus billing

JOBS Plus is a subsidized work program administered by the State of Oregon, Oregon Department of Human Services. Individuals receiving Temporary Assistance for Needy Families (TANF) can be placed with private or public employers and receive a subsidy for wages paid. Employers determine the wage rate and pay the worker directly.

JOBS Plus workers receive a paycheck in lieu of public benefits. There is no requirement that the employer hire the worker at the end of the JOBS Plus subsidy. Employers are reimbursed by ODHS at the Oregon minimum wage plus employer wage taxes and workers' compensation costs. Employers are reimbursed for a maximum of 26 weeks.

The Direct Pay Unit (DPU) administers payment to JOBS Plus employers.

Click here for JOBS Plus.

Assisting child care providers with the approval process

The Direct Pay Unit (DPU) is responsible for many things, but helping child care providers become listed and approved with ODHS|OHA is one of the most prominent. This is a process which includes:

- Reviewing Provider Listing Forms (DHS 7494) to ensure child care providers meet ODHS|OHA pre-service requirements;
- Entering provider information into the Legacy system;
- Changing the List Status of a provider to Failed if they do not meet ODHS|OHA pre-service requirements, including health and safety requirements;
- Referring child care providers in need of assistance meeting health & safety requirements to their

local Child Care Resource and Referral (CCR&R) office; and

- Forwarding listing forms to the Background Check Unit (BCU) for possible approval.

Child care provider payment

In addition to assisting child care providers in the process of becoming listed, DPU also assists in the payment process for families receiving child care subsidy. For families receiving JOBS child care through the TANF program, this means:

- Setting up the connection between families and their child care providers;
  - To set up the connection, families can contact DPU via phone by calling 1-800-699-9074 Monday through Friday 8:30am-4:30pm, or eligibility staff can submit a Connection Request Form to DPU.ChildCare@dhsoha.state.or.us.
- Sending Child Care Billing (CCB) and JOBS Child Care Billing (JCCB) forms to a family's child care provider(s);
- Answering questions from families, providers, and ODHS|OHA staff on their phone line;
- Replacing CCBs and JCCBs as needed and processing adjustment payments to child care providers when a family's eligibility has changed;
- Processing provider changes, such as a change in address, household composition, or other changes;
- Providing technical assistance with the billing process to ODHS|OHA staff (this does not include eligibility assistance); and
- Referring families and child care providers to community resources as needed.

ERDC Assisting child care providers with the approval process

The Direct Pay Unit (DPU) is responsible for many things but helping child care providers to become listed and approved with ODHS|OHA is one of the most prominent. This is a process which includes:

- Reviewing Provider Listing Forms (DHS 7494) to ensure child care providers meet ODHS|OHA pre-service requirements;
- Entering provider information into the Legacy system;
- Changing the List Status of a provider to Failed if they do not meet ODHS|OHA pre-service requirements, including health and safety requirements;
- Referring child care providers in need of assistance meeting health & safety requirements to their local Child Care Resource and Referral (CCR&R) office; and
- Forwarding listing forms to the Background Check Unit (BCU) for possible approval.

Child care provider payment

In addition to assisting child care providers in the process of becoming listed, DPU also assists in the payment process for families receiving child care subsidy. For families receiving ERDC, this means:

- Setting up the connection between families and their child care providers;

  - To set up the connection, families can contact DPU via phone by calling 1-800-699-9074 Monday through Friday 8:30am-4:30pm, or eligibility staff can submit a Connection Request Form to DPU.ChildCare@dhsoha.state.or.us.
- Sending Child Care Billing (CCB) forms to a family's child care provider(s);
- Answering questions from families, providers, and ODHS|OHA staff on their phone line;
- Replacing CCBs as needed and processing adjustment payments to child care providers when a family's eligibility has changed;
- Processing provider changes, such as a change in address, household composition, or other changes;
- Closing ERDC cases when there is a Copay Not Met (CNM) – i.e., the family did not meet their copay responsibility;
- Providing technical assistance with the billing process to ODHS|OHA staff (this does not include eligibility assistance); and
- Referring families and child care providers to community resources as needed.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

Oregon Administrative Rule(s)

461-155-0150 – Child Care Eligibility Standard, Payment Rates, and Copayments

Background Check Unit (BCU)

The Background Check Unit reviews criminal and child protective service (CPS) records for those wishing to become ODHS|OHA approved home care workers, personal support workers, or ODHS|OHA approved child care providers. Their duties include, but are not limited to the following:

- Conducting criminal history, adult protective service (APS), child protective service (CPS), and other records checks as required by state and federal law or rules
- Performing background checks and provide support to all Oregon Department of Human Services (ODHS) and Oregon Health Authority (OHA) employees, contractors, subcontractors, vendors and volunteers who provide services, as well as ODHS and OHA regulated providers, including those who are licensed, certified, registered or employed by qualified entities
- Responding to reports of new criminal or protective service history on BCU-covered providers (BCU may conduct no more than one criminal records check on a subject individual within a two-year period unless certain criteria are met), and
- Failing or denying listing on child care provider records check. On re-evaluations, this stops CCBs from going out to this provider and generates a notice to the parent(s). On new child care providers, no payment will be made from ODHS|OHA.

SNAP This does not apply to the SNAP program.

TANF No additional program-specific information.

ERDC No additional program-specific information.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM **ORS 443.004 directly impacts the background check process.**

In this Oregon statute, public funds may not be used to support, in whole or in part, the employment in any capacity of individuals in certain positions if the individual has specific convictions. Individuals found ineligible for employment due to ORS 443.004 do not have hearing rights regarding this determination from the Background Check Unit.

ORS 443.004 has the following impacts: For APD/AAA programs and the Developmental Disabilities programs: The length of ineligibility based on a conviction depends on the age of the vulnerable individuals being served. Details regarding the crimes list are available in an APD/DD flyer.

Note: ORS 443.004 does not cover nursing facilities, hospitals or any non-paid positions such as volunteers or adult foster home household members

Click here for all current background check policies effective 2/10/2020.

Oregon Administrative Rule(s)

461-165-0180 – Eligibility of Child Care Providers
943-007-0001 to 0501 – Criminal Records Checks and Abuse Checks for ODHS|OHA Employees, Volunteers, Contractors, and Providers

Job Participation Incentive (JPI)

Job Participation Incentive (JPI) is to provide an additional food benefit to help increase the ability for parents with children to meet the nutritional needs of their families.

JPI benefit provides a $10 payment per month to SNAP cases with individuals that meet the TANF federal work participation rate by working at unsubsidized employment. The incentive is issued through the Oregon Trail (EBT) card connected to the SNAP open case. The benefits have the same USDA restrictions as the monthly SNAP food benefits. Individuals must be parents of a dependent child under 18. Also, the individual needs to meet SNAP citizen or qualified non-citizen criteria and be in the benefit group for SNAP.

ODHS|OHA will not count JPI as income for any ODHS|OHA program the participant is eligible for. The incentive will allow ODHS|OHA to include these individuals in the TANF federal work participation rate.

Initial enrollment

For initial enrollment, ODHS|OHA will review for JPI eligibility when they process the application for SNAP benefits.

To be enrolled in the JPI program, an individual must:

- Be an eligible adult in a SNAP benefit group and the parent of an eligible dependent child in the same SNAP benefit group;
- For anyone in the SNAP benefit group to have not received any of the following in the same month as JPI: Employment Payments, Post-TANF, SFPSS or TANF program benefits;
- Be working at an unsubsidized paid employment averaging weekly hours that meet federally required participation rates. (For self-employed participants, income must be equivalent to hours at Oregon minimum wage);
  - Average of 20 weekly hours for a single parent with a dependent child under 6 years, or
  - Average of 30 weekly hours for a single parent with a dependent child age 6 to under 18; or
  - Combined average of 35 weekly hours for a two-parent family with a dependent child under 18 that does not receive ERDC benefits; or
  - Combined average of 55 weekly hours for a two-parent family with a dependent child under 18 that receives ERDC benefits.
- Provide employer-produced documents of paid, unsubsidized work hours covering a consecutive two-week period that has occurred within the last 60 days;
- Anticipate the weekly employment hours will remain the same or increase for the SNAP reporting period; and
- Report changes as required for SNAP cases in CRS, SRS or TBA reporting systems.

In a two-parent family, only the working parent(s) need to be in the SNAP benefit group. The other parent needs to be in the SNAP filing group.

There is no formal application process for JPI. ODHS|OHA will identify eligible participants as they process SNAP benefits. ODHS|OHA will not pend or deny JPI benefits.

Ongoing enrollment

Ongoing enrollment will be determined as SNAP cases are updated:

- Participants will need to provide employer-produced documents of paid, unsubsidized work hours each time requested by ODHS|OHA or no later than the last day of the sixth month in conjunction with SRS and recertification time frames; and
- Participants will need to continue to meet all JPI eligibility criteria.

If a participant loses JPI eligibility in a month, the participant may apply and, if eligible, receive other TANF-funded benefits.

Initial month of eligibility has to be issued manually by using EN or IN issuance code.

Verification of eligibility

Participants must provide documentation to ODHS|OHA when it is requested. Documentation needs to be from an employer that verifies the number of work hours or, if income is derived from self-employment, the participant will need to provide verification of self-employment income. Work hours can also be verified through collateral contact,

including The Work Number or verbal evidence given by an employer or written evidence given by a third party that has direct knowledge of the hours worked or self-employment income.

The following information is to be verified at initial application, at interim change report, at renewal and/or when reported changes occur:

- Hours worked;
- Parent of a dependent child;
- SNAP eligibility; and
- Reporting requirements for SNAP CRS, SRS or TBA reporting system.

Verbal employer verification and verification of work hours from anyone but employer should be limited and used as a last resort for verification. ODHS|OHA will narrate the conversation: who they received the information from and what the information was.

Financial eligibility requirements

To be eligible for JPI, the participant will need to meet SNAP financial eligibility. If a participant is making more than the categorical eligibility limit, they become ineligible for benefits.

Resource and resource limits

JPI participants do not need to meet resource or resource limit requirements. They should be considered categorically eligible for SNAP.

JPI income and payment standards

Participants must submit employer verified hours worked for a two-consecutive-week period. Eligible participants will receive a $10 JPI food benefit each month as long as they continue to meet SNAP eligibility requirements and enrollment criteria for JPI.

Calculating hours for JPI, JP2, J82

Guidance on calculations in the following situations:

- Contracted/Piecework – Hours are determined using the monthly gross income and dividing it by the Oregon minimum wage and 4.3 weeks in a month.
- Commission – When ODHS|OHA does not have proof of hours for commission, take total amount received and divide by the Oregon minimum wage and 4.3 (if received monthly) 2.15 or 2, etc.
- S-Corporations – A Subchapter S-corporation is incorporated under Chapter S of the Internal Revenue code. Each shareholder is responsible to file their own taxes on the profits the corporation distributes.
- For example, a law firm or other partnership may incorporate their business under Chapter S. Owners or shareholders of a company are NOT self- employed and the profits distributed to shareholders of a S-Corporation are therefore not divided by minimum wage to obtain hours worked. Applicants/recipients must provide documentation of work hours (paystubs w/hours, employer contact, etc.)
- Salary –ODHS|OHA needs verification of hours worked for salaried jobs. Applicants/participants need to

provide documentation of work hours (paystubs w/hours, employer contact, etc.)

The WAGE screen cannot be used as a current primary source of verification of hours worked, but if the participant hhas current salary verification and reports the same job and hours as prior work quarters, then the hours from WAGE can be used to determine weekly work hours. ODHS|OHA will narrate how they came to their determination.

Program benefits

JPI payments are treated as follows:

- The JPI is issued out as a food benefit and should be excluded for all programs.

Making Job Participation Incentive (JPI) issuances

When a participant has been determined eligible for JPI, there are codes that need to be added to ODHS|OHA systems. Without proper coding the benefit may not get issued correctly and/or the individual will not help Oregon meet TANF federal work participation rates. The monthly payments are made by entering the correct HH type in the system. The work participation hours are gathered by entering the correct Case Descriptor and Need/Resource coding.

Making updates to or create a UCMS case

Identify UCMS cases that can be used for JPI in the following order:

- An open UCMS in P2/M5 status where the JPI eligible individual is listed as a member (ex. AD or NO);
- An inactive UCMS case where the JPI eligible individual is listed as a member and this person was the payee on the case before; or
- Create a UCMS case to house the JPI coding.

Update the identified UCMS case with the following codes:

- Program type “P2” unless Participant is also eligible for ERDC – then “M5.”;
- JPI Case Descriptor coded on the JPI eligible individual;
- JPI, JP2 or J82 need resource (n/r) coded on the JPI eligible individual. The end date should match the SNAP Reporting date (which is the SRS period, the end of TBA or the recertification period). The amount should reflect the average weekly hours the JPI eligible individual is employed, this entry must be minimum:
  - 20.00 for JPI n/r
  - 30.00 for JP2 n/r
  - 35.00 for J82 n/r for a two-parent family not receiving ERDC (P2 case)
  - 55.00 for J82 n/r for a two-parent family receiving ERDC (M5 case)
- Use the Need Resource (n/r) to enter the hours – the system will count this as weekly participation hours, not as a dollar amount.
- Add ‘S’ to the JS (job status) field of the JPI eligible individual to reflect that this person is in a TANF-related but state-funded program.
- Add last grade completed to the JPI eligible individual – if known. (Do not guess.)

- There needs to be a child (under 6 for JPI and under 18 for JP2 or J82) on the case and there needs to be a parent relationship coded on the child. Add the parent letter for the parent on the case. There does not need to add absent parent information.
- For J82 cases, it is important to code the mom and dad fields on the children of the parents on the case to establish a two-parent household.
- Upon saving the UCMS setup, ODHS|OHA will be required to add or update the TANF Report Data for each individual on the case. This is required information for reporting the individual's federal work participation hours.

When coding JPI on a two-parent case where the family receives ERDC, code the JPI on the m5 case.

These cases are not subject to the requirement to cooperate with the Division of Child Support to establish paternity and pursue child support.

Making updates to or creating a FCAS case

When making updates, ODHS|OHA will do the following:

- Add JPI (for a single parent with a child under 6);
- Add JP2 (for a single parent with a child 6 to under 18);
- Add J82 (for a two-parent family with a child under 18)
- Update the household (HH) type to the case. The worker may add it at same time as REC, TBS and SRS transactions with or without an ADJ ISS.

Issuing JPI

Use the 'N' issuance type when issuing JPI. This code will track the JPI and JP2 benefit issuances. There are a separate issuance from a participant's regular SNAP benefits. JPI is not considered a SNAP benefit, but they are a food benefit. The 'N' issuance type can be used with either 'I' or 'E' with an ISS transaction code (IN or EN).

The issuance type requires you to fill in the amount and the date. For the amount, ODHS|OHA will issue increments of $10, $20, $30, and no more than $40, depending on how many months of benefits needs to be issued. For the 'date field' put the month and year of the benefit start month.

Reminder: do not use the "D" issuance type. This is funded with SNAP dollars, not TANF

Benefit period

There are no prorated JP, JP2 or J82 benefits. A participant who is eligible for JPI, JP2 or J82, receives the full $10 for a month which makes them eligible for the month.

Reporting requirements

JPI participants must report changes in accordance with SNAP reporting requirements.

Click here for Acting on reported changes.

To continue to be eligible for JPI, participants will need to report and verify work hours every six months using the

Interim Change Report for Supplemental Nutrition Assistance Program (SNAP) (DHS 0852) and Employment Related Day Care (ERDC) (DHS 0862) form or the Application for Services (DHS 0415F) packet.

The JPI certification period aligns with SRS due date, TBA end date or recertification due date for SNAP. The certification period is a six-month or less period. Enrollment could be fewer than six months if a participant is enrolled in JPI in the middle of an SRS period or in TBA.

Benefits will not begin again until the participant has submitted complete documentation to ODHS|OHA and has been determined eligible for JPI based on enrollment criteria.

What to do when a participant reports a change

When a JPI participant reports a change in the middle of a report period, ODHS|OHA will make a re-determination of whether the change affects the participant's eligibility for JPI.

Changes that affect a Participant's eligibility for JPI include:

- JPI participant lost employment or decreased average weekly work hours to be less than what is needed to meet TANF federal participation rates:
  - 20 hours weekly for single parents with children under 6,
  - 30 hours weekly for single parents with children 18 or under,
  - 35 hours for a two-parent family not receiving ERDC
  - 55 hours for a two-parent family receiving ERDC);
- The JPI participant is no longer the sole parent of a qualifying dependent child and does not qualify for JPI as a two-parent family;
- The JPI participant is no longer receiving SNAP benefits;
- The JPI participant no longer has a dependent child under 18 in their SNAP benefit household.

For a change reported during the certification period that will end JPI eligibility (and not decrease SNAP benefits), remove all JPI coding and send a basic decision notice to the participant. The effective date of the change is the end of the month in which a basic decision notice was sent.

No notice is required to end JPI in the following situations:

- When a participant applies for and is determined eligible for Pre-TANF, SFPSS or TANF;
- When a prior decision notice with established eligibility period has already been provided; and
- When it is determined the Participant has moved out of state or when whereabouts are unknown.

ODHS|OHA will act on all changes reported by a JPI participant that:

- Are required to be reported; or
- Are considered verified upon receipt.

For a change reported at interim (DHS 0852) reporting or renewal, that ODHS|OHA determines the participant to no longer be eligible for JPI, all JPI coding will be removed. No other actions are needed, including no participant notice. The effective date of the change is the month the interim report or renewal period ended.

Late, incomplete or nonreporting

Individuals will need to provide employer-produced documents of paid-unsubsidized work hours each time requested by ODHS|OHA no later than the last day of the sixth month in conjunction with SRS and renewal.

If a late interim report is processed and the participant would have been JPI eligible, retroactive JPI benefits may only be issued to the previous four months. The participant is eligible for a retroactive JPI payment beginning the month ODHS|OHA received verification of work hours and the participant met all other JPI criteria. SNAP households determined JPI-eligible based on two-parent eligibility may not receive JPI prior to June 2014.

If it is discovered a participant failed to report information or a change they are required to report and, as a result, the SNAP benefit group was completely ineligible to receive a SNAP payment and a JPI issuance, ODHS|OHA will file an overpayment against the filing group. The JPI overpayment will be pursued as part of the larger SNAP overpayment.

Click here for Overpayments.

If a participant failed to report a change that made the SNAP benefit group eligible for reduced SNAP benefits but ineligible for JPI, an overpayment for the JPI issuance will not be pursued.

Oregon Administrative Rule(s)

461-135-1260 — Specific Requirements; Job Participation Incentive
461-145-0410 — Program Benefits
461-180-0130 — Effective Dates; Restored Benefits
461-170-0011 — Changes That Must be Reported
461-175-0200 — Notice Situations; General Information
461-175-0210 — Notice Situations; Client Moved or Whereabouts Unknown
461-175-0300 — Notice Situation; Prior Notice

Other resources

TANF Transitions *includes screenshots: Explains the requirements for timely reporting of details about new or changed income for ONE to reduce, close, and transition TANF cases accurately.

Quality Control unit

The Quality Control (QC) unit provides information about eligibility and the correctness of benefits. This is a part of a federal and state Performance Reporting System.

The results of the information gathered by QC serve as a management tool and a means to help office staff discover and correct errors. Federal agencies or state management in ODHS, HSD or APD may use the information gathered by the Quality Control (QC) unit. QC review information may influence agency policy decisions or legislative actions. The QC information is also used to update training and influences corrective action plans.

QC is a multipurpose system. It conducts QC reviews to determine:

- If households and/or individuals are eligible for benefits and receiving the correct benefits.

- If the decision to deny, terminate or suspend benefits was correct.

QC conducts QC reviews on federally matched programs. The programs reviewed include SNAP and Medical. Cases are chosen monthly for review. Other programs (i.e., TANF) may be affected in the course of the QC review. They are from a statistically reliable statewide sample.

QC uses specific review methodology to conduct the reviews based on using state policy, approved waivers after implementation, federal regulations and state and federal laws.

An important function of QC is to determine the number and kinds of errors in the total caseload. QC analyzes the case findings and shares the results for management decisions. With the knowledge gained, management can determine the cost/benefit of corrective actions.

Participant cooperation with QC

Except for medical programs, cooperation with QC is an eligibility requirement for programs receiving a federal match. Therefore, participants must cooperate with the QC review process. Refusal to cooperate will result in the termination of their benefits. The QC reviewer will notify an ODHS|OHA worker when an individual fails to cooperate. When this happens, send a timely notice to end benefits for the entire eligibility group.

The household may reapply for benefits, but they will not be eligible again until they cooperate with the QC review. This does not apply to medical programs.

Worker action on cases selected for QC review

A worker must do all the following when notified a case has been selected for review:

- Gather all case material from all relevant databases.
- Send the material within three working days to the QC reviewer, when requested.
- Do not discuss the pending review with the program participant before the QC home visit. The one exception is if the individual has failed to cooperate with the QC reviewer. QC will use the form Quality Control Request for Branch Assistance (MSC 0375) to request branch office assistance.

This includes not contacting the individual after receipt of the error decision notice, Quality Control Unit Medicaid Case Review Report (DHS 0372) to discuss statements made to QC. Only discuss restoration of benefits or a repayment plan.

- Notify QC immediately if QC selects a case, and the branch transferred the case to a different branch. Inform QC of the date the transfer occurred and the branch receiving the case.
- Any changes made on the case after the branch is notified the case is to be reviewed may affect future benefits but will not affect the benefits under review.

QC review process

The QC review process focuses on verification of all factors of eligibility, benefit amount and type. The QC reviewer obtains verification through case record review and field investigation. Case record review includes all relevant agency computer screens. Field investigation includes a personal interview (for SNAP) with the individual and any collateral contacts needed to obtain verification.

The QC reviewer looks at eligibility and the amount of benefits for a point in time. The reviewers make a determination about eligibility for the sampled month. If eligible, the reviewer determines if the correct benefit amount and type was authorized. If the review is of a denied, suspended or terminated case, the QC reviewer determines if the decision to deny, suspend, or terminate was correct.

QC relationship with local offices

QC uses information from ODHS|OHA records and may use certain local store front office resources for gaining additional information. The review itself must be completely independent of the local store front office, with one exception. The exception is to gather additional medical information needed to prove eligibility. The reviewer may ask the local store front office to request medical information or a report.

QC staff is responsible for evaluating the information and making an eligibility determination.

Distribution of QC findings

QC shares individual case review decisions with branch/agency staff when the review is completed. The local office has five working days to agree or disagree with the QC findings. If the branch does not respond by agreeing or disagreeing within the five-day time frame, the reviewer's findings and conclusions are considered final.

To disagree with the review findings, ODHS|OHA staff must present factual evidence and documentation about why the review finding is in error. QC must receive the facts supporting the disagreement within the five working day period.

In addition, when they disagree with the QC decision, local offices can ask QC to expand the review and make further contacts or look at different policies. However, the final decision on the review is with QC alone.

QC and the agency must resolve the disagreement before the QC completion deadline. Program or other appropriate staff may help resolve the disagreement.

Data analysis

The Program Integrity Unit analyzes QC data to give management a clear picture of QC findings. The analysis includes the following:

- Findings of which error rates are increasing or decreasing.
- Estimated caseload dollar loss associated with the error rate and different types of errors.
- Identification of errors that corrective action can specifically address.
- Identification of the cause of the errors.
- Clear and concise summaries and explanations of QC findings for distribution and use to plan or evaluate corrective actions.

The Program Integrity Unit distributes information monthly to appropriate management staff and Central Office staff and generates semiannual and annual reports for corrective action planning.

Oregon Administrative Rule(s)

461-105-0410 — Client Requirement to Cooperate in Quality Control Review; ERDC, REF, REFM, SNAP, and TANF

Rights and responsibilities

Rights of participants

ODHS|OHA's participants have the following rights. ODHS|OHA workers must explain and provide options to receive rights and responsibilities to individuals either orally, in writing or in the appropriate alternate format:

- The right to information about the programs administered by ODHS|OHA.
- The right to confidentiality for individually identifiable information to the extent provided under federal and state law, including the administrative rules of ODHS|OHA.
- The right to refuse social services unless the service is court-ordered or is related to a case plan (See Definitions; SNAP Employment and Training Components and Activities, OAR 461-001-0020, and Definitions of Terms, Components, and Activities; JOBS, Pre-TANF, TANF, OAR 461-001-0025) or required treatment (see Requirement to Attend an Assessment or Evaluation, or Seek Medically Appropriate Treatment for Substance Abuse and Mental Health; Disqualification and Penalties; Pre-TANF, TANF, OAR 461-135-0085)
- The right to request a hearing to the extent provided in Hearing Requests (OARs 461-025-0310 and 461-105-0010)
    - A provider payment is considered a participant benefit paid to a provider, not a provider benefit. Therefore, the right to a hearing resides with the participant and not the provider, except in circumstances where a provider is denied listing or is assessed an overpayment.
- The right to apply for any program administered by ODHS|OHA.
- The right to be offered available screenings or evaluations that identify barriers or the existence of a disability unknown to and relevant to the program
- The right to decline a screening or evaluation that would disclose the existence of a disability unknown to the program
- The right to receive a decision on eligibility within the timelines set forth in Application Processing Time Frames; Not Pre-TANF or SNAP (OAR 461-115-0190) and Application Processing Time Frames; SNAP (OAR 461-115-0210)
- The right to apply for and receive benefits and services without discrimination
- The right to courteous, fair and dignified treatment by ODHS|OHA personnel and to file a complaint with ODHS|OHA about staff conduct or customer service to the extent provided in OAR 407-005-0100 to 407-005-0120.
- The right to file a complaint with ODHS|OHA about discrimination or unfair treatment as provided in Procedure DHS 010-005-01, "Filing a Client Complaint or Report of Discrimination" or Report of Discrimination and Other Remedies Available for Alleged Discrimination (OAR 407-005-0030).

Note: ONE will automatically send the Rights and Responsibilities Notice when a case is approved.

Responsibilities of participants

To be eligible for benefits, individuals must do all the following:

- Provide true, complete and accurate information required to determine eligibility, and verify that information to the extent permitted by their physical and mental condition or authorize ODHS|OHA to obtain verification.
- Comply with the eligibility requirements of the program for which they are requesting or receiving benefits.
- Report within 10 calendar days any changes that could affect their eligibility for benefits.
- Accept social services that are court-ordered or related to a case plan.
- Cooperate with case reviews by providing requested information and verification.
- Complete the application process or inform ODHS|OHA of their decision to withdraw the application for program benefits.
- Share these responsibilities with a spouse who resides in the same household.

Responsibilities of ODHS|OHA

ODHS|OHA must explain and provide options to receive the following information to participants, either orally, in writing or in the appropriate alternate format:

- The participant's responsibilities listed above
- The participant's rights listed above
- The eligibility requirements of the program for which they are applying or receiving benefits
- What the required verification is and methods for providing verification
- The methods ODHS|OHA may use with the permission of the individual to obtain verification the individual is unable to provide
- The social services and community resources available
- ODHS|OHA's responsibility to:
  - Administer cash, medical, services and SNAP programs within the laws, regulations and available funds, and
  - Establish and enforce child support obligations of noncustodial parents by referral to the proper support enforcement agency
- ODHS|OHA's right to do all the following:
  - Recover overpayments
  - Obtain payments or repayments from medical insurance coverage
  - Recover cash and medical benefits from the estates of certain deceased program participants (see 461-135-0835 for specifics.

When rights and responsibilities are requested in writing use the following forms:

- **For all programs except medical,** use form DHS 0415R.
- **For medical programs,** use form OHP 9025, which includes R&R.

Note: If an individual is applying for multiple programs, both R&R forms must be provided.

Note: For ONE, rights and responsibilities must be provided when capturing a verbal signature via the call center software, except for passive medical renewals that do not require a signature. A case note is required when rights and responsibilities are provided prior to capturing the verbal signature.

Nondiscrimination

Nondiscrimination in determining eligibility

ODHS|OHA should determine eligibility without discrimination on the basis of race, color, gender, national origin, disability, political beliefs, age or religious creed.

Discriminatory actions

The rules of ODHS|OHA protecting individuals with disabilities against discrimination are set out at OAR 407-005-0000 to 407-005-0030.

The following acts of discrimination on grounds of race, color, gender, disability, political beliefs, age, religious creed or national origin are specifically prohibited:

- Denying an individual any service, financial aid or other benefit provided under any program
- Providing any service, financial aid or other benefit to an individual that is different or is provided in a different way from that provided to others under the program, unless such action is necessary to provide individuals with disabilities with aids, benefits or services as effective as those provided to others
- Subjecting an individual to segregation or separate treatment in any way related to receipt of any service, financial aid or other program benefit
- Restricting an individual in any way from any advantage or privilege enjoyed by others receiving any service, financial aid or other benefit under any program
- Treating an individual differently from others in determining whether they satisfy any admission, enrollment, quota, eligibility, membership or other requirement or condition individuals must meet to be provided any service, financial aid or other benefit provided under any program
- Denying an individual an opportunity to participate in any program or afford them an opportunity to do so that is different from that afforded others under the program
- Denying a person the opportunity to participate as a member of a planning or advisory body that is an integral part of the program.

Complaints about discrimination

There is an ODHS|OHA-wide complaint process. See sections 21 to 24 of DHS-010-005.

ODHS|OHA will accept all complaints of discrimination, written or verbal. Any ODHS|OHA employee who receives a complaint of discrimination, whether verbal or written, must report the complaint to their supervisor. For all complaints except discrimination complaints for SNAP, the Client Comment or Complaint form (DHS 0170) may be used.

If an individual verbally alleges that a discriminatory act has been committed but does not put it in writing, the person receiving the complaint will do so. Record the following information:

- Name, address and telephone number or other means of contacting the complainant
- Location and name of the organization or office accused of discriminatory practices
- The nature of the incident, action or aspect of program administration that led the person to allege discrimination
- The reason for the alleged discrimination (age, race, color, gender, religious creed, national origin, political belief or disability)
- Names, titles (if appropriate) and addresses of people who may have knowledge of the alleged discriminatory acts
- The date or dates on which the alleged discriminatory actions occurred.

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

FCS Civil Rights staff will work with the Office of Equal Opportunity to resolve civil rights complaints.

Display the USDA nondiscrimination poster, "...and Justice for All," prominently in the local store front office and all issuance offices. Provide participants and other low-income households with access to nondiscrimination statutes, policies and complaint procedures within 10 days of a request.

See ODHS-010-005-01, Filing a Client Complaint or Report of Discrimination.

SNAP

The SNAP analysts keep a record of all complaints and their disposition for a period of three years. All complaints should contain the information as specified in (d) below.

If an individual verbally alleges a discriminatory act has been committed but does not put it in writing, the person receiving the complaint will do so. Record the following information:

- Name, address and telephone number or other means of contacting the complainant
- Location and name of the organization or office accused of discriminatory practices
- The nature of the incident, action or the aspect of program administration that led the person to allege discrimination
- The reason for the alleged discrimination (age, race, color, sex, religious creed, national origin, political belief or handicap)
- Names, titles (if appropriate) and addresses of people who may have knowledge of the alleged discriminatory acts
- The date or dates on which the alleged discriminatory actions occurred.

Food and Nutrition Service Civil Rights staff will work with the Office of Equal Opportunity to resolve civil rights complaints.

Display the USDA nondiscrimination poster "...and Justice for All" prominently in branch offices and all issuance offices. Provide participants and other low-income households with access to nondiscrimination

statutes, policies and complaint procedures within 10 days of a request.

TANF No additional program-specific information.

ERDC No additional program-specific information.

REF No additional program-specific information.

MSP

Rights of participants

At initial application and at each renewal, provide individuals the Rights and Responsibilities form, which informs individuals they have the right to courteous and fair treatment without discrimination.

The right to have a decision on eligibility made by ODHS|OHA within 45 days from the date of request.

The right to request a hearing in the following situations upon the timely completion of a request for hearing:

- ODHS|OHA has not acted on a request or application for public assistance within 45 days of the application.
- ODHS|OHA acts to deny, reduce, close or suspend benefits.
- ODHS|OHA claims that a benefit was an overissuance.
- The individual claims that ODHS|OHA previously underissued benefits and ODHS|OHA denies the claim.

The claimant asks for a hearing to determine if the waiver of an intentional program violation (IPV) hearing was signed under duress.

Discriminatory actions

No individual with a disability shall, by reason of such disability, be denied the benefits of the services, programs or activities of ODHS|OHA.

ODHS|OHA is required to make reasonable modifications in policies, practices or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless ODHS|OHA can show that making the modifications would fundamentally alter the nature of the service, program or activity. ODHS|OHA must not use any eligibility criteria that screen out or tend to screen out an individual with a disability from fully and equally using any service, program or activity, unless such criteria can be shown to be necessary for providing the service, program or activity.

OSIPM

Rights of participants

At initial application and at each renewal, individuals must be provided the Rights and Responsibilities form, which informs individuals they have the right to courteous and fair treatment without discrimination.

The right to have a decision on eligibility made by ODHS|OHA:

- If the decision is based on a presumptive disability decision, 90 days from the date of requests
- In all other programs, within 45 days from the date of request

- The right to request a hearing in the following situations upon the timely completion of a request for hearing:
  - ODHS|OHA has not acted on a request or application for public assistance within 45 days of the application.
  - ODHS|OHA acts to deny, reduce, close or suspend benefits.
  - ODHS|OHA claims that a benefit was an overissuance.
  - The individual claims that ODHS|OHA previously underissued benefits and ODHS|OHA denies the claim.
  - The claimant asks for a hearing to determine if the waiver of an intentional program violation hearing was signed under duress.
  - ODHS|OHA establishes or changes the individual's service liability or participant fee.
  - A service re-assessment of an individual conducted in accordance with Division 411-015 has resulted in a reduction or termination of nursing home services, in-home and community-based waivered services (411-015-0005), spousal pay services (411-030-0080), or Independent Choices services (Division 411-036).

Discriminatory actions

No individual with a disability shall, by reason of such disability, be denied the benefits of the services, programs or activities of ODHS|OHA.

ODHS|OHA is required to make reasonable modifications in policies, practices or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless ODHS|OHA can show that making the modifications would fundamentally alter the nature of the service, program or activity. ODHS|OHA must not use any eligibility criteria that screen out or tend to screen out an individual with a disability from fully and equally using any service, program or activity, unless such criteria can be shown to be necessary for providing the service, program or activity.

Oregon Administrative Rule(s)

461-105-0010 — Rights of Clients
461-105-0020 — Responsibilities of Clients
461-105-0190 — Discriminatory Actions
461-135-0835 — Limits on Estate Claims
461-105-0180 — Nondiscrimination

Other resources

Phone Contact: Describes the process for support staff and Eligibility Workers on how to serve Oregonians calling into local office and ONE Customer Service Center

Rights and Responsibilities - Phone Applications: Covers options to capture signature for R&R including verbal signature

Call Center Software – Playing Rights and Responsibilities & Capturing Verbal Signature *includes screenshots: Walks through the process when the Oregonian chooses to listen to their Rights and Responsibilities, including playing rights and responsibilities recording in Intelligent Desktop, capturing a verbal signature in Intelligent Desktop, listening to and downloading recordings in TantaComm, and uploading the verbal signature (.wav file) to ONE.

File a Complaint for Oregonians: Provides quick reference for different forms and complaint areas available for submission.

Chapter 4: Working with families

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Chapter 4:
Working with families

Section 1: Family assessment

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Family assessment

Introduction

Assessment is an ongoing process with the intent of understanding a participant or family's needs, strengths and goals. Information gained through the assessment process is used to build a plan and to match individuals with the most suitable programs and services. The assessment may also be used to help identify possible resources to meet the needs of the family.

The screening and assessment requirements for Medicaid Long-Term Care (LTC) services are different than those of other programs. Screening and assessment information for LTC can be found on APD's Case Management Staff Tools page and will not be addressed in this section.

Other resources

Crisis Response: Covers helpful tips and best practices for managers and workers when crisis situations arise

Screening and assessment requirements

Individuals who are applying for or receiving SNAP, TANF and REF program benefits may be required to cooperate in determining their employment status.

SNAP This does not apply to the SNAP program.

TANF The Employability Screening (DHS 415A) form is the designated initial screening tool required to be completed by TANF applicants who are parents or caretaker relatives in the need group. This form helps family coaches determine employment status of TANF participants. Assistance is provided by SSP should the family need help in completing the form.

Work authorized TANF and REF applicants must receive an overview of the JOBS program and be given information about services available through other ODHS|OHA programs, such as Family Support and Connections (FS&C), State Family Pre-SSI (SFPSS) and Temporary Assistance for Domestic Violence Survivors (TA-DVS).

All eligible JOBS participants are offered screenings for:

- Domestic violence
- Learning needs
- Substance use
- Mental health, and
- Physical health.

Participants have the right to decline screenings.

Referral for a learning disability, mental health or substance use disorder evaluation must be offered when:

- Participants score high on the initial assessment (Learning Needs Screening or GAIN-SS-MH or AD)
- A barrier was identified and recommendation for mental health or substance use disorder treatment came from a psychological evaluation, or
- Participants self-disclose untreated mental health or substance use disorder issues.

Information gained from the evaluation including diagnosis, accommodations and recommendations will be reviewed with participant, and the case plan should be adjusted as appropriate. All accommodations must be offered and documented in the case record.

Participants identified by a qualified medical professional as needing mental health or substance use disorder treatment must cooperate and follow through with the referral and the treatment program requirements.

The Employability Screening form includes questions to help identify a possible disability that would affect engagement and the choice of activities. All individuals are protected from discrimination based on physical, mental, cognitive, addiction or learning disabilities. All services are available to participants, regardless of disability status, and activities should be reasonably modified, if necessary, to allow those with disabilities to engage. Participants are also provided reasonable accommodations to engage in JOBS services and activities.

ERDC This does not apply to the ERDC program.

REF This does not apply to the REF program.

Other resources

Hand-off to Family Coach: This process walks support staff/transfer clerks, eligibility workers and family coaches through the hand-off processes for CASH.

Family assessment expectations

SNAP This does not apply to the SNAP program.

TANF The family assessment is to be completed by work authorized caretaker relatives in the need group alongside their family coach prior to goal identification and plan development. Family coaches are required to offer all domains of the family assessment within 90 days of TANF approval at both initial application and recertification. The family assessment may be conducted over a series of appointments, or in one sitting, whichever is most convenient for the participant. The purpose of ongoing assessment is to evaluate the effectiveness of the plan and success in reaching milestones.

IIf the participant declines to complete all or part of the family assessment, the family coach must narrate that the offer was made but declined. The family assessment may be offered again in the future if circumstances change or if the participant feels more comfortable completing at a later date once trust has been established. If it becomes difficult to offer or complete the assessment, family coaches should narrate the efforts and why all domains have not been addressed.

Screening and assessment information includes participants' strengths, interests, disability concerns, family circumstances, JOBS eligibility, and vocational aptitudes and interests. This information is then used when working with the participant to determine goals, JOBS program engagement and necessary support services.

Areas covered during the family assessment include, but are not limited to:

- Level of safety and affordability in current living situation for all family members
- Immediate service needs such as food or ability to maintain food security
- Ability to meet basic needs with current income
- Safety and reliability of transportation options
- Stability and appropriateness of child care arrangements
- Availability and access to clothing for adults and children
- Immediate service needs such as medical access or ability to obtain and maintain affordable medical access
- Physical health challenges
- Emotional health challenges
- Substance use challenges
- Children's behavior challenges
- Developmental needs and school engagement of children
- Social support from family, friends and community
- Immediate safety need or ability to maintain safety
- Participant's training and education needs
- Participant's ideal learning environment
- Communication challenges that limit training or employment
- Current workplace skills including decision making, communication, people skills, time management, problem solving and prioritizing
- Previous work experience, and
- Legal issues that prevent employment or housing.

Family coaches are required to complete the data tracking spreadsheet for all families that complete the family assessment. This data allows SSP to measure the progress of the participant services being used and the resources needed. This data will also help SSP produce statewide data for the Oregon Legislature to consider when making decisions about funding allocations.

ERDC No additional program-specific information.

REF No additional program-specific information.

What to do with the assessment

The goal of all screenings and the family assessment is to gather information and develop the most robust and thorough plan between the participant and SSP as well as identify the need for accommodations. All screening results and family assessment scores should be entered in the system in order to track progress and positive growth.

Assessment best practices

Screenings and the family assessment should be offered as part of the initial eligibility process at each recertification and at any time the participant shares there have been significant changes.

SNAP No additional program-specific information.

TANF When discussing the family assessment, family coaches should remember to:

- Explain the intent of screenings and assessment to the participant ahead of time
- Identify strengths the participant already possesses
- Listen to the participant and ask them to offer their best thinking on their goals
- Allow the participant an opportunity to self-identify a possible disability or other challenges to employment, as well as how it may affect their ability to reach their goals
- Use open-ended questions and try to focus on a natural flow
- Look for indicators of challenges such as domestic violence, disability or substance use disorder that may affect progress toward the participant's goals
- Be aware of local labor market, referral processes and resources to address any challenges that may arise during the conversation
- Discuss how the participant has dealt with job issues in the past, and
- Remember to involve partners and other supports as appropriate.

ERDC No additional program-specific information.

REF No additional program-specific information.

Oregon Administrative Rule(s)

461-130-0305 — General Provisions; Employment Programs
461-135-0085 — Requirement to Attend an Assessment or Evaluation, or Seek Medically Appropriate Treatment for Substance Abuse and Mental Health; Disqualification and Penalties; Pre-TANF, REF, TANF Rule
461-135-0475 — Specific Requirements; Pre-TANF Program
461-135-0485 — Requirement to Complete an Employability Screening and Overview of the Job Opportunity and Basic Skills (JOBS) Program; Pre-TANF and TANF
461-190-0231 — Re-engagement; JOBS, Pre-TANF, REP, SFPSS, TA-DV

Chapter 4:
Working with families

Section 2: Engagement in the JOBS Program

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Engagement in the JOBS Program

TANF This applies specifically to the TANF program.

What is JOBS engagement?

To receive a full TANF grant, JOBS-eligible participants must engage with the activities specified in their case plan. These activities may include pursuing available assets such as child support, alcohol or drug diagnostic appointment or treatment, referrals to Vocational Rehabilitation Services, employment-related activities and domestic violence support groups.

Engagement is encouraged through identification of goals, strengths, barriers and resources, development of plans with participants, sharing problem-solving responsibilities with the participant and by helping the participant see the possibility for personal growth.

Participants who are JOBS eligible must also accept a bona fide offer of employment, whether it is temporary, permanent, full time or seasonal. Once they are employed, participants must maintain employment.

ODHS will support engagement by informing participants about any support services or programs that can help them reach their goals.

It is important that a participant engages with the activities specified in their case plan. Participants with continued noncooperation may lead to receiving a TANF grant reduction.

Who must cooperate with the JOBS program?

A caretaker relative of a dependent child or unborn is eligible for JOBS engagement if they:

- Are in the same filing group as the dependent child or unborn; and
- Are not JOBS-exempt per section 3 of this chapter.

Non-citizens who receive TANF or whose children receive TANF are required to prepare for or pursue employment if they can legally work in the United States.

Participants with physical or mental disabilities are not JOBS-exempt. Per the Americans with Disabilities Act (ADA), all participants must have access to JOBS activities and support services as long as accommodating them does not fundamentally alter the purpose or intent of the JOBS activity in which they would engage.

All participants must engage in the process of determining appropriate JOBS activities. This includes providing information and documentation to support JOBS-exempt status.

Refugees within their first 12 months in the U.S. who live in the New Arrival Employment Service (NAES) project area must engage and follow the NAES employment program rules.

Adults in the State Family Pre-SSI program, including both adults in a two-parent household, are able to engage in the JOBS program but they are not subject to JOBS disqualification or TANF time limits.

Who is considered JOBS-exempt from the employment program?

The following participants are JOBS-exempt from JOBS engagement and disqualification:

A JOBS exemption identified with ** must be verified by a licensed or certified professional that is qualified to determine the condition or circumstance. A JOBS exemption cannot be given until verification is received.

- Parents providing care for a family member living in the home who has a disability (see OAR 461-001-0000 rules definitions). Medical documentation to support the need for the parent to remain in the home to care for the disabled family member is required. (a DHS 7785 can be used to document need);
- Non-citizen participants who are not authorized to work in the United States;
- Recipients of supplemental security income (SSI) from the Social Security Administration;
- Non-needy caretaker relatives;
- For REF participants age 65 years of age or older, or those for whom participate is likely to cause undue hardship to the individual.

JOBS-exempt individuals are not eligible to have a TRACS case plan and not eligible for JOBS support services, this includes parents determined JOBS exempt based on caring for a family member living in the home who has a disability. If the parent is requesting to engage in JOBS and receive support services, the JOBS exemption would be ended.

Participants experiencing DV-related safety issues or concerns are not considered JOBS-exempt from engagement, however this can be built into their JOBS plan.

Who can volunteer for the JOBS program?

The following participants from the need group are JOBS-volunteers and are not subject to disqualification. If these individuals choose to engage in the JOBS program and create a plan, the JOBS exemption status would need to be removed.

A state exemption identified with ** must be verified by a licensed or certified professional that is qualified to determine the condition or circumstance.

- Participants who are pregnant and have reached the first of the calendar month prior to the month in which the due date falls;
- Participants experiencing medical complications due to pregnancy that prevent participation in activities of the program**;
- VISTA volunteers;
- A parent who is 20 years or older during the first six months after the birth of their dependent child. ODHS|OHA may require the parent to engage in parenting classes or a family stability activity;
- A parent under age 20 years old during the first sixteen weeks after the birth of their dependent child. ODHS|OHA may require the parent to participate in parenting classes, a family stability program, or an educational track if they have not completed high school, GED program, or its equivalent;
- During the seventh and eighth month of pregnancy, participants are only required to participate 10 hours a week. Verification of due date from a qualified medical professional is required.

A parent with a child under six months old may volunteer for the JOBS Program and request support services. Only

one parent may be a JOBS volunteer for the six months following a dependent child's birth.

For further information see OAR 461-130-0310: Participation Classifications: Exempt, Mandatory, and Volunteer

Changing status from a JOBS volunteer to JOBS-eligible

When a JOBS volunteer's status changes from JOBS-exempt to JOBS-eligible, ODHS cannot impose a disqualification while the participant was JOBS-exempt.

It is important for the ODHS branch office to explain how the participant's JOBS status has changed and the requirements of the program.

ODHS also needs to do the following:

- Review the JOBS rights and responsibilities form and have the participant sign if they have not done so within the previous 12 months

Non-engagement in JOBS program

Non-engagement exists when a JOBS-eligible participant fails to complete the activities as specified on their case plan without good cause.

Additionally, participants in the JOBS program are considered not engaging if they fail to do the following without good cause:

- Accept a bona fide offer of employment, whether temporary, permanent, full-time, part-time or seasonal;
- Schedule and keep all appointments and interviews;
- Attend and complete scheduled activities as specified on the case plan;
- Attend drug and alcohol assessment or treatment, or attend mental health treatment (See OAR 461-135-0085).
- Notify ODHS or the JOBS contractor of the reason for not keeping any assigned activities, including all appointments, classes and activities.;
- Provide ODHS with verifiable documentation of JOBS engagement hours, including, but not limited to paid work, job search, employment readiness activities, family stability activities and educational activity hours.

Non-engagement with JOBS and domestic violence

If the domestic violence affected the participant in a way that made it unsafe for them to engage or if they were otherwise affected by the domestic violence (e.g., court appointments, did not receive notices, abuser sabotaged the participant's ability to engage in planned activities, etc.), consider a plan to capture the activities they are engaged in, potentially including a domestic violence (DV) step.

If the participant did not engage and it was not a result of domestic violence, follow the normal JOBS re-engagement process.

Good cause for non-engagement with the JOBS program

Good cause is what ODHS considers a valid reason or circumstance that keeps a participant from engaging in their

case plan. It is the participant's responsibility to provide evidence to establish good cause for non-engagement and to work with ODHS staff to try to resolve problems that interfere with engagement. It is important to determine whether the participant is able or unable to engage with their case plan.

A JOBS program participant may have good cause for not engaging if any of the following is true:

- Engagement or placement at a specific activity would place the participant at risk of domestic violence;
- Engagement in a specific activity would have an adverse effect or risk on the participant's physical or mental health. Documentation from a licensed or certified professional that is qualified to determine the condition or circumstance is required;
- Non-engagement is caused by an aspect of the participant's disability;
- ODHS failed to provide a needed accommodation or modification in order for the participant to engage;
- The worksite violates established health and safety standards;
- A pregnant participant is in their seventh or eighth month of pregnancy and either works in a job that requires them to work more than 10 hours;
- A pregnant participant has reached the first of the calendar month prior to the month in which the due date falls and is JOBS-exempt;
- Appropriate child care (or day care for an incapacitated person in the household) is not available or there is a breakdown in child care arrangements for a child in the household. The participant must attempt to get child care from another provider. "Appropriate child care" means that: (a) both the provider and the place where care is provided meet health, safety and provider requirements as defined in OAR 461-165-0180; (b) the care accommodates the parent's work schedule; and (c) the care meets the specific needs of the child, such as age and special needs requirements;
- The participant's failure to engage is due to a circumstance beyond his/her reasonable control (see OAR 461-130-0327).

Good cause for missed appointments

Good cause for missing JOBS Program appointment with ODHS, ODHS contractor or designee, community service provider as related to the participant's case plan, or scheduled mental health or alcohol and drug treatment appointments and activities includes:

- A verified mental or physical illness, impairment or condition preventing engagement;
- A verified court appearance or temporary incarceration (30 days or less);
- A verified breakdown in transportation with no readily accessible alternative;
- A verified adverse circumstance(s) that affected the participant's ability to attend, as determine by ODHS;
- Inclement weather that prevented the participant and others similarly situated from traveling;
- Family problems, including medical, legal, domestic violence or school problems with other family members;
- A legitimate breakdown in communication, such as ODHS or contractor failure to inform the participant of an appointment;
- Due to an aspect of a known or previously unknown disability;

- ODHS or contractor failed to provide a needed accommodation or modification.

Good cause for a missed A&D treatment appointment must be granted if an aspect of a disability related to A&D caused the participant to miss the appointment. For example, if memory loss caused by past methamphetamine use caused the participant to miss an appointment, good cause must be granted. However, workers are not required to grant good cause when a participant reports they missed an appointment because they were using alcohol or drugs at the time.

Good cause when participants meet federal engagement requirements

Good cause is granted when a participant meets the following federal requirements even though they may not have completed all the hours agreed to in their case plan:

- A single custodial parent with a child under 6 years of age if they engage for an average of 20 hours per week in core activities;
- A single custodial parent caring for a child under the age of 6 who has clearly demonstrated an inability to obtain needed child care;
- Gross misconduct (e.g., drunkenness or insubordination) does not have to be preceded by a warning from the employer;
- A single custodial parent with a child age 6 or over is engaging in core and noncore activities for an average of 30 hours a week, 20 of which must be core activities;
- A participant who is married or a single head-of-household under 20 years old who:
  - Maintains satisfactory attendance at a secondary school or the equivalent; or
  - Participates in education directly related to employment for an average of at least 20 hours per week.

What is re-engagement?

The re-engagement process provides an opportunity for ODHSIOHA to use Strength-Based and Trauma Informed Care practices, to gain an understanding of what may be preventing a participant from engaging in services and to allow the participant an opportunity to engage in a plan that is right for their family's needs and goals.

Re-engagement is a process intended to encourage participants to engage in case plan activities. It is important that a participant is treated in a manner that is in line with our Agency's Core Values, Mission and Vision. The re-engagement process is initiated when a concern related to the plan or engagement in the plan has arisen.

The re-engagement process can be initiated by the participant, ODHS, ODHS contractor or a community partner. It is a team approach redesigned to holistically engage the JOBS-eligible participant in JOBS related activities and possible wraparound services. The team is composed of the participant, ODHS representatives and other persons (e.g., ODHS contractor representative, a neutral third party, etc.) related to the case plan or family goals.

It should be conducted via a face-to-face meeting or if necessary due to participant hardship, over the phone.

The outcome of the re-engagement appointment must be clearly narrated by using the TRACS Re-engagement Narrative or the Re-engagement page in TRACS.

The re-engagement process is intended to:

- Clarify ODHS|OHA's understanding of the participant's goals:
  - How do the planned activities support the participant's goals;
  - What is not working for the participant and how we can improve it.
- Identify what the participant believes could change to meet their goals; and
- Identify what resources both the participant and ODHS|OHA can provide to support future engagement.

Re-engagement begins when the participant misses a planned activity or appointment or stops engaging in an ongoing planned activity.

Activities could include, but are not limited to:

- Any activity on the participant's case plan;
- Missed appointment with the Family Coach or JOBS contractor such as a JOBS appointment or orientation;
- Low or no attendance for any JOBS activity in the participant's case plan.

Once ODHS|OHA has determined a participant has stopped engaging in their ongoing case plan, ODHS|OHA must make contact to determine good cause.

If good cause is determined and ODHS|OHA is able to engage with the participant, the re-engagement process stops.

If good cause is not determined or ODHS|OHA is unable to engage with the participant in JOBS activities, the re-engagement process continues.

ODHS|OHA must provide the participant with timely written notice of JOBS re-engagement appointment so they can make arrangements or request accommodations timely to insure engagement in services. ODHS|OHA must mail notice of a formal re-engage JOBS appointment using the JOBS Re-engagement Notice (DHS 7869). The notice is required to be mailed no less than seven calendar days prior to the appointment. A copy of the notices can be delivered during a home visit, but this does not replace the mailing of the notification requirement.

Note: It is possible that the conversation during the home visit may lead to engagement of the participant which may end the re-engagement process.

ODHS|OHA must add re-engagement (RE) step to TRACS:

- Planned start and end date must equal the date of the re-engagement appointment;
- The description line needs to identify the time and location of the re-engagement appointment;
- The updated PDP does not need to be mailed to participant, as they will receive a corresponding re-engagement letter.

The re-engagement (RE) step is used to track re-engagement outcomes. It allows a "data point" to compare re-engagement outcomes.

Note: Before a disqualification may be applied, the participant must have had the opportunity to participate in the re-engagement process (OAR 461-190-0231). Mail a re-engagement appointment letter offering an opportunity to participate in the process. Give the participant enough time between delivery of the re-engagement letter and the appointment date in order for them to make arrangements to attend.

Re-engagement appointment/staffing

The re-engagement appointment provides the participants with an opportunity to share what has changed in their situation and what is preventing engagement. The re-engagement staffing is intended to give ODHS|OHA a structured process of reviewing for possible limitations or obstacles that could be preventing engagement, provide resources, and encourage engagement in services.

During the re-engagement appointment, ODHS|OHA must provide participants with:

- A review of JOBS program requirements;
- A review of the formal re-engagement process; and
- A review of possible outcomes, including grant reductions.

ODHS|OHA works with the participant to re-evaluate the appropriateness of current plan activities and modify the plan based on the participant's goals, strengths, barriers and resources. Support participants in making informed decisions regarding program requirements, expectations and consequences for non-engagement.

Using strength-based practices, re-engagement appointments should:

- Be used to gather information for ODHS|OHA to make a determination of "good cause" or "no good cause" for nonengagement in services;
- Provide the participant an opportunity to complete screenings they may have missed such as learning needs, mental health or substance use;
- Provide the participant with additional community resources and allow them the opportunity to develop a new plan that meets their family's goals and needs, such as:
  - Possible referral to services within ODHS (such as SFPSS or TA-DVS), referral to community partners (such as housing, Family Support and Connections or A&D treatment);
- Re-evaluate the appropriateness of current plan activities and modify the plan based on the participant's goals, strengths, barriers and resources; and
- Help participants make informed decisions.

When all needed information is available at the time of the re-engagement appointment, the case review will take place at the same time. When all needed information is not available at the time of the re-engagement appointment, ODHS|OHA must follow up on all needed information prior to making any determination.

Things to keep in mind:

- Setting:
  - Try to create a space that is empowering, hopeful, culturally diverse and soothing.
- Confidentiality:

- Be aware of your surroundings;
- Be aware of others around you who may overhear this information; and
- During group settings, limit oversharing of customer's personal situations.

- Conflict:
  - Be aware of staff's personal biases that could influence their decision-making;
  - Be aware of participants who have conflict with other participants or staff; and
  - Use clear, concise, and positive language that is strength-based.

Case review and staffing

Case review and staffing gives ODHS|OHA time to ensure understanding of the participant's situation. It allows time to collect needed information required in the re-engagement process prior to making a team determination.

When all needed information is available at the time of the re-engagement appointment, the case review will take place at the same time. When all needed information is not available at the time of the re-engagement appointment, ODHS|OHA must follow up on all needed information prior to making a determination.

During the re-engagement process ODHS|OHA must review:

- Information from the participant's Employability Screening Tool and Family Assessment;
  - Determine if there are potential barriers ODHS|OHA has not addressed that could have prevented engagement;
  - If barriers exist, clearly narrate what steps ODHS|OHA took to address reported barriers;
  - If it is determined that ODHS|OHA failed to address reported barriers, ODHS|OHA may not impose a grant reduction or disqualification.
- Child risk review: Review if a reduction in TANF benefits would result in additional risk to children in the filing group:
  - Review is completed in collaboration with Child Welfare staff. (Child risk review may be done after re-engagement staffing,but must be done prior to team determination.)
  - If there is a determined child risk, ODHS|OHA may not impose a grant reduction or disqualification.
- Information about potential or known disability or limitations: Review the case for potential documented or reported disabilities or limitations using:
  - Information on the DHS 415A;
  - Information from screenings/evaluations documented on the TRACS testing page;
  - Information on the TRACS Disabilities page; and any
  - Recommendations from mental health or A&D treatment providers, doctors or other professionals.
- Home visit: Provide services and options for participants during the re-engagement process:
  - A Home Visit must be attempted within 30 days prior to a grant reduction. (An attempted home visit may be done after re-engagement staffing but must be done prior to team determination.)
  - Home visit sites are not limited to the participant's home. They can take place on the participant's front

porch, yard, nearby community park or other neutral location in the community as determined through conversation with the participant;

- Sending the following forms prior to or after home visits are optional:
  - » Notice of Home Visit (DHS 7997);
  - » Home Visit Resource Letter (DHS 7998);
  - » Notice of Attempted Home visit (DHS 7999);

Offer any screenings, assessments or evaluations that have not been completed or determine whether an updated or further screening/assessment might be needed (e.g., A&D/MH screening, Learning Needs Screening (LNS), Domestic Violence screening or Physical Health Needs screening):

- The alcohol and drug, Domestic Violence, mental health and physical health screenings should be offered a minimum once every 12 months. LNS only needs to be completed once; however, if the participant didn't score 12 or above on a previous screening there may be indicators requiring additional learning needs screenings;
- Screenings can be offered in person, over the phone or in writing. Regardless how the screening was offered, it will need to be documented in TRACS that an offer has occurred;
- A screening is considered completed when it has been:
  - Offered – Accepted – Conducted – Documented;
  - Offered – No Show – Documented;
  - Offered – Refused – Documented.

If a screening is refused, the refusal must be documented in TRACS. Use of the ODHS TANF/JOBS Program Client Rights – Screenings and Evaluations form (DHS 7826) is optional.

Note: GAIN-SS and LNS should only be administered ODHS|OHA staff or designees that have met ODHS|OHA training requirements and who are comfortable and capable of administering said screenings.

These tools should be administered one-on-one between a participant and ODHS|OHA staff or designee with appropriate follow up provided by ODHS|OHA at time of screening.

The LNS must be conducted where ODHS|OHA staff or designee ask the questions verbally and records the response. The participant may be given a copy of the screening tool.

Information regarding the participant's current safety: Review the case for potential documented or reported instances of Domestic Violence or other potential safety risks:

- Family Assessment;
- Last application;
- UCMS coding;
- TRACS or case narratives.

When reviewing for ongoing safety concerns look back six months in the case record. Each potential safety incidence must be determined individually as a factor or not a factor in the participant's nonengagement.

Information from community partners (e.g., domestic violence service providers, community action agencies, housing, etc.) or other agencies with which the participant may be working, etc., should be considered when determining if the participant's safety risk directly prevented them from engaging in the JOBS program requirements.

Note: Participants currently experiencing domestic violence regardless of whether they have an open DV grant are JOBS-eligible.

Their plan can consist of services to meet their safety needs such as family stability, housing and safety planning with an advocate. or

ODHS|OHA determination/staffing outcomes

ODHS|OHA must make a determination based on all the information gathered during the re-engagement process of whether the participant does or does not have good cause for nonengagement in planned activities.

In TRACS, clearly document the situation that led to the request for re-engagement, including:

- The participant's perception of the situation;
- Steps taken to encourage re-engagement;
- Findings of good cause or no good cause (even if the participant is now willing to re-engage);
- Staffing with community partners and Child Welfare;
- Home visits or attempted home visits (required at the first instance of grant reduction and before a total grant reduction);
- Screenings completed (or offered);
- Alternative resources offered or available to the participant; as well as
- Any outcomes from the re-engagement process.

Good cause determination

The local re-engagement team determines the participant had good cause for nonengagement:

- Document the process and outcome in the Re-Engagement Record on TRACS or a TRACS narrative using the statewide Re-engagement TRACS (form) narrative ;
- Do not apply a grant reduction;
- Engage the participant in appropriate ongoing JOBS program activities;
- Finalize re-engagement page or save the Re-engagement TRACS (form) narrative into TRACS.

Things to consider while determining good cause:

- Was the participant JOBS-exempt during the engagement period or any time of the re-engagement process? (JOBS exemption may have not been known to ODHS|OHA before the staffing.)
- Was there a situation outside of the participants control that prevented engagement?
- Did the participant have ongoing challenges in the following areas and ODHS|OHA failed to provide consideration, reasonable accommodations or referrals?

- Active DV (last six months);
- Ongoing MH (with treatment);
- Addictions (in treatment);
- Learning needs / disability;
- Physical health (participants or others in HH).

No good cause determination, grant reduction

The local re-engagement team determines the participant did not have good cause for nonengagement.

- Document the process and outcome in the Re-Engagement Record on TRACS or a TRACS narrative using the statewide Re-engagement TRACS (form) narrative;
- Apply disqualification at the appropriate level;
- Finalize the re-engagement page or save the Re-engagement TRACS (form) narrative into TRACS;
- Continue to attempt to engage the participant in JOBS program activities.

No good cause determination, no grant reduction

The local re-engagement team determines the participant did not have good cause for nonengagement but is not imposing a grant sanction.

- Document the process and outcome in the Re-Engagement Record on TRACS or a TRACS narrative using the statewide Re-engagement TRACS (form) narrative;
- Finalize the re-engagement page or save the Re-engagement TRACS (form) narrative into TRACS;
- Connect the family with additional agency and community resources, such as Child Welfare, Family Support and Connections and other local community agencies and or partners; and
- Continue to attempt to engage the participant in JOBS program activities.

When does the re-engagement process end?

The re-engagement process ends when any of the following are met:

- ODHS|OHA and the participant agree to case plan and the participant completes two-consecutive weeks of cooperation. The participant is considered successfully re-engaged in JOBS;
- Efforts to re-engage are unsuccessful:
  - The participant clearly indicates the intent not to participate in the re-engagement process;
  - The participant is willfully noncompliant and has the ability to be fully engaged;
  - The participant refuses to take appropriate steps to address identified barriers to participation; or
  - The participant did not have good cause for not complying with a requirement of the program and the participant is able but unwilling to address the issue through activities to remove the barrier.
- There is no appropriate activity available in which the participant may engageand/or there are no support services available to support engagement in appropriate activities.

Who can be disqualified from the JOBS program?

Individuals who are JOBS-eligible and required to engage with the activities specified on their case plan and who fail to engage without good cause are subject to disqualification/grant sanction.

JOBS disqualifications are applied independently to any JOBS-eligible individuals who do not engage in JOBS program requirements. In multi-parent households, more than one adult can be disqualified if the individual adults do not engage in JOBS program requirements.

Click here for Program compliance.

Effective date for ending a disqualification

A participant or JOBS-eligible adult in the need group who informs ODHS|OHA they intend to cooperate in JOBS activities must:

- Complete a new or revised case plan or agree to complete each activity in the current case plan; and
- Be assigned a cooperation period of two consecutive weeks.

The disqualification ends after the participant completes two consecutive weeks of cooperation:

- If the disqualified person or another JOBS-eligible adult in the need group demonstrates cooperation prior to the effective date of the disqualification:
  - Do not impose the financial penalty;
  - Code the appropriate DQ C/D history under the noncooperative individual.
- If the first day of the month occurs during the two consecutive weeks of cooperation:
  - Restore benefits effective the day the participant completed the two weeks of cooperation;
  - Code the appropriate DQ C/D history under the noncooperative individual.
- If cooperation starts after the effective date of the disqualification:
  - Restore benefits effective the day the participant completed the two weeks of cooperation;
  - Code the appropriate DQ C/D history under the noncooperative individual.

Click here for examples: Engagement in the JOBS program.

Oregon Administrative Rule(s)

461-130-0305 — General Provisions; Employment Programs
461-135-1195 — Specific Requirements; SFPSS Eligibility
461-110-0330 — Filing Group; TANF
461-130-0310 — Participation Classifications: Exempt, Mandatory, and Volunteer
461-130-0315 — Requirements for Mandatory Employment Program Individuals; Pre-TANF, REF, SNAP, TANF
461-130-0327 — Good Cause
461-190-0231 — Re-engagement; JOBS, Pre-TANF, REF Employment Program, SFPSS, TA-DVS
461-130-0330 — Disqualifications; Pre-TANF, REF, SNAP, TANF
461-130-0335 — Removing Disqualifications and Effect on Benefits
461-135-1200 — Domestic violence
461-135-0085 — Requirement to Attend an Assessment or Evaluation, or Seek Medically Appropriate Treatment for Substance Abuse and Mental Health; Disqualification and Penalties; Pre-TANF, REF, TANF
461-135-0200 — Multiple Disqualifications; TANF
461-135-0089 — Demonstrating Compliance with Substance Abuse and Mental Health Requirements; Restoring Case Benefits; Pre-TANF, TANF

Chapter 4:
Working with families

Section 3: Case plan development

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Case plan development

Introduction

Case plan development is a process that continues throughout the life of a case. Information that informs the development of a case plan is gained during all conversations with the participant, from eligibility intake, through assessment, screenings and ongoing appointments.

Case plans are individualized and developed in partnership with the participant. Plans should be built on strengths, resources and goals and should reflect what the participant believes to be achievable. Included in the plan should be activities that support the participant in meeting their goals, reducing or eliminating barriers, and promoting family stability.

The case plan development requirements for Medicaid Long-Term Care (LTC) services are different than those of other programs. Case plan development information for LTC can be found on APD's Case Management Staff Tools page and will not be addressed in this section.

Plan requirements

Case plans are required for individuals in the JOBS, REP, SFPSS and TA-DVS programs. The plans should be used as an agreement between the participant and SSP. Details should include activities the participant feels will help them move forward as well as support services SSP has agreed to provide.

Case plans should be reviewed regularly and modified when circumstances change. Plans for JOBS participants are in effect even if they are not signed. This allows SSP to create plans following phone calls or home visits with the participant, even if there is no option to print and sign a formal plan.

For TANF applicants, the case plan should be developed by the end of the initial screening and assessment process. All screenings and assessments should be offered before a plan is documented.

Oregon Administrative Rule(s)

461-001-0025 — Definitions of Terms, Components, and Activities; JOBS, Pre-TANF, TANF
461-190-0151 — Case Planning; JOBS, Pre-TANF, REP, SFPSS, TA-DVS

Plan expectations

- Case plans are individualized, based on the unique needs of each participant.
- Participants are in charge of their own plan and they, rather than SSP, should be primarily responsible for determining the actions on their plan.
- Individuals are informed about their rights to develop a plan, choose whether to release information and decide if individuals outside of the benefit group are included in the planning process.
- For individual in the TA-DVS program, initial case plan development should focus on any immediate safety concerns. Ongoing plan development should look at both safety issues and stabilizing the family from the effects of domestic violence.

- SFPSS case planning will focus on the SSI/SSDI application process.
- Long-term goals in case planning can include family stability, increased self-sufficiency and employment.
- Short-term goals include the steps to address safety and immediate family stability, and to reduce or eliminate barriers to the individual's long-term goals.
- Plans may include activities for the adults and the children, or only activities for the children if the adults are not participating.
- All case plan activities and connected support services are entered in the TRACS system.

Oregon Administrative Rule(s)

No current OARs apply.

Identifying activities and support services

For each goal identified by the participant, try to find matching activities that align with those goals. Assist the participant in exploring the range of possible activities that may reflect their short- and long-term goals.

In addition to the participant's goals, consider the outcomes of all screenings and assessments completed by the individual. This leads to a plan more likely to address their unique needs and goals.

Discuss what support services the individual will need to complete these activities. Document what SSP will pay for and what other resources the participant may use.

Oregon Administrative Rule(s)

No current OARs apply.

Reviewing and documenting the plan

When updating or reviewing case plans with participants, confirm their understanding of the agreements made. Make changes to the plan as necessary, following up through regular contact with the participant. Narrate updates to the plan in TRACS as well as any conversation had with the participant.

Provide a copy of and review the DHS 7819 (Your Rights and Responsibility While in JOBS, JOBS Plus, and Refugee Employment Services) form with the participant to ensure their understanding and their agreement of the requirements for the JOBS program. No signature is required on the 7819 form.

A narration that the 7819 was provided and discussed with the participant and that their understanding of the agreement was confirmed is required in order for a disqualification to be upheld. Additionally, the 7819 needs to be reviewed as part of the JOBS re-engagement process.

Oregon Administrative Rule(s)

No current OARs apply.

Targeted Case Management

OHDS receives federal Medicaid funds when Targeted Case Management (TCM) service(s) are provided to TANF participants.

To be considered a TCM service, a family coach must be providing the service(s) to TANF participants age 14 or older and the service(s) must be a qualifying service.

Qualifying TCM Services:

- Activities to identify barriers that are affecting a participant's ability to achieve their goals and become self-sufficient. This may include activities to identify supports or provide resources for the identified barriers
  - Examples: A&D and mental health and learning disability screenings; Problem-solving with clients to address client barriers.
- Screenings and assessments
  - Examples: Completing the family assessment collection tool (FACT)
- Developing Personal Development Plans (PDP)
- Referrals to service providers
  - Examples: Identifying needed resources and making referrals to those resources
- Monitoring participant engagement with their PDP
  - Examples: Making sure clients are attending the JOBS activities on their case plan; and updating case plans.

Family coaches will need to change the case management flag in TRACS to "yes", if not done automatically by the system, when they take a qualifying TCM action, for that TCM action to be counted towards funding.

Additionally, the Random Moment Sample System (RMSS) impacts federal TCM funding. When a family coach receives an RMSS survey and is performing a TCM qualifying activity, it is important the family coach reflects the TCM work they performed in the RMSS survey accurately.

State and Federally prohibited activities

The Oregon TANF program, including JOBS support services, is funded using federal block grant. Federal funding cannot be used to support activities that are deemed illegal under federal law. When an individual gains employment or is seeking employment in a prohibited activity they are not eligible for the below benefits.

- Jobs Participation Incentive (JPI)
- Reduced Co-pay (RCP)
- Employment Payments (EPCA)
- Support Services
- TANF Childcare

An example of a prohibited activity is working in the Marijuana industry. TANF participants engaged in the JOBS program are also not allowed to have an active TRACS step to record their engagement in these activities as these hours are not countable. When individuals gain employment in a prohibited activity, the placement is not allowed to be captured in TRACS.

Chapter 4:
Working with families

Section 4: Evaluating progress

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Evaluating progress

Introduction

The purpose of evaluating progress is to maintain communication with the participant and to provide the most appropriate services to individuals and families. These services include not only case plans activities, but also referrals to other services.

Identifying progress

Progress is not identified only through the completion of an activity, but also by changes in the individual's situation and readiness to move toward their goals. Progress can be identified through:

- Contact with the participant and discussion around their own challenges and successes
- Review of attendance records
- Reports from contracted or community providers
- Information gathered in ongoing evaluation and assessments.

Oregon Administrative Rule(s)

No current OARs apply.

Modifying plans

When it becomes apparent there is a need to modify the plan, SSP should work in partnership with the participant to make the necessary changes. Changes may include the number of hours for an activity, the activity itself or the support services agreed upon to ensure the participant's success.

Any change in the plan or in support services must be documented. If the change causes a reduction in support services, formal notice is required.

Oregon Administrative Rule(s)

No current OARs apply.

Best practices

- Have regular contact scheduled for all participants.
- Narrate plan outcomes and modifications in the case record.
- Continue to ask open-ended questions, summarizing what you hear from the participant.
- Remind the participant that they know what is best for themselves and their family; build a plan to reflect on their own goals.
- Expect the participant will share more about themselves as trust increases.
- Remember not all paths to self-sufficiency will be linear. Instead, focus on the success of the participant and

help them to continually focus on their short- and long-term goals.

Oregon Administrative Rule(s)

No current OARs apply.

Chapter 4:
Working with families

Section 5: Collaborating with partners

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Collaborating with partners

Introduction

The intent of collaborating with partners is to ensure families are able to access the most holistic and supportive services as they work toward their short- and long-term goals. When families are being served by other agencies, it is important to discuss those services and build a plan that reflects those efforts. When establishing service relationships with partners, it is important to focus on the individual's goals and desired outcomes.

When collaborating with families, it is important to identify the recourse the participants bring to the process, who they are already working with, and what additional resources may be helpful. If appropriate, SSP may help participants contact and obtain services from other benefit programs and resources. Any time other agencies may be involved in serving the family, it is important to obtain the appropriate releases.

Referring to partners

Once a case plan has been developed and the participant has identified their own goals and needs, SSP can offer additional resources through contracted entities or community partners. The referral to partners should only happen after the participant has granted permission; participants have the right to change their mind at any time.

Staff may advocate with partners on behalf of the participant, refer to previously developed community partner relationships or assist the participant in finding a specific partner that meets their needs.

Oregon Administrative Rule(s)

461-105-0060 — Release of Information to the Client
461-105-0070 — Client Authorization for Release of Client Information to Third Party
461-105-0100 — Release of Client Information to Law Enforcement Officers
461-105-0120 — Release of Information on Child Support and Paternity Cases
461-105-0130 — Disclosure of Client Information

Best practices

- Have regular contact scheduled for all participants.
- Narrate plan outcomes and modifications in the case record.
- Continue to ask open-ended questions, summarizing what you hear from the participant.
- Remind the participant that they know what is best for themselves and their family and build a plan to reflect their own goals.
- Expect the participant to share more about themselves as trust increases.
- Remember not all paths to self-sufficiency will be linear. Instead, focus on the participant's success, and help them continually focus on their short- and long-term goals.

Oregon Administrative Rule(s)

No current OARs apply.

Chapter 4:
Working with families

Section 6: Child support programs

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Child support programs

Introduction

The Department of Justice (DOJ) Division of Child Support (DCS) establishes:

- Paternity
- Establishes child support orders
- Enforces child support.

Child support orders can include cash support, cash medical support, and private health insurance from absent parent(s).These services help children in need, encourage family stability, return money to the state and reduce the state's cost in providing public assistance.

Accounting

DCS provides billing, receipting, payment distribution and record-keeping services on all Oregon child support cases being enforced by DCS or a district attorney (DA).

Oregon Administrative Rule(s)-DOJ

137-055-1070 — Provision of Services

Specific child support cases

TANF and Medicaid cases

DCS establishes paternity and establishes child support orders and enforces child support when a child:

- Is currently receiving TANF assistance
- Has received TANF assistance in the past and past-due support owed for the child has been assigned to the state to reimburse past TANF assistance,
- Has received TANF assistance in the past and is continuing to receive ongoing child support services, or
- Is currently receiving Medicaid

Note: Currently there are no medical referrals sent to DCS until modifications are made to the ONE system.

Other cases

For cases that are not current or former TANF, county DA offices provide child support services at the request of eligible families. (In some Oregon counties, DCS provides these services in lieu of the DA under a separate contract with the county.)

In 1997, ODHS and DCS entered into arrangements with Oregon Tribes to provide child support services on lands under tribal jurisdiction.

If any participants who are not required to pursue child support want help establishing paternity or pursuing child

support, SSP will refer them to their local child support office.

Assignment of support rights

Support assignment requirement

The purpose of assigning support rights is to allow the state to recoup TANF paid to the family. For TANF the terms of the assignment are specified in the R&R's section of applicant portal and on the Application for Services (DHS 0415F). For medical, terms of the assignment are in the application for Oregon Health Plan (OHP) benefits (OHP 7210). By signing the 415F, 7210 or by providing a signature for TANF or medical benefits via either applicant or worker portal, TANF and medical participants automatically assign their support rights to the state. Assigning support rights is a condition of eligibility for TANF and medical.

Who must assign their rights?

Applicants:

- TANF applicants must assign their rights to all child support and spousal support to the state for all persons in their TANF benefit group. (This does not apply to applicants who are a two-parent family.).
- Parents/guardians must assign their rights to all cash medical support and absent parent's health insurance coverage for children in their care.

Participants:

- TANF participants must assign their rights to all child support and spousal support for all persons in their TANF benefit group to the state. (This does not apply to participants in SFPSS, JOBS Plus, or who are a two-parent family.)
- Parents/guardians must assign their rights to all cash medical support and absent parent's health insurance coverage for children in their care who receive Medicaid medical benefits.

Non-parent caretaker relative:

- When a participant is a caretaker relative but not a parent of the child in the TANF benefit group, the child support rights are still assigned to the state even though the caretaker relative is not the legal holder to support owed for the child. Because the child is getting TANF, support is still assigned to the state (this does not apply to caretakers who are a two-parent family).
- Legal guardians/caretaker relatives must assign their rights to all cash medical support and absent parent's health insurance coverage for children in their care.

Amount of support assigned

When a family receives TANF cash assistance, they assign their rights to child and spousal support up to the total amount of unreimbursed assistance (URA). URA is the amount of cash assistance paid for a family minus the child and spousal support payments kept by the state to repay to the state account.

If support arrearages are owed to a TANF applicant/participant who has received TANF in the past, the arrearages for months when the applicant/participant received TANF are assigned to the state to repay the past TANF. Both current TANF and past arrearages are assigned. Arrearages that exceed the URA account are not subject to

assignment. Additionally:

- There is no assignment and no accumulation of URA for TANF participants who are:
  - In JOBS Plus or State Family Pre-Social Security (SFPSS) or
  - A two-parent family.
- URA does not include any amount of child support pass-through.

Special considerations: assignment of support

The following are special considerations for assignment of support:

- The non-parent caretaker relative (e.g., a grandparent or an aunt) must cooperate in pursuing child support from both absent parents unless there is good cause.
- In benefit groups that have more than one absent parent who owes support, assigning support rights covers all current and past due support owed by all absent parents.
- Assignment of ongoing support owed by an absent parent ends when the TANF benefits end for that parent's child(ren). However, any support accrued while TANF, up to the URA balance, was open remains assigned to the state.
- • In situations when there are more than one absent parent and all of the children of one of the absent parents are removed from the benefit group , assignment of ongoing support owed by that absent parent ends. (For the other children in the benefit group, assignment of support remains active). The participant becomes entitled to receive any ongoing support payments for the children removed from the benefit group. The state, however, retains its claim to all assigned support arrears owed by the absent parent and that accrued while the TANF cash grant was open (not to exceed the total amount of TANF cash benefits provided to the group).
- When a person reopens a TANF grant, there will be URA for the current cash grant benefits and any past monthly cash benefits that have not already been repaid to the state.
- For assignments entered before October 1997, all past-due support is permanently assigned to the state up to the total URA.

Procedure for assigned support

When child support is assigned to the state, it must be paid through DCS. If the TANF participant and the parent who pays support (absent parent) have a support order in place that is not being paid through DCS, DCS will send both of them a letter to notify them that child support payments must now be sent to DCS.

Oregon Administrative Rule(s)-DOJ

137-055-6020 — Disbursement by Electronic Funds Transfer/Electronic Data Interchange
137-055-6021 — Allocation, Distribution, and Disbursement: General Provisions
137-055-6022 — Distribution and Disbursement
137-055-6024 — Allocation of Collections to Multiple Cases

Oregon Administrative Rule(s)-ODHS
461-120-0310 — Assignment of Support Rights; Not SNAP
410-200-0225 — Assignment of rights

See Child Support QRG for details on entering child support income

Procedures for turning direct child support payments over to the Division of Child Support

Although child support is required to be paid to DCS when there is an assignment of rights in place, at times the absent parent continues to directly pay the TANF participant. When this happens, the participant must turn over the support to DCS. To turn over a direct payment of cash child support to DCS, the participant has the following options:

- Turn over the cash child support in person at the Salem DCS office located at 4600 25th Avenue NE, Suite 180, Salem, OR 97301.
- Take the cash child support to a payment kiosk at one of the locations listed below. (There is a small fee deducted for paying at the kiosk. This means the absent parent will get credit for the child support payment minus the fee). The kiosk locations are found at oregonchildsupport.gov/payments.
- Purchase a money order and send to the attention of: Oregon Department of Justice, PO Box 14506, Salem, OR 97309. The payment needs to have the child support case number and absent parent's or participant's name written on the money order.

When child support is paid directly to a participant receiving TANF and the participant turns the child support over to DCS, the participant will be sent any child support pass-through the participant is eligible to receive.

Click here for Child support pass-through and disregard.

Procedures when TANF participant does not turn over a direct payment of child support

Direct support

If a TANF participant (single parent or single caretaker relative TANF case not in SFPSS or JOBS Plus):

- **Reports receipt** of a direct child support payment from an absent parent but does not turn over the child support to DCS, ODHS counts the entire amount of child support against the TANF grant benefits. ODHS does not allow any disregard of the child support.

- **Does not report receipt** of a direct child support payment to their ODHS worker and does not turn over the support to DCS, ODHS establishes a TANF overpayment against the participant for the dollar amount of any support payments retained by the participant. The case record must document the reason for writing the overpayment.

Third-party payments

- **Reports third-party payment** for the benefit of the family-When a participant reports to ODHS that an absent parent is making payments to a third-party, such as for the family's rent, mortgage, car, or utilities, ODHS counts the value of the third-party payment against the TANF benefit amount. ODHS does not allow any disregard of a third-party payment.
- **Does not report third-party payment** for the benefit of the family-that an absent parent is making third-party payments for the family, ODHS establishes a TANF overpayment against the participant for the dollar amount of the third-party payment. The case record must document the reason for writing the overpayment.

Oregon Administrative Rule(s)

461-120-0310 — Assignment of Support Rights; Not SNAP
461-145-0080 — Child Support and Cash Medical Support

See Child Support QRG for details on entering child support income

Requirement to cooperate, noncooperation penalties and good cause

Requirement to cooperate with DCS in obtaining child support payments

Child support for TANF applicants

To be eligible for TANF, caretaker relatives must agree to cooperate unless good cause exists (see below) with DCS in establishing paternity and obtaining support payments for all children in the benefit group. (This does not apply to applicants eligible as a two-parent family.)

TANF applicants are asked the following two questions at intake:

1. Do you agree to cooperate with establishment of paternity, location of the absent parent, and establishment of a child support order?
2. Do you have good cause for noncooperation with child support?

When a TANF applicant does not agree to cooperate and there is no good cause for noncooperation, TANF benefits are denied.

After the eligibility intake, TANF applicants will also be asked if there is any additional information, they would like to voluntarily provide about the absent parent. The applicant is not required to give DHS information about the absent parent and is not penalized for not providing this information to DHS. (Once TANF is open, DCS may require this information from the case members and can request TANF sanctions if it is not provided. For more information,

see “Child support for TANF participants” below.)

Child support for TANF participants

This does not apply to TANF participants in JOBS Plus, SFPSS, or who are a two-parent family.

This also does not apply to cases where the only child(ren) are not in the benefit group due to receiving SSI.

TANF participants must cooperate (unless good cause exists; see below) with DCS in establishing paternity, locating the absent parent and obtaining support payments for all children in the benefit group. When a TANF participant who is required to cooperate does not cooperate and there is no good cause for the noncooperation, the participant will be subject to the penalties below.

Child support for Medicaid applicants

Parents and guardians are required to cooperate with DCS in obtaining cash medical support and health insurance coverage from absent parents. If a parent or guardian does not agree to cooperate with DCS and does not have good cause, it is appropriate for the parent or guardian’s medical request to be denied. If at any time good cause is found, the ONE system must be updated to reflect good cause. The same process used to determine good cause for TANF will be used for medical.

What is cooperation for TANF participants?

Cooperation with child support exists when the participant provides information that DCS needs or requests to establish paternity, locate the absent parent, or to establish, modify or enforce a child support order for the child(ren) in the TANF benefit group.

When DCS requests information, the participant demonstrates cooperation by supplying enough information for DCS to proceed with appropriate action. The information DCS may request includes, but is not limited to:

- Regarding all absent parents of the dependent children:
  - Full legal name and nicknames
  - Social Security number
  - Current or last known address
  - Current or last known employer, including name and address
  - If a student, current or last known school
  - Criminal record, including where and when incarcerated
  - Date of birth, or age
  - Race
  - Date and place of each child’s conception (if paternity is not established)
  - Any known group or organizational affiliations
  - Names and addresses of close friends or relatives
- Any other information DCS requests that would help locate or identify an absent parent of a child in the benefit group

- Supplying documentation or explanation of efforts to get information requested by DCS (if unable to provide any necessary information listed above)
- Keeping appointments with DCS related to establishing paternity
- Returning telephone calls or responding to correspondence or inquiries through an online account when requested by DCS
- Otherwise demonstrating a good faith effort to obtain necessary information to locate and identify each alleged parent or absent parent, establish legal paternity, establish and enforce a support order, and obtain support payments.

Encouraging cooperation

ODHS encourages participants to cooperate with DCS by emphasizing these points:

- Support from the absent parent could help lessen the child's feelings of abandonment or desertion.
- Establishing paternity can entitle the child to receive SSB or veterans' benefits on the alleged father's account, should the alleged father die or become entitled to disability benefits.
- Support payments can help families pay for living expenses and assist with financial stability , especially after the family is no longer eligible for TANF.
- If the participant has safety concerns, ODHS offers the participant potential options for safely collecting support. This can be done by establishing a contact address and/or filing a "nondisclosure of information" request within the Client Safety packet on Good Cause Version A (DHS 8660). Give the participant a copy of this packet to help discuss options for safely collecting support.

Determining noncooperation

DCS informs ODHS via DCS' Origin system and ODHS' ONE system interface when a participant is not cooperating with the establishment of paternity, location of the absent parent or establishment of a support order (noncooperation). ODHS then contacts the participant to explore what is getting in the way of cooperation with DCS. If the participant cannot be reached by phone, use the Child Support Cooperation form 1-019 through the ONE system for a 10-day pend to determine if good cause exists. If the participant does not contact ODHS to discuss what is getting in the way of cooperation with DCS proceed with the sanction process. If contact is made and:

- **If the participant claims good cause** for not cooperating, ask the participant for more information and work with the participant to determine if they qualify for a good cause exception.
- **If the participant does not claim good cause** for not cooperating, or **if the participant claims good cause and ODHS determines the participant does not have good cause**, apply penalties per below.

Participants in JOBS Plus or SFPSS or who are a two-parent family are not required to cooperate with child support (and are not penalized for noncooperation).

Good cause for failure to cooperate; child support

A participant may claim good cause for not cooperating with DCS to establish paternity or to collect child support.

If the participant claims good cause due to a domestic violence situation, TA-DVS should be discussed with the participant as well as any other crisis intervention or domestic violence counseling services that may be locally

available.

Good cause for failure to cooperate with child support exists when any of the following are true:

- Cooperation is reasonably anticipated to result in emotional or physical harm to child or to the caretaker relative.
- One of the following circumstances exists and ODHS believes continuing efforts to obtain support would be detrimental to the child(ren):
  - The child was conceived due to incest or rape.
  - Legal proceedings for adoption are under way before a court.

If good cause is found, DCS will take no action to establish paternity or establish a child support order or to enforce child support on a new or ongoing child support case.

When DCS determines a participant is not cooperating and there is an open TANF case, DCS informs ODHS via DCS' Origin system and ODHS' ONE system interface. Before imposing a penalty for noncooperation, ODHS contacts the participant to explore what is getting in the way of cooperation, determine if ODHS can assist in whatever DCS is asking the participant to do and determine if the participant had good cause.

If good cause is found on an open TANF case (or determined after TANF case closure with current medical eligibility), ODHS will update the good cause field in the ONE system. The request for good cause is reviewed at application and renewal for TANF.

When a TANF or Medicaid participant tells DCS that pursuing paternity or support may cause a safety concern for the participant or the child(ren) , DCS will inform ODHS of the claim for good cause via the ONE/Origin interface.

- ODHS will reach out to the TANF participant to determine whether there is good cause for noncooperation with support, or whether claim of risk may be an option to safely pursue paternity and support.
- If ODHS determines the case should have good cause for noncooperation with support, the worker will take appropriate case action.
- If ODHS determines the case does not have good cause, the worker will take appropriate case action.
- ODHS will add a case note in ONE regarding the good cause determination or the reason there is not good cause. When TANF is closed and there is no existing medical eligibility the former TANF participant must notify DCS that they would like to request good cause and DCS determines whether good cause exists.

ODHS cannot remove good cause coding on a closed TANF case. When TANF is closed and a parent or caretaker no longer wants good cause, the parent or caretaker must notify DCS and DCS removes the good cause coding.

Good cause; ODHS responsibilities

ODHS informs applicants and participants of their right to claim good cause and asks if they have good cause, both when the participant applies for assistance and at each renewal of eligibility.

If the applicant or participant claims good cause due to a domestic violence situation, TA-DVS should be discussed as well as any other crisis intervention or domestic violence counseling services that may be locally available.

When a person applies for TANF and one or both parents of any child in the benefit group are absent from the

benefit group, ODHS will do the following:

- Explain to the applicant that, unless they have good cause for not cooperating or are eligible for TANF as a two-parent family, agreeing to cooperate with DCS in efforts to obtain child support payments is a condition of eligibility for TANF, and
- Explain to the applicant the purpose of the referral to DCS and encourage the participant to cooperate with DCS for the benefit of the children.

ODHS verbally reviews with the applicant:

- The requirement, at intake, to agree to cooperate unless there is good cause.
- The requirement, while receiving benefits, to cooperate with DCS unless there is good cause.
- Good cause for noncooperation. (The DHS 8660 may be used when reviewing good cause. This form includes information about both good cause and claim of risk.)

Note: Enter a case note to indicate the cooperation requirements and good cause for noncooperation were verbally reviewed with the applicant.

Confidentiality of participant's address: Under state law, certain information that is confidential under ODHS rules could be released during legal proceedings. For example, the participant's home address could be revealed to the absent parent if the address appears in the absent parent's copy of a child support order.

Contact address: If the participant does not want their address revealed to the absent parent and does not want to claim good cause, the participant may ask DCS to use a contact address. The participant can provide or update their DCS contact address through their online DCS account, verbally or in writing at any time their child support case is open. The contact address must be in Oregon and will be used for child support purposes only.

Note: The contact address will only be used once DCS adds the address to their computer system. A contact address should be provided to DCS as soon as possible to minimize any chance of the other address being shared with the court or other parties.

If ODHS knows the participant would like to use a contact address, ask the participant to update their address through the DCS online account or contact their DCS worker.

Caution:

- If a contact address has been in place for six months, DCS will attempt to contact the participant to ask if the contact address is still valid prior to initiating a new legal action. The contact address will stay in effect until the participant retracts it or mail is returned from this address. If the provided contact address is no longer valid, and a new address isn't provided, DCS will use the participant's home address or other contact address on record, if any.
- Participants must pick up mail at their contact address. If participants do not pick up their child support-related mail, they may lose an opportunity to request parentage testing or to help determine a proper monthly support order.
- Even if the participant claims good cause, they may want to designate a contact address (for mailing child support information only). This is because law requires DCS to provide services (including establishment of paternity) to caretaker relatives, parents, and absent parents who apply for services; this includes,

self-alleged fathers. If the only address on the case is the ODHS address, this address will be on the legal documents during any subsequent proceedings. If the participant claiming good cause wants to use another address such as a contact address, this is allowed.

- The contact address is the address that will be included on legal papers, which the other party may receive copies of. Designating a contact address allows DCS to proceed when a participant does not want the other party to have their home address.

Nondisclosure of information based on a claim of risk: ODHS will advise the participant that DCS has protection available for participants who would cooperate with child support if their personal identifying information will not be revealed. This is known as "claim of risk."

Before initiating any court proceedings, DCS will notify the participant in writing that:

- DCS must include the participant's personal identifying information in any motions, pleadings, petitions, orders or other legal documents filed with the court, and
- To avoid having their personal identifying information revealed in court documents, the participant may work with DCS to file a nondisclosure of information based on a claim of risk. To file a nondisclosure of information based on a claim of risk request, the participant must provide a contact address.

If the participant files a claim of risk in response to receiving notification from DCS of a forthcoming legal action, DCS will reveal the participant's personal identifying information to the court only in the form of sealed documents submitted to the court. These documents do not become public record.

- The participant can contact DCS to request claim of risk at any time. However, if ODHS knows the participant would like to request claim of risk, ODHS should have the participant complete the Claim of Risk form (within DHS 8660) and ODHS should email the form to ChildSupportCaseIntake@doj.state.or.us.

Evidence of good cause; child support

Evidence of good cause for noncooperation with child support includes, but is not limited to:

- A participant's statement, for participants who believe pursuing support will put their safety or the safety of their child(ren) at risk
- A participant's statement as evidence of incest or rape and the detrimental effect of pursuit of support on the child
- Court records, other legal records or written statements from a public or licensed private social agency or an attorney regarding possible or pending adoption of the child(ren) in question
- Sworn statements from individuals, other than the participant, with knowledge of the circumstances that provide the basis of the participant's claim of good cause.

Penalties for noncooperation; child support

TANF applicant

TANF applicants at initial intake, renewal, and reapplication who do not agree to cooperate with DCS without a good cause reason are considered ineligible for TANF and will be denied TANF benefits for the entire filing group.

TANF participant

Families who do not cooperate with DCS and do not have good cause, will have TANF benefits sanctioned and eventually closed . When it is determined that noncooperation with DCS exists, the family coach will need to add a new record in the cooperation with child support section to reflect noncooperation with the correct child and absent parent situation.

The family coach will need to apply a child support sanction CS1 to begin the sanction process. The ONE system will generate a timely reduction notice (CASH NOE).

- The net monthly TANF benefit amount, after income deductions and reductions for JOBS noncooperation are applied (where applicable), shall be reduced by the following percentages:

Level	Benefit Reduction	Effective Date
CS1	25%	1st month following the month in which failure to cooperate is determined
CS2	50%	2nd month following the month in which failure to cooperate is determined
CS3	75%	3rd month following the month in which failure to cooperate is determined
CS4	100% ineligibility	4th month following the month in which failure to cooperate is determined, and all subsequent months in which failure to cooperate continues

  Once a sanction (CS1) is applied to the case, ONE moves from one month to the next applying child support sanctions automatically, without intervention required, for sanctions CS1 to CS3. Timely notices are sent automatically. When a penalty rolls to CS3 and prior to imposing a CS4, ODHS uses the existing grant termination staffing process to assess the family's situation. When appropriate, community partners are involved in the family assessment. The CS3 penalty must be manually updated to CS4 by the Family Coach.

- Once a penalty has ended, any subsequent penalties for noncooperation with support will start at the first level (CS1, 25 percent, per above) for participants who were previously disqualified or penalized for noncooperation but later had full benefits restored.
- For SNAP, when a TANF payment is reduced or ends due to DCS noncooperation, ODHS will count the amount the TANF benefit payment would have been if not reduced for noncooperation, for the duration of the penalty. This is done automatically by the ONE system..

Oregon Administrative Rule(s)

137-055-1160 — Confidentiality — Finding of Risk and Order for Nondisclosure of Information
461-120-0340 — Client Required to Help Department Obtain Support from Noncustodial Parent; TANF
461-120-0350 — Clients Excused for Good Cause from Compliance with Requirements to Pursue Child Support, Health Care Coverage, and Medical Support

Collecting absent parent information

Voluntary questions about absent parents at intake and renewal

ODHS may ask a TANF applicant or participant if there is any information they would like to voluntarily provide about the absent parent. Applicants and participants are not required to give ODHS information about absent parents and are not penalized for not providing this information to ODHS. Once TANF is open, DCS may require this information from the case members and can request TANF sanctions if it is not provided. Absent parent information that a participant may voluntarily provide needs to be entered in ONE on the absent parent referral screen in post eligibility. The participant may choose to voluntarily answer questions such as:

- What is the absent parent's first name, middle initial, and last name?
- What is the absent parent's last known address?
- The absent parent's sex, SSN or DOB
- Has paternity been established?
- Has the absent parent ever been ordered (by a court or administrative agency) to pay child support for your child? If so, what is the civil action #, date, county court name, and state? What was the date of the order, amount of the order and frequency?
- Does the NCP (absent parent) work? Where does the NCP (absent parent) work, or where has the NCP (absent parent) worked? Do you have the name/ address of the NCP's (absent parent) last employer? Is the NCP (absent parent) self-employed? What is the name and address or location of the business and what kind of business is it?
- Has the NCP (absent parent) ever signed an acknowledgment of paternity, or any other documents that he is the father? If so, do you have a copy? If so, in what state?

TANF cases to be reported to DCS

The following cases must be reported to DCS unless there is good cause for noncooperation with support:

- New TANF cases (except for a two-parent family)
- Ongoing TANF cases.

Note: This does not apply to participants who are in the SFPSS or JOBS Plus programs, or who are getting employment payments or who are a two-parent family.

Spousal support/alimony cases: DCS will not establish an order for spousal support. However, DCS will enforce an existing order for spousal support for a participant receiving assistance or if the absent parent of a child on the grant has been ordered to pay spousal support for the participant and DCS is enforcing a child support obligation for the child. Spousal support collected by DCS is applied to the unreimbursed assistance (URA).

Caretaker relative other than a parent: When both parents are absent, and the caretaker is someone other than a parent, DCS will pursue support from both the absent parents.

Parents of a minor parent (grandparents): If a minor parent is receiving a TANF grant, DCS will generally not pursue enforcement against either parent of that minor parent unless there is an existing order. When there is no existing support order against the mother or father of a minor parent receiving TANF, DCS will only pursue support if the minor parent is living with a caretaker and is coded as a child on the grant. However, in all cases, ODHS

reports the absent parent of the minor parent's child to DCS.

Paternity cases: Except when paternity has already been legally established for all children in the benefit group or when a participant has been granted "good cause," ODHS may ask the participant if they would like to voluntarily complete a Parentage Declaration form (MSC 0112FLS) for each child included in the benefit group. If the participant would like to complete the Parentage Declaration form, ODHS asks if they would like help completing it. ODHS cannot require a participant to complete this form. This form is available via a link on the ODHS Forms Server or the DOJ website DECLARATION IN SUPPORT OF ESTABLISHING PARENTAGE A guide for assisting participants in completing this form can be found in Staff Tools-TANF-Child Support. DCS may require this form once they process the TANF referral or update.

Voluntary Acknowledgment of Paternity: ODHS uses the Voluntary Acknowledgment of Paternity Affidavit (OHD 45-21) instead of the Parentage Declaration (MSC 0112FLS) in all cases where:

- Paternity has not been legally established, and
- The child was born in Oregon or Washington, and
- The mother was not married when the child was born, and
- The child was not born within 300 days after the mother's marriage terminated, and
- Both the mother and alleged father are present, have had their rights and responsibilities presented to them and willingly sign the Voluntary Acknowledgment of Paternity Affidavit to establish the alleged father is indeed the legal father.

According to federal law, parents must hear the "Statements of Rights and Responsibilities" printed on the back of the Voluntary Acknowledgment of Paternity Affidavit. Staff may read this statement out loud to the parents, or parents may watch the DVD provided by the state and available on the DCS website at http://www.oregonchildsupport.gov/paternity.

This form must be notarized.

ODHS sends the completed Voluntary Acknowledgment of Paternity form by regular mail to DCS at Oregon Child Support Program, PO Box 14680, Salem OR 97309. (This form cannot be emailed.)

The Voluntary Acknowledgement of Paternity form and the Birth Record order form (required) is available in PDF via the OHA website. If participants do not have the ability to print they can request blank copies of the Voluntary Acknowledgment of Paternity form and Birth Record order form by emailing Kristen.farrell@DHSoha.state.or.us. When requesting this form, include the number of forms needed, whether the form is needed in English or Spanish and the address to which the forms should be sent.

Paternity cases with more than one possible father: If the participant names more than one man as being a possible father for the child, the participant may be asked by ODHS if they would like to voluntarily complete the Parentage Declaration, for the man who the participant thinks is the most likely father. The participant will list the other possible father(s) in the appropriate section on the form. If DCS or a court finds a man named on the Declaration is not the father, DCS will ask the participant to complete a new Declaration for the next most likely father.

"Father unknown" cases: If the participant wants to voluntarily complete a Parentage Declaration but does not

know the name or identity of the alleged father, or the name or identity of any of the possible fathers when more than one man is a possibility, the participant writes "unknown" on the Parentage Declaration. This will provide a sworn statement that the identity of the father is unknown.

Completion of forms:

Although a participant may not be required by ODHS to complete a parentage form, DHS may ask the participant whether they would like to complete the form. When the participant chooses to voluntarily complete the form, ODHS may assist by doing the following:

- Make sure the form is legible and as complete as possible.
- If the participant wants to complete the form but has a safety concern, make sure they understand their right to ask DCS for a contact address, to make a claim of risk for nondisclosure of information or to ask for good cause for noncooperation with support, as discussed in this section.
- The Parentage Declaration (MSC 0112FLS) does not have to be notarized.
- The Voluntary Acknowledgment of Paternity Affidavit (45-21) does have to be notarized.

Sending completed Parentage Declaration forms to DCS: When a parentage form has been completed, promptly forward the completed form to: Oregon Child Support Program, PO Box 14680, Salem OR 97309 or ChildSupportCaseIntake@doj.state.or.us, subject to the following additional requirements and considerations:

- Do not ask a TANF applicant if they would like to complete the Parentage Declaration. This conversation should not happen until TANF has been opened. Once TANF has been opened, DHS may ask the participant if they would like to voluntarily complete the form.
- Do not send the Parentage Declaration for an unborn child.
- Carefully review the form to make sure it is filled out completely and the answers are consistent. See guide for completing the Parentage Declaration Form in Staff Tools-TANF-Child Support

Process when ERDC or SNAP participants want child support services

For ERDC and SNAP cases where the participant wants child support services, ODHS should refer the case to DCS by having the participant complete an Application for Services (CSF 03 0574) for each absent parent and send the completed and signed form to Oregon Child Support Program, PO Box 14680, Salem OR 97309 or CSPCentralMail@doj.state.or.us.

DCS responsibilities (paternity)

Genetic testing: If the mother names more than one possible father or has named only one possible father and he denies paternity, DCS must conduct genetic testing to determine the named father is the actual father before establishing paternity. Genetic testing requires obtaining genetic samples (by means of a buccal swab) from the alleged father, the mother and the child. Results are available approximately four to six weeks after everyone's sample is taken. Once paternity is established, DCS will give the mother and father a copy of the order that established him as the father.

When an alleged father is excluded by genetic testing, DCS will issue an order of non-paternity and will send copies to the now-excluded alleged father, the mother and the court. If the mother named only one possible alleged

father and that father is excluded by genetic testing, reexamination of paternity information the mother provided is required.

Establishing paternity for self-alleged fathers when mother is absent: When the mother is absent from the home, but information indicates a self-alleged father is in fact the child's father, DCS must first try to find the mother and serve her with legal papers (unless she is deceased) before establishing paternity. This process may be delayed if the mother cannot readily be located.

A self-alleged father may begin the process of establishing paternity through DCS by completing and signing the DCS form Request to Establish Paternity and Statement of Rights, Self-Alleged Father (CSF 01 0760) and sending the form to DCS. This form may be obtained through DCS.

Note: When a man applies for TANF as the father of a child, ODHS accepts the statement that he is the father unless it is questionable. When the relationship is questionable, ODHS asks for proof that paternity has been legally established.

Proof of paternity is:

- For instate-birth parentage listed on OVERS
- For out of state-child's birth certificate

Deceased absent parent or alleged father – special considerations

Even if the absent or the alleged father is deceased, DCS may be able to establish paternity or pursue estate assets that could help the child(ren). By establishing paternity for a child when the alleged father is deceased, DCS may enable the child to qualify for Social Security survivor's benefits on the deceased father's account, or for an inheritance. If this situation occurs, ODHS will:

- Notify DCS that an alleged father or an absent parent is deceased so DCS can start appropriate actions.
  - If the participant has claimed good cause with regard to the deceased absent parent or alleged father, ODHS contacts the participant to re-evaluate whether the good cause claim is still necessary and explains to the participant that cooperating with DCS could now result in the child(ren) qualifying for Social Security survivor's benefits, an inheritance or other benefits.

Oregon Administrative Rule(s)

137-055 -2020 — Case Assignment

Disbursement of child support payments

Division of Child Support (DCS) responsibilities

When DCS receives a support payment on an active TANF case, the support payments will be kept by the state up to the total amount of unreimbursed assistance (URA). The URA is reduced by the full amount of the support payments received, including any amounts passed through to the family.

Oregon Department of Human Services (ODHS) responsibilities

ODHS ends TANF benefits when ongoing monthly support, either by itself or with other ongoing income (not including any amount of child support pass through and disregard), exceeds the monthly benefit amount, unless there is reason to believe ongoing support will not continue (such as if the absent parent has just become unemployed). TANF benefits must end no later than the end of the third consecutive month.

When the monthly court-ordered support amount (not including the amount of child support pass through and disregard) is for less than the monthly benefit amount, but a support payment is received by DCS includes support arrears that exceeds the benefit amount and this support payment is not anticipated to continue, consider the payment to include a one-time payment on support arrearage.

If the support that includes arrears exceeds the benefit amount and are anticipated to continue the arrears sent to the participant is considered countable unearned income.

When TANF benefits are ending because support payments to DCS are exceeding the TANF income standards, ODHS will inform the participant that DCS will send future support payments directly to the participant.

Child support disregard and pass-through

Disregard and pass-through

Disregard means child support, up to $50 per dependent child or minor parent per financial group per month. It is not to exceed $200 per financial group per month and is not counted as participant income. Disregard includes current child support only.

Pass-through means child support intended for a TANF participant, up to $50 per dependent child or minor parent per financial group per month and not to exceed $200 per financial group per month. This amount is sent to the participant before any remaining amount of current child support is kept by the state. Pass-through includes current child support only. Pass-through entered into the ONE system is not counted as income when determining ongoing TANF eligibility and benefits.

TANF applicants and participants

Single-parent applicants have to assign their rights to child support to the state. Disregard, but not pass-through, applies to single-parent applicants because the state does not withhold child support until TANF is open. The only months in which a single parent household (not in SFPSS or JOBS Plus) receive a disregard is in the initial month of application, at renewal and when eligibility is being redetermined in the middle of a certification period.

Single-parent participants will receive a pass-through of $50.00 per dependent child or minor parent per month not to exceed $200.00 per financial group per month. Pass-through only includes current child support. Pass-through entered into the ONE system is not counted as income when determining ongoing TANF eligibility and benefits.

Certain caretaker relatives, including needy and non-needy caretaker relatives: IIn the case of a caretaker relative other than the parent on a child support case where the child named in the child support order does not reside in the parent's home, the following is the process by which the pass-through is redirected to the needy or non-needy caretaker:

- If the child support case already has a joinder (which means the needy or non-needy caretaker has been

added to the child support order as the judgment creditor) and the needy or non-needy caretaker opens TANF and a subsequent child support payment is received, the child support computer system (Origin) will disburse the child support payment and send the appropriate pass-through amount to the needy or non-needy caretaker.

- If the child support case does not already have a voluntary redirect in place and a joinder has not yet been initiated, Origin will alert the child support case manager to begin the process. The needy or non-needy caretaker will not receive a pass-through until DCS is able to establish a child support obligation on the caretaker's behalf. Once a support obligation has been established and a subsequent child support payment is received, the pass-through will be sent to the needy or non-needy caretaker.

The pass-through to the needy or non-needy caretaker is not counted as income when determining ongoing TANF eligibility and benefits.

Two-parent families and SFPSS

Two-parent households and families in SFPSS receive a child support disregard. Pass-through does not apply because the state does not withhold child support for these participants, so the participants already receive their child support. Two-parent households and families in SFPSS receive a disregard up to $50.00 per dependent child or minor parent per financial group per month not to exceed $200.00 per financial group per month. The disregarded amount of child support is excluded from the countable child support income for TANF at application, upon a reported change requiring re-evaluation of TANF eligibility, and at renewal.

JOBS Plus

When a participant is engaged in a JOBS Plus activity, their full child support is re-directed back to the participant and any child support received by the participant is not counted as income for TANF.

Verifying child support

When it is necessary to verify the amount of child support an ODHS applicant or participant received or a absent parent paid, use the "Request for Child Support Case Information" form. Participants may provide verification of child support income from their DCS online customer portal.

This is a Division of Child Support (DCS) form to be used by SSP staff when requesting verification of child support for the purposes of administering the ERDC, SNAP, TA-DVS or TANF program. When using this form, it is important to do the following:

- Include the dates for which you are requesting payment information.
- Make sure the family unit you are requesting information for is correct. Family unit identifies the parent (or caretaker relative), absent parent and their associated children. If there is more than one absent parent associated with the ODHS case, complete separate family unit boxes for each absent parent.
- Attach the completed form to an email and send it to DHSChildSupportQuestions@doj.state.or.us.
- Allow two business days for a response from DCS.

Other resources

Child Support QRG: How to enter child support income in ONE, verifying child support, and child support as it relates to each program.

Chapter 4:
Working with families

Section 7: Tribal programs

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Tribal programs

Introduction

Under current federal law, Native American tribes are granted the authority to establish and operate programs specifically for their enrolled members. This allows for services to be offered in a culturally specific manner.

Tribes are afforded considerable discretion in designating both their service areas and service populations.

Oregon's tribes

There are nine federally recognized tribes in Oregon, including:

- Burns Paiute Tribe
- Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians
- Confederated Tribes of Grand Ronde
- Confederated Tribes of Siletz Indians
- Confederated Tribes of the Umatilla Indian Reservation
- Confederated Tribes of Warm Springs
- Coquille Indian Tribe
- Cow Creek Band of Umpqua Tribe of Indians, and
- Klamath Tribes.

There is also federal recognition that the Tolowa Dee-Ni' Nation has recognized land based in Oregon, but the tribe operates out of California.

Tribal recognition is determined by the federal Bureau of Indian Affairs. Each tribe operates as a sovereign nation and chooses how to work with its enrolled members.

Tribal TANF

Through the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), tribes are granted the authority to offer a tribal TANF program. This authority is similar to the authority granted to states, in that tribes are allowed to determine their own TANF eligibility criteria, benefit standards, program services and sanctions. Unlike states, tribes have the option to implement or not implement TANF programs.

In Oregon, there are currently two tribes operating their own tribal TANF programs. The Confederated Tribes of Siletz Indians implemented their TANF program in October 1997 while the Klamath Tribes implemented their TANF program in July 1997.

The TANF service areas and service populations of these tribes are:

- Confederated Tribes of Siletz Indians
  - Service area – Benton, Clackamas, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Tillamook, Washington

and Yamhill counties

- Service population – Single-parent families, two-parent families, caretaker relative (nonparent) families and pregnant tribal members

- Klamath Tribes
  - Service area – Klamath County
  - Service population – Single-parent families, two-parent families and caretaker relative (nonparent) families.

Families who indicate tribal affiliation must apply for TANF services through either the Confederated Tribes of Siletz Indians or Klamath Tribes if they:

- Reside within the Siletz or Klamath Tribes' services areas, and
- Belong to the respective tribal service population.

Tribal families will first need to apply directly with their tribe for TANF services. They do not have the option of applying to the Oregon Department of Human Services (ODHS) for TANF services. The tribes will then determine whether these families meet their tribal TANF program eligibility criteria. The eligibility criteria are established by each tribe and are not required to be consistent with the ODHS TANF program.

If a family fails to meet the tribal TANF eligibility criteria as determined by the tribe, they may apply for and receive ODHS TANF services. If a tribal family is determined to be ineligible for tribal TANF services solely due to the imposition of a tribal TANF sanction, that family is not eligible for ODHS TANF services.

Tribal TANF families are not eligible for ODHS JOBS services or ODHS child care support services. When financial assistance for child care or any other support service is needed, Tribal TANF participants must seek that assistance from the tribe.

Oregon Administrative Rule(s)

No current OARs apply.

Chapter 4:
Working with families

Section 8: Narration and computer entry

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Narration and computer entry

Introduction

The purpose of narration and computer entry is to create a documented, detailed history of the participants case plan services. This is necessary so anyone within ODHS|OHA is able to work with the family, fully informed of past decisions and actions, and with the tools and necessary information to support the participants' plans and goals.

The detailed case record also allows for program services and components to be evaluated for effectiveness. ODHS|OHA is responsible for keeping case management and benefit details documented.

TRACS

The TRACS system serves as one of the electronic case records for each individual or family. It is available to all appropriate program staff and stores case notes, personal development plans, plan details and household contact information. In addition to narrations, TRACS is equipped with additional tools for capturing case details and participant details. Some of these features include:

- Testing page
- Disability and accommodation pages
- Plan detail, including attendance.

Oregon ACCESS

The Oregon ACCESS system is the electronic case record for each individual applying for APD's Long-Term Care services. It is available to APD/AAA case managers to complete LTC service screenings and assessments, case planning and other LTC case management activities. Oregon ACCESS is not used for LTC service eligibility for individuals with intellectual or developmental disabilities (I/DD) or behavioral health (BH) needs. Service eligibility and case management for individuals with I/DD is determined in the eXPRS system by an Office of Developmental Disabilities Services (ODDS), Community Developmental Disabilities Program (CDDP) eligibility specialist . Service eligibility and case management for individuals with behavioral health needs are determined by a local Community Mental Health Programs (CMHP) Behavioral Health Specialist.

This section does not address narration and computer entry for LTC services.

Click here for more information on APD service eligibility and case management.

Click here for more information on I/DD service eligibility and case management.

Case Notes - Narrations: Lists situations in which case notes in ONE are required.

Appropriate narration

Narration is vital in order to provide accurate information to partners, to evaluate family engagement services at the state and local levels, and to show how ODHS|OHA arrived at decisions regarding coaching and family engagement. Some important reminders include:

- Narratives should contain concise, descriptive, objective observations of an individual's engagement.
- All personal development plans, support services, timelines, accommodations, referrals and family engagement should be recorded in narration.

The following case information and actions should always be included in narration:

- Results of screenings and assessments
- Specific accommodations, and whether or not they were offered and accepted
- Case plans and support services
- Re-engagement efforts
- Participant goals
- Referrals to resources and community partners
- Receipt of documents or information from families, related to case management
- All completed and attempted contact with participants and individuals.

The following information is considered inappropriate for the case record and should never be narrated:

- Child abuse reports
- HIV/AIDS status
- Personal opinions
- Information not relevant to the case or working with the family.

Note: When elderly abuse is reported to Adult Protective Services (APS), workers should only narrate the referral. Do not include any details of the alleged abuse. Use the following wording; "Based on information received, an APS referral was made."

Oregon Administrative Rule(s)

461-105-0010 — Rights of Clients

Secure and restricted narration

Health Insurance Portability and Accountability Act (HIPAA) requires ODHS|OHA to add a second level of security relating to substance use disorders or mental health. We are required to secure or restrict information when narrating or creating a disability record where a provider has included a diagnosis, prognosis or treatment information relating to substance use disorders or mental health.

Secure narrations should be used in all situations where the narration or disability record includes a diagnosis, prognosis or treatment information from a qualified provider.

Restricted narrations should be used only when the participant requests certain employees have access to a qualified provider's diagnosis, prognosis and treatment information.

Documenting plans

Documenting plans is an essential part of working with families. It provides a detailed record of a family's goals, barriers and resources.

Click here for Case plan development.

Computer entry

The purpose of computer entry is to ensure eligibility has been appropriately determined and benefits are issued correctly. The electronic case detail provides a detailed description of the individual's or family's situation at any point in time.

ODHS|OHA is responsible for keeping a documented history for each individual or family who applies for or receives benefits.

Chapter 4:
Working with families

Section 9: Employment and training (E & T) services

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Employment and training (E & T) services

Introduction

Working with families often includes helping to connect them with services or activities in order to help them reach their goals. For individuals in either the SNAP or TANF program, there are components designed to support participants by connecting them to employment, preparing them for employment and linking them to training.

SNAP components

Click here for SNAP employment services.

TANF components

For individuals connected to the TANF program, the Job Opportunity and Basic Skills (JOBS) program is their connection to stability, wellbeing, education and training, job readiness and employment services. The JOBS program seeks to connect participants to activities that will help them achieve their short- and long-term goals. Whether a participant is already working, is ready to look for work, needs additional training or needs to address barriers keeping them from working, there is a JOBS component available to help.

Developed as a tool for the staff, the JOBS Activity Guidelines (JAG) is intended to provide a more detailed description of each of the JOBS activity. The JAG also outlines how each activity is connected to support service payments, how each activity may be interconnected to the other programs, as well as best practices for working with families in each activity.

Please see link to JAG in Staff Tools.

Chapter 4:
Working with families

Section 10: Support service payments

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Support service payments

Introduction

The intent of Temporary Assistance for Needy Families (TANF) Job Opportunity Basic Skills (JOBS) support services payments are to provide individualized assistance for participants to support their ability to successfully engage in JOBS activities that promote:

- Family Stability;
- Build skills for and reduce barriers to employment
- Accept job offers and retain employment.

Support services are subject to the limitations of state and federal funding and should be used as part of a Personal Development Plan (PDP) with participants. Exploration of the participant's strengths and resources as well as local community resources are part of the overall equation for support services.

Ensuring those engaging in SSP TANF JOBS program have timely, appropriate, and equitable access to JOBS support services is a top priority for all. It is important all involved with the process around the state have a shared understanding of the intent, scope, and parameters of funding. ODHS staff are asked to utilize this guide to inform and guide practice and process at the local level.

A few key areas to highlight:

- Equity should center all work.
  - Those requesting, consulting, and authorizing support services funding should be aware of how personal bias and judgement impact access.
  - Those who develop, review, and modify processes should be aware of our systems deep-rooted framework based on white privilege and work to actively uproot processes that are inequitable. Framed as being good stewards of funding or ensuring program compliance, a family's lack of access to much needed support may be the result of an existing paternalistic view of what is deemed appropriate and essential. Put simply, our system is grounded on a framework based on white privilege. Proactively challenging that model by mindfully accessing our own biases is the responsibility of all. This is an area for collective growth.
- Support families to identify long term solutions to ongoing needs. Support services are intended to provide short-term individualized assistance and are not intended to be used on an ongoing or repeated basis.
  - Engage in deliberate and authentic conversation with families on feasible and reasonable strategies.
  - Connect families with culturally responsive resources that support longer term solutions.
- Regardless of a rural or urban setting, families should have access to support services funding in a consistent, equitable, and timely manner across the state. Guidance outlined within this guide and associated tools/resources is intended to provide clarity and promote consistency in how ODHS employees view and approve access.

Importantly, if existing rules, policies, or processes are serving as barriers to equitable and timely access for individuals and families, please notify the TANF Policy Box for review and consultation. You are also encouraged

to talk with your manager or contact the TANF Policy Box if/when you are uncertain as to how to most effectively support families receiving TANF through support services funding.

Supporting Personal Development Plans (PDPs)

ODHS supports individuals in attaining self-sufficiency by providing payments for items families may need to be able to participate in available JOBS activities on their PDP.

Payments can be made for items such as child care and transportation. They may also include other payments needed to be successful in plans to address work readiness, education or family stability.

Support service payments are authorized in advance of the participant beginning the JOBS activity or employment. They should be issued in time for the participant to be able to participate in the planned activities.

In approving support service payments, SSP must consider lower-cost alternatives. Family coaches should work collaboratively with families to seek resources as appropriate and use support service payments as needed.

Oregon Administrative Rule(s)

461-190-0211 — Case Plan Activities and Standards for Support Service Payments; JOBS, Pre-TANF, REF, REP, SFPSS, TA-DVS, TANF

Eligible individuals

In order to receive a support service payment, an individual has to meet both of the following criteria:

- The individual must be one of the following people:
  - A TANF recipient who is not otherwise ineligible from the JOBS program
  - A TANF-related program recipient or non-TANF recipient who is:
    - A participant in the SFPSS Program
    - A disqualified individual if any of these payments are necessary for the person to re-engage in the JOBS program and end their current disqualification
    - Serving an IPV disqualification and is required to and is engaged in specific JOBS activities
    - An adult who, due to TANF time limits, is no longer receiving cash assistance but whose minor children remain on assistance; the adult is engaged in a JOBS PDP
    - An adult who is not in the benefit group due to being an ineligible non citizen, however they are a work eligible non-citizen
- The individual has agreed to participate in an activity or set of activities as outlined in the PDP.

Oregon Administrative Rule(s)

461-190-0211 — Case Plan Activities and Standards for Support Service Payments; JOBS, Pre-TANF, REF, REFM, SFPSS, TA-DVS, TANF

Approval and denial of payment requests

An individual may request a support service by phone, in person, in writing or by using the Request for Temporary Assistance for Needy Families (TANF) Support Services and Notice of Decision and Action Taken (DHS 7822) form.

When an individual requests a support service payment, ODHS has 30 days in which to make an eligibility decision if the individual is receiving ongoing TANF. ODHS should act as quickly as possible to either approve or deny a request for a support service payment. ODHS will make an adequate and timely support service payment available to individuals to ensure they are able to engage in activities.

When a request for support services is received, the payment request should be entered into ONE and either approved or denied as soon as possible.

There may be circumstances where SSP does not have enough information to determine whether an individual is eligible for a support service payment. In those instances, it may be necessary to issue the participant a Notice of Pending Status (DHS 0210) requesting the specific information or verification necessary to determine payment eligibility. In these instances refer to the JOBS Support Services Guide found under the JOBS Program section of the TANF Staff Tools Page.

Approving a payment

Discussions around needed support services should occur during the PDP development process. This provides an opportunity for the worker to discuss what support the participant needs to be successful in completing their PDP, resources the participant may have available, resources within the community, and lower cost alternatives. Agreed upon payment should be noted in the PDP.

When approving a request for a support service payment, ONE will send the participant a notice of support services approval.

Denying a payment

Sometimes participants request support services for items that either are not allowable or are not supported by their PDP activities. In these situations, the family coach would deny the support services request. The family coach would enter the request into ONE and select a denial reason from 'Manual Denial/Withdrawal/Cancellation Reason' field. ONE will send the participant a basic decision notice based on the entered selection reason.

Sometimes, after having a conversation with the participant the family coach needs to modify the participant's support services request. This can be due to the request not being reasonable to cover the support services need, discovery of a lower cost alternative, or to better meet the participant's needs. A modification could be to decrease or increase the original amount requested as appropriate.

In these situations, the family coach will still enter the request with the entire requested amount into ONE. The final approved payment amount will be entered 'Issuance Amount' field, prompting a reason to be selected in the 'Issuance Amount Reduction Reason' field. ONE will send a basic decision notice explaining the reason their full request was not met, based on the entered selection.

SSP may reduce, close or deny all or part of an individual's request for a support service payment if any of the following are true:

- The participant does not meet the definition of an eligible person

- The individual making the request for the support service payment is disqualified for non-cooperation with their PDP (However, the branch may authorize support service payments to disqualified participants if these payments are necessary for the participant to re-engage in the JOBS program and end their disqualification.)
- The request is not related to the individual's PDP, or
- A lower-cost or no-cost alternative is available.

When support services are stopped, denied or reduced, the participant is eligible for an expedited hearing.

Oregon Administrative Rule(s)

461-175-0200 — Notice Situations; General Information
461-190-0211 — Case Plan Activities and Standards for Support Service Payments; JOBS, Pre-TANF, REF, REP, SFPSS, TA-DVS, TANF

Ending or changing support services provided

Staff must update the 'Other Payments Module' in ONE if a payment a participant has received on an ongoing basis is stopped, closed or reduced. The effective date for closing ongoing support service payments is the day the PDP activities expire or the day the payment is no longer needed. Timely notice is required for all support service closures or reductions.

Oregon Administrative Rule(s)

461-190-0211 — Case Plan Activities and Standards for Support Service Payments; JOBS, Pre-TANF, REF, REP, SFPSS, TA-DVS, TANF

Verification of need for support service payments

Payments made to the participant – The exact amount of support services made payable to the participant, for basic transportation and employment related support services, such as fuel and clothing, do not need to be verified by the participant. Family coaches have a conversation with the participant as to what is reasonable and can make a determination, rounding up to the nearest dollar amount. **Participants should not be asked to provide receipts or verification of exact cost for a request. Additionally, participants are not required to seek multiple "bids" for support services.** If the requested amount seems questionable family coaches may either Google the cost or research the cost with local venders, rounding up to the nearest dollar amount.

Payments made to a vendor – All payments made directly to vendors require verification of the exact amount as the vendor must have the exact payment amount. Verification can include but is not limited to the following:

- Bill or shut off notice from public utility;
- Rental agreement;
- Phone call with vendor;
- Bill from vendor;
- Quote from vendor;
- Other written or verbal communication outlining the cost of the item.

Oregon Administrative Rule(s)

461-190-0211 — Case Plan Activities and Standards for Support Service Payments; JOBS, Pre-TANF, REF, REP, SFPSS, TA-DVS, TANF

Child care support service payments

Support service payments for child care will be provided, when child care is necessary to enable the individual to participate in their approved JOBS program activities specified in the PDP. Support service payments for child care are made directly to the child care provider and are limited by the following criteria.

Payment for child care in the JOBS program is limited as follows:

- Child care payments may only be made to eligible providers who are approved with ODHS.
- The payment made is either the actual rate charged by the care provider or ODHS maximum rates, whichever is less.
- Care is only paid for the minimum hours necessary, for the individual to participate in approved JOBS program activities, this includes their meal and commute time.
- Child care hours should be for actual time spent participating in JOBS approved activities. Anticipated hours will affect authorized hours on child care billing forms, so this should be closely monitored to ensure attendance (actual hours used) is recorded properly.
- Child care for TANF participants is issued by JOBS Child Care Billing (JCCB) with no copay.

Click here for Child care payment process.

Oregon Administrative Rule(s)

461-190-0211 — Case Plan Activities and Standards for Support Service Payments; JOBS, Pre-TANF, REF, REP, SFPSS, TA-DVS, TANF
461-160-0040 — Dependent Care Costs; Deduction and Coverage
461-155-0150 — Child Care Eligibility Standard, Payment Rates, and Coverage

Housing and utility payments

Although the intent of the monthly TANF cash grant is to help a family meet their basic needs, there are times where a need for housing or utility support service payments is identified. When appropriate, payments for housing, including rent and mortgage costs, can be made. Utility bills, including internet payments may also be a cost that can be covered. In both cases, all other support service payment guidance applies, and the cost should be related to a need outside of the family's control.

See JOBS Support Services Guide for more information.

Oregon Administrative Rule(s)

461-190-0211 — Case Plan Activities and Standards for Support Service Payments; JOBS, Pre-TANF, REF, REP, SFPSS, TA-DVS, TANF

Transportation payments

SSP will provide payment for transportation costs incurred in travel to and from JOBS or other approved activities. Payment is made to support an individual's engagement in their PDP.

In considering transportation payment options, it is vital that staff evaluate all aspects of the individual's transportation need and which method of transportation most appropriately meets that need.

Transportation payments may include, but are not limited to:

- Bus passes or other public transportation
- Gas vouchers
- Vehicle repairs

When providing support services for gas, it is important to remember the department DOES NOT require a participant to provide verification of valid driver's license or car insurance. This is because the participant being allocated the support service may not be the one driving or it may not be their car, but the need to travel is still necessary to participate in their PDP.

Oregon Administrative Rule(s)

461-190-0211 — Case Plan Activities and Standards for Support Service Payments; JOBS, Pre-TANF, REF, REP, SFPSS, TA-DVS, TANF

Payments related to educational costs

Often, the most appropriate activity for an individual to work toward their goals is education or training. In this case, SSP can support these activities with a plan and support services. For costs related to education and training, SSP may help with things such as books, class fees, uniforms and supplies. In the event an individual requests assistance with tuition or program enrollment costs, ODHS should first consider other options including financial aid or community resources. For any remaining tuition, district leadership may approve support service payments subject to local budgets and the participant's plan, only when a Vocational Training (VT) step is active on the PDP.

Support Service Payments for Tuition

Support service payments for tuition are intended only for individuals who are not currently eligible for financial aid but are actively working towards regaining financial aid eligibility. Lower cost alternatives such as FAFSA and other resources must be explored and accepted (if available to the induvial) before support service payments are made. There are several reasons in why a participant may not be eligible for financial aid. Some examples include but are not limited to;

- Unsatisfactory student progress: Examples:
  - GPA is too low,
  - Completion rate of credits attempted does not meet the federal minimum requirement
- Past student loans are in default with the federal Department of Education
- Unpaid balances to educational institutions. This is money owed directly to the current or previous educational

institution the individual attended.

These payments are meant to help cover tuition cost, books, and supplies while they work to resolve their financial aid ineligibility. Payments should be short-term, reviewed at each school term (defined by the institution), and the individual must show satisfactory progress towards resolving their financial aid ineligibility.

Individuals requesting these support services payments must provide a financial aid reinstatement letter from their educational institution before the department can consider approval.

Satisfactory Progress

For individuals to receive more than one term of support services for tuition, they must show that they are making progress towards resolving their financial aid standing. When reviewing the progress status of individuals, it is important to keep in mind that everyone has a unique situation and should not be compared to other situations, regardless of similarities.

Individuals must complete the following to accurately determine if satisfactory progress is being made:

- Provide documentation from their academic advisory/financial aid office indicating they are making progress towards resolving their financial aid status.
  - Examples of documentation include but are not limited to: Letter from their institution, official print out of grades/credits received, or signed form, etc.
- Meet with their family coach to discuss the progress they are making.

Points of conversation should include:

- What steps they took that helped them get closer to the goal of resolving their ineligibility to receive financial aid?
  - Examples of appropriate steps may include but are not limited to:
    - Maintained or increased GPA (at least 2.0 GPA)
    - Maintained or increased course completion rate (70% or higher if required by the institution)
    - Consistent attendance in most of their courses
- Have they encountered any new barriers that may make it harder to continue making progress?
- What is their plan for next term to ensure that they continue making progress?

Questions that family coaches may want to consider when prepping for the conversation, if applicable:

- What was the original issue keeping them from being eligible for financial aid?
- What does their institution consider satisfactory progress?
  - GPA, course completion rate, tuition payment
- What does their lender consider satisfactory progress to maintain financial aid?

While satisfactory progress must include the items listed above, if an individual experienced a hardship during the academic term which affected their ability to make progress towards resolving their financial aid status, an in-depth conversation should occur. It is important to look at all factors that may have played a role in hindering their ability to make progress and determine:

- What actions were taken in attempt to continue to make progress?
- How will the situation look differently this term?
- Are there any additional supports needed from the department, such as childcare or housing, that would help them be more successful moving forward?

Note: For attendance purposes if an individual was unable to obtain attendance documentation as outlined in the JAG, attendance credit cannot be given, and hours would be unexcused.

JOBS activities

Attending classes college or university usually takes time and is a process to get there. Did you know there are a variety of JOBS activities that can represent the hours the participant spends along the way? Below you'll find some examples. Please see the JOBS Activity Guidelines (JAG) for more information about each activity.

1. Job Search/Job Readiness (JO) can be used to capture time spent:
   (a) Applying for vocational training program, college, or university
   (b) Completing financial aid applications
   (c) Other activities or supports needed for enrollment such as SAT/ACT prep and test taking hours. (need to determine if self study)
2. Job Skills Training (JS) is appropriate for participants:
   (a) Attending college classes at less than a part-time enrollment rate, such as one course at a time – they may not have been required to apply and be admitted to the college
   (b) Pre-apprenticeship programs
3. Self-Initiated Training (SI) is appropriate for those who have been admitted and enrolled in a two or four-year program, earning credit toward an undergraduate college degree. Can be used to capture time spent:
   (a) Classes
   (b) Study time
   (c) Activities required to fulfill degree requirements (labs, unpaid volunteer work, clinicals, etc.)
4. Vocational Training – Activity that provides participants with up to 18-month access to specific vocational educational training that will lead to a certificate, job offer, and/or career. Can be used to capture time spent:
   (a) Classes
   (b) Study time
   (c) Activities required to fulfill degree requirements (labs, unpaid volunteer work, clinicals, etc.)

Oregon Administrative Rule(s)

461-190-0211 — Case Plan Activities and Standards for Support Service Payments; JOBS, Pre-TANF, REF, REP, SFPSS, TA-DVS, TANF

Other support service payments

When no other resources are available, ODHS can also provide payment for other items needed to look for work, accept a job offer or work toward family stability. Some examples of these payments may include, but are not limited to, the following:

- Interview clothing
- Work uniforms or boots
- Grooming or personal hygiene needs
- Bonding and licensing
- Food handler card.

Oregon Administrative Rule(s)

461-190-0211 — Case Plan Activities and Standards for Support Service Payments; JOBS, Pre-TANF, REF, REP, SFPSS, TA-DVS, TANF

Non-allowable payments

Support services may not be used to pay for the following items:

- Nonessential items, such as television
- Legal costs, including fine, reinstatement fees, court costs, restitution or other costs associated with a penalty
- Purchase of a car, recreational vehicle, motor home, etc.
- Pet-related costs including pet deposits, pet fees, kennels, etc.
- ERDC copayments.

No support service payments may be made to individuals who are not eligible for the JOBS program. This includes individuals who are:

- Receiving SSI payments
- Non-citizens who are not authorized to work in the United States
- Non-needy caretaker relatives
- Exempt in order to provide care to a disabled household member.

Oregon Administrative Rule(s)

461-190-0211 — Case Plan Activities and Standards for Support Service Payments; JOBS, Pre-TANF, REF, REP, SFPSS, TA-DVS, TANF

Issuing payments

Payments are made by ODHS staff designated by the branch or contractor staff designated by ODHS to issue vouchers or checks. All payments except JOBS Plus wage reimbursement and child care are made using one of the following methods:

- Check based on request entered in ONE
- Revolving fund check
- Negotiables out of the branch office. These items must be entered into ONE as JOBS Incidentals and tracked following local branch process.

Revolving fund checks should only be used when there is an urgent need.

Oregon Administrative Rule(s)

461-190-0211 — Case Plan Activities and Standards for Support Service Payments; JOBS, Pre-TANF, REF, REP, SFPSS, TA-DVS, TANF

Best practices

Click here for the JOBS Activity Guidelines and JOBS Support Services Guide.

Chapter 4:
Working with families

Section 11: Home visits

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Home visits

Introduction

Home visits are an important tool in working with families. They can be helpful with engaging participants in their plan, developing relationships in an environment where the individual feels most comfortable and delivering important information regarding benefits.

Although the concept of home visits implies the contact must happen in the participant's home, this is not always the case. These visits may occur in a public setting, such as a park, library or coffee shop. They may also take place in a shelter, school or other partner's location. The goal is to meet the family or individual where they are comfortable and where it is convenient.

Home visits as a tool

There are many reasons for conducting a home visit. Some of the most common include:

- To make contact and relationship building convenient for participants
- To meet the safety needs of individuals who do not feel safe coming into the office
- To accommodate a medical or mental health condition.

Family coaches and engagement specialists should not use home visits to conduct an investigation but rather as a tool to engage with families. Meeting a family in a comfortable and safe environment may lead to more open conversations and allow individuals to better identify:

- Their strengths that make change possible
- Barriers that may be standing in the way of change
- Possible resources and supports that will lead to better outcomes.

Appropriate home visits

Although there is general guidance around home visits provided by Central Office and the Self-Sufficiency Training Unit, many local offices or districts have developed more specific procedures. It is important that staff follow local processes for conducting and tracking home visits. In most situations, home visits should be planned and scheduled in advance. Staff should have a specific goal in mind when scheduling the home visit.

Identifying the purpose of the home visits allows staff to better plan for the engagement opportunity. Some questions to ask may include:

- Why is the home visit needed? The answer to this question will vary depending on your position and the reason for the home visit.
- What are the benefits to the family? Is there any way to help the individual look forward to the home visit?

Whenever possible, the home visit should benefit the family by either providing resources or information, eliminating the need for the individual to come into the office, or creating a safe space to share personal information.

Things to remember

When conducting a home visit, it is important to be as prepared as possible. However, if questions arise that cannot be answered without additional research or verification, inform the family that they can expect an answer when staff are back in the office.

Safety is something to be aware of when conducting home visits. Some things to keep in mind:

- Be aware of any details that may affect the visit, such as previous domestic violence, pets in the home, remote location, or a history of mental health or substance use.
- Observe the surroundings; watch for potential safety issues or hazards on the property.
- Staff should always trust their instincts. If at any time a person feels unsafe, they should excuse themselves from the appointment.

Home visiting best practices

When planning the home visit:

- Read narratives and review the case information before the home visit.
- Be aware of any cultural considerations that may affect the home visit.
- Contact the family, explain the purpose and benefits of the visit, and set up a convenient time. It may also be beneficial to remind the family the day before the visit.
- Make a travel plan that considers the location, schedule a state car, and follow local processes for notifying the office of your home visit.
- Gather the important information you will need on the home visit, such as:
  - Questions or information to discuss with the participant
  - Any forms or resources you want to share
  - State identification and business cards.

Note: Do not take the case file or records from the office.

When conducting the home visit:

- Remember that this is the family's home. Show respect for them and their belongings at all times.
- Even if the home visit is scheduled in advance, at the point of the home visit, ask the participant if it is a good time.
- Ask for or wait for permission to enter before going into the residence.
- Ask who else may be in the house.
- If asked to leave at any time, respect that request and leave immediately.

When returning to the office after the home visit:

- Follow your office procedures for checking in.
- Document the home visit in TRACS.

- Follow up on things learned at the home visit or agreements you made with the family.

Chapter 4:
Working with families

Section 12: State Family Pre-SSI Program (SFPSS)

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

State Family Pre-SSI Program (SFPSS)

Program intent and overview

Intent

The intent of the state Family Pre-SSI (SFPSS) program is to provide interim cash assistance, case management and professional level support to TANF-eligible adults and their families while they are pursuing Supplemental Security Income (SSI). The TANF-eligible adult must have severe physical or mental impairment(s) that has been assessed and determined to meet the program impairment criteria by the program's disability analyst.

Overview

The state Family Pre-SSI program is funded by General Fund dollars. ODHS|OHA recoups a portion of the money allocated for the program through SSI reimbursement. When the TANF-eligible adult is found eligible for this program, they agree to and sign an *Interim Assistance Authorization* (DHS 7814). This contract allows ODHS|OHA to be reimbursed for the adult's portion of any SFPSS payments made to the family out of the initial lump-sum payment the adult receives from SSI.

Eligibility

To be eligible for the State Family Pre-SSI program, all of the following must be true:

- The adult must:
  - Be eligible for and receive assistance through the Temporary Assistance for Needy Families (TANF) program;
  - Meet the program's impairment criteria; and
  - Have signed an *Interim Assistance Authorization* (DHS 7814).

ODHS|OHA will advise participants that the adult portion of the SFPSS cash benefits paid to the family is subject to recovery per the Interim Assistance Authorization.

Eligibility determination groups for SFP are the same as the TANF program.

Oregon Administrative Rule(s)

461-115-0715 — Required Verification; SPFSS
461-135-1195 — Specific Requirements; SFPSS Eligibility

Nonfinancial requirements

The family, including the adult, must meet all of the nonfinancial requirements for the TANF program to be considered eligible for the SFPSS program.

These requirements are:

- Age;

- Residence;
- Citizen/non-citizen Status;
- Social Security Number;
- School Attendance;
- Pursuing Assets;
- Pursuing Substance Abuse and Mental Health Treatment;
- Cooperating with Division of Child Support (DCS);
- Living with a Caretaker Relative.

Specific program requirements

The participant must:

- Complete the application process for SSI,
- Cooperate with ODHS|OHA in applying to the Social Security Administration for SSI, if eligible, and
- Attend all appointments designated by ODHS|OHA and relating to obtaining SSI.

If the SSA finds that the participant does not meet the SSI disability criteria, they may continue receiving SFPSS cash benefits without Program Review Team review while appealing the SSA finding, until a decision is rendered by an Administrative Law Judge (ALJ) for the Social Security Administration's Office of Hearings and Appeals. A participant who loses their appeal to the ALJ, are no longer eligible for SFPSS program, unless they are determined by the Program Review Team to continue program eligibility.

In addition, a participant whose impairments no longer meet the criteria in OAR 461-125-0260 is no longer eligible for the SFPSS program.

The decision by the ALJ is binding unless the participant has a new or significantly worsened impairment as determined by the Program Review Team or unless ruling or legal errors were made on the case by the ALJ.

Legal costs

If an SFPSS participant has been denied by the Social Security Administration (SSA) at the initial and reconsideration level, they will be encouraged to obtain legal counsel. ODHS|OHA will provide a list of attorneys specializing in SSI litigation. The SFPSS participant may choose their own attorney. The legal fees will be paid by SSA based on their regulations.

Disability determination

The disability determination is a process that determines if the individual:

- Meets the listing of impairments found in 20 C.F.R. Part 404, subpart P, Appendix 1; or
- Meets the medical vocational guidelines found in 20 C.F.R. Part 404, subpart P, Appendix 2 for SSI; or
- Meets the definition of disability in 20 C.F.R. §§404.1505 or 416.905.

Impairments

The participant must have a physical or mental impairment or a combination of both that can be expected to last for a continuous period of no less than 12 months from the filing date. The medical condition must meet or equal the Listing of Impairments as found in Social Security Regulations contained in 20 CFR Part 404, subpart P, Appendix 1.

Most of the listed impairments are permanent or expected to result in death. For all others, the evidence must show that the impairment is expected to last for a continuous period of 12 months from the filing date. The diagnosis of a listed impairment is not enough in making a determination for SFPSS.

The 14 Listings of Impairments Contained in 20 CFR subpart P Appendix 1:	
100.00	Growth Impairments
1.00	Musculoskeletal System
2.00	Special Senses and Speech
3.00	Respiratory System
4.00	Cardiovascular System
5.00	Digestive System
6.00	Genito-Urinary System
7.00	Hemic and Lymphatic System
8.00	Skin Disorders
9.00	Endocrine System
10.00	Multiple Body Systems
11.00	Neurological
12.00	Mental Disorders
13.00	Malignant Neoplastic Diseases
14.00	Immune System

Meeting a listed impairment

If the participant's medical evidence contains a set of signs, symptoms, and laboratory findings which match the criteria included under a listing, the participant's impairment meets the listing and the participant is medically eligible for the SFPSS program.

Equaling a listing

The medical findings are at least equal in severity and duration to the listed findings. If the participant's impairment is not listed, ODHS|OHA considers the listed impairment most like the participant's impairment to decide whether the participant's impairment is medically equal to the listed impairment. If the participant has more than one impairment, and none of them meets or equals a listed impairment, ODHS|OHA reviews the symptoms, signs, and laboratory findings about the participant's impairments to determine whether the combination of those impairments is medically equal to a listed impairment.

Individual does not meet or equal a listed impairment

The participant will be eligible for the SFPSS program if they do not meet or equal a listed impairment or have a medical condition that is expected to be terminal within 12 months, provided the participant:

Meets the medical vocational guidelines found in 20 C.F.R. Part 404, Subpart P, Appendix 2 for SSI.

Basic work activity: Any kind of work activity that averages at least eight hours a day for which income is received, regardless of the adequacy to meet the participant's needs. Work performed against medical advice or at an activity center or sheltered workshop is not basic work activity.

Light work: Work that requires lifting no more than 20 pounds at a time. Frequent lifting or carrying objects weighing up to 10 pounds and requires occasional stooping. It also requires standing or walking for a total of approximately six hours of an eight-hour workday.

Past relevant: Work that the individual has performed in the last 15 years and that constitutes substantial gainful activity as defined in 20 CFR 404.1574 and 404.1575, effect November 1, 2003. Also, the past relevant work must have lasted long enough for the participant to learn the techniques, acquire the necessary information, and develop the facilities needed for average performance of the job situation.

Sedentary work: Work that requires lifting no more than 10 pounds at a time and occasionally lifting or carrying articles such as docket files, ledgers, and small tools. Although sitting is involved, a certain amount of walking and standing is often necessary in carrying out job duties. Periods of walking and standing should total no more than two hours of an eight-hour workday and sitting should total approximately six hours of an eight-hour workday. Most unskilled sedentary jobs require good use of the hands and fingers for repetitive hand/finger actions.

Severe physical impairment: An impairment that significantly limits the participant's physical ability to do basic work activity.

Unskilled work: Requires little or no judgment to do simple duties that can be learned on the job within 30 days.

Participants are not eligible if ODHS|OHA determines that drug addiction or alcoholism is material to their disability. These participants cannot be considered impaired on that diagnosis of drug addiction or alcoholism alone. On the other hand, a diagnosis of drug addiction or alcoholism should not have an effect on a disability evaluation that is averse to the participant. Drug addiction and alcoholism are diagnostic terms; they do not denote impairment value or severity. It is necessary to evaluate the severity of the impairment which may be associated with, manifested by, resulting from, or coexisting with these diagnoses. In making the decision, the key issue is whether the participant would continue to meet the definition of disability even if drug or alcohol use were to stop.

Financial requirements

For the tables below, "adult" means an individual who is age 18 years or older, and either a parent (see OAR 461-001-0000) or caretaker relative (see OAR 461-001-0000).

The payment standard for the family in the SFPSS program is based on the following:

When one adult in the filing group (see OAR 461-110-0330) is applying for SSI:

Individuals in need group	Adult payment	Total payment standard
1	$125	$339
2	125	432
3	125	506
4	125	621

5	125	721
6	125	833
7	122	923
8	113	1,030
9	112	1,093
10	112	1,204

When there are two individuals in the filing group who are either a parent (see OAR 461-001-0000) or a caretaker relative (see OAR 461-001-0000), and one of them is an adult and applying for SSI.

Individuals in need group	Adult payment	Total payment standard
2	$93	432
3	74	506
4	115	621
5	100	721
6	112	833
7	90	923
8	107	1,030
9	63	1,093
10	111	1,204

When two adults in the filing group are applying for SSI:

Individuals in need group	Adults payment per adult	Total payment standard
2	$93	432
3	74	506
4	115	621
5	100	721
6	112	833
7	90	923
8	107	1,030
9	63	1,093
10	111	1,204

The standard for 11 individuals or more in the need group is the sum of the Adult Payment (single adult), Adults Amounts (two adults) for 10 individuals in the need group, plus the payment for 10 individuals in the need group, plus $110 for each additional individual in the need group.

Oregon Administrative Rule(s)

461-155-0320 — Payment Standard; SFPSS

Issuing benefits and changes

Overview of changes

Participants can report changes by telephone, office visit, report forms or in writing. The change is considered reported the day it is received by ODHS|OHA. When a change is reported for one program, consider it reported for all programs in which the participant participates.

Participants must report most changes within 10 days of their occurrence. The 10-day time frame starts when the change occurs, with two exceptions:

- The 10-day time frame for earned income begins upon the participant's receipt of the first paycheck from a new job, on the participant's receipt of the first paycheck reflecting a change in the rate of pay or on the last day of employment in the case of a job separation;
- The 10-day time frame for unearned income occurs the day the participant receives the new or changed payment.

The agency will narrate the information received. At times, the action is simply to note that a change was reported because it does not affect the benefit amount. Other times, the action will be to recalculate benefits and send the appropriate notice.

Oregon Administrative Rule(s)

461-170-0011 — Changes That Must be Reported

Effective dates: initial month's benefits

Cash benefits: The effective date for initial month's benefits is:

- The first of the month following the day all eligibility requirements are met and verified; or
- If the day all eligibility requirements are met and verified falls after the compute deadline, the initial month of cash benefits will be the first of the month following the month after compute deadline.

Oregon Administrative Rule(s)

461-180-0070 — Effective Dates; Initial Month Benefits

Effective dates: other

The effective date is the day that an action will be taken, or a change made on the case. When a change is not made on a case by the effective date, make the change as soon as possible and supplement benefits for the current month, restore lost benefits for past months or write an overpayment as appropriate.

The effective date of an action is determined by the type of action and the reporting system.

Actions to close or suspend are effective on the last day of the month in which the notice period ends. The effective date for denying benefits is the earlier of the following:

- The date the decision is made that the participant is not eligible; OR
- The end of the application processing time frame, if the application or required verification is incomplete.

Changes causing increase of benefits can have different effective dates, depending on when the participant reports the change and whether it has to do with adding a person. If the participant reports the change prior to the month

in which it will occur, the effective date is the first of the month in which it will occur, unless the change is for adding a person.

When a person is being added to an open case, the effective date is the date which all eligibility requirements are met. If benefits have been issued for the month and adding the new person would reduce benefits, add the person the first of the following month. When the change is not reported until the month it occurs or later, the effective date is the first of the month following the date the change was reported.

Changes causing reduction of benefits, are effective the first day of the month after the timely notice period expires. If the change will end benefits, the effective date is the last day of the month in which the timely notice period expires.

Effective dates: special circumstances

Restored benefits

When participants are underpaid benefits that are legally theirs or have benefits denied or closed in error, they are entitled to a supplemental of those benefits. This called restoration of lost benefits. When an ODHS|OHA error caused the underpaid of benefits, the effective date of restoration is the date the error was made, up to a maximum period of 12 months.

When a participant error caused the underpaid benefits, the effective date the participant notifies ODHS|OHA of the error, the month the agency discovers the error or the date of a hearing request.

Redetermination of eligibility

At initial application, a filing group is approved for benefits for a specific certification period. Prior to the certification period expiring, it is time for a redetermination of eligibility to approve or deny continuing benefits. Eligibility is at least once every 12 months for meeting the TANF program requirements.

The redetermination of benefits is required not only when the certification period expires, but also at any other time ODHS|OHA determines that eligibility for benefits is questionable.

The process involves reviewing the application and supporting verifications. Participants must cooperate in the redetermination process. Failure to do so causes ineligibility and benefits are stopped.

If the group receives SNAP benefits, certify the TANF benefits for the same period as SNAP, so that eligibility for SNAP and TANF will come up for review at the same time. This allows participants to apply for multiple program benefits on one application.

The effective date for continuing eligibility at the end of the redetermination period is one of the following:

- If the redetermination form is received before the end of the last month of the redetermination period, the effective date is the first of the month after the redetermination period ends;
- If the redetermination form is not received before the end of the participant's last month of eligibility, end the benefits unless the filing group has:
  - Contacted the branch; and
  - Completed the redetermination within the month following the last month of the redetermination period.

Give the filing group 45 days from the date that the participant contacts ODHS|OHA to re-establish their eligibility under the same or a different medical program. If all necessary eligibility information is received prior to the end of the 45-day period, take the appropriate case action (continue current medical eligibility, change program, end benefits), and send appropriate decision notice(s).

If circumstances or information needed to determine eligibility is expected to be received after the 45-day deadline and the participant has no control over the circumstances or information, the 45-day application process may be extended.

Redetermination interview

All interviews are conducted by ODHS|OHA. An interview is needed for SFPSS participants once every 12 months for continued program eligibility.

Interviews should be scheduled as promptly as possible to ensure compliance with the application processing time frames. Interviews may be at the branch office, out of office or by phone.

Oregon Administrative Rule(s)

461-115-0430 — Periodic Redeterminations; Not EA, ERDC, REF, REFM, SNAP or TA-DVS

Participation, cooperation and re-engagement

Program participants, including both parents in a two-parent household, are required to participate in activities deemed necessary by ODHS|OHA. These may include family stability activities, medical-related activities, employment-related activities and activities related to the SSI process.

SFPSS program participants have access to the entire range of activities offered to TANF participants and may in fact benefit from work-related activities.

ODHS|OHA and the disability analyst will develop an individualized case plan in partnership with the SFPSS participant.

In the event a participant is not cooperating with their individual case plan, the situation will need to be reviewed. This review is referred to as the “Re-Engagement” process.

The re-engagement will be led by ODHS|OHA and the disability analyst. They will consult with qualified and appropriate medical professionals during the re-engagement process.

The re-engagement process is used to determine if the participant had good cause for not cooperating with their individualized case plan.

Good cause is what ODHS|OHA considers as valid reasons or circumstances that kept the participant from cooperating with elements of their individualized case plan. It is the participant’s responsibility, with the assistance of ODHS|OHA, to provide evidence to establish good cause for noncooperation and to work with the SFPSS program staff to try to resolve problems that interfere with cooperation. It is important to determine whether the participant is unable or unwilling to cooperate with their case plan.

Good cause for noncooperation with activities

Good cause for noncooperation with activities include:

- Cooperation or placement at a job site would place the participant at risk of domestic violence;
- Participation in a required activity would have an adverse effect or risk on the participant's physical or mental health:
  - Documentation from a qualified and appropriate professional is required.
- The SFPSS program failed to provide a needed support service payment in time for the participant to participate;
- Noncooperation is caused by an aspect of the participant's disability;
- The SFPSS program failed to provide a needed accommodation or modification in order for the participant to participate;
- The work site violates established health and safety standards;
- A pregnant participant is in her seventh or eighth month of pregnancy and either works in a job that requires her to work more than 10 hours each week or has a case plan that requires her to participate more than 10 hours each week;
- A pregnant participant has reached the first of the calendar month prior to the month in which the due date falls and is now considered JOBS-exempt;
- Appropriate child care (or day care for an incapacitated person in the household) is not available or there is a breakdown in child care arrangements for a child in the household. The participant must attempt to get child care from another provider;

  "Appropriate child care" means that:

  - Both the provider and the place where care is provided meet health, safety, and provider requirements as defined in OAR 461-165-0180;
  - The care accommodates the parent's work schedule; and
  - The care meets the specific needs of the child, such as age and special needs requirements.
- The work attachment position or employment offered is vacant due to a strike, lockout or other labor dispute;
- The work attachment position or employment requires a participant to join a union and the participant has religious objections to unions;
- The participant belongs to a union and the employment goes against the conditions of the participant's membership in that union. Good cause does not exist if the employment is not governed by the rules of the union to which the participant belongs;
- The job referral or employer is discriminatory in terms of age, sex, race, religious or political belief, marital status, disability or ethnic origin. Age, sex and disability requirements are allowable when there are valid or legal reasons for the requirements;
- The person's participation in Grand Ronde Tribe new program activities prevents or interferes with participation in SFPSS assigned activities or completion of assignments;
- The participant's failure to participate is due to a circumstance beyond his/her reasonable control;

- The wage for the participant's current or potential job is:
  - Less than minimum wage; or
  - If minimum wage laws do not apply, the wage (rate for piecework) is less than that normally paid for similar work.

Good cause for missing appropriate medical appointments

Good cause for missing appropriate medical appointments (including mental health and substance treatment, SFPSS program appointments and appointments required by the Social Security Administration) includes:

- A mental or physical illness, impairment or condition preventing compliance;
- A verified court appearance or temporary incarceration (30 days or less);
- A verified breakdown in transportation with no readily accessible alternative;
- Inclement weather that prevented the participant and others similarly situated from traveling;
- Family problems, including medical, legal, domestic violence or school problems with other family members;
- Verified adverse circumstances that affected the participant's ability to attend, as determined by ODHS|OHA;
- A legitimate breakdown in communication, such as ODHS|OHA or contractor failure to inform the participant of an appointment;
- Due to an aspect of a known or previously unknown disability;
- ODHS|OHA or contractor failed to provide a needed accommodation or modification.

Good cause related to Alcohol & Drug (A&D) treatment

Good cause for a missed A&D treatment appointment must be granted if an aspect of a disability related to A&D caused the participant to miss the appointment. For example, if memory loss caused by past methamphetamine use caused the participant to miss an appointment, good cause must be granted. However, the agency is not required to grant good cause when a participant reports they missed an appointment because they were using alcohol or drugs at the time.

Good cause for noncooperation with substance abuse or mental health treatment

A participant who is identified in need of mental health or substance abuse treatment must cooperate and follow through with the treatment program requirements. The treatment services must be provided to the participant at no cost. Participants may have good cause for missing scheduled appointments or activities because of the circumstances specified under item above. Also, good cause exists if a domestic violence victim fails to cooperate with a treatment plan when the batterer is also receiving treatment from the same provider.

Good cause for not pursuing assets

A participant may have good cause for not pursuing assets if any of the following is true:

- The assets are unavailable because:
  - They are not in the participant's possession (e.g., a participant has title to a car, but the car is stolen); or

  - They are jointly owned with others who are not in the financial group, who are unwilling to sell, and the participant's interest is not reasonably saleable.
- The participant is incompetent and there is no legal representative to act on behalf of the participant. The participant's condition must be verified by a doctor or other authorized person on the form designated by ODHS|OHA;
- The participant is a victim of domestic violence and pursuing the asset will put the participant or the participant's children at risk of further, future violence;
- The asset is an irrevocable or restricted trust and cannot be used to meet the basic monthly needs of the financial group.

What is noncooperation?

Noncooperation exists when a participant fails to complete the assigned activities as specified on their individualized case plan, which was developed in partnership with ODHS|OHA, without good cause. The assigned activities may include cooperating with family stability requirements, cooperating with activities in pursuit of SSI/SSDI, cooperating with medical appointments, cooperating with alcohol and substance abuse or mental health treatment program requirements, pursuing available assets, etc.

Additionally, participants who are in the SFPSS program are considered not cooperating if they fail to do the following without good cause:

- Meet the requirement to keep appointments and interviews;
- Attend all scheduled classes and activities;
- Spend a SFPSS support service payment on the goods or services the payment was intended to cover, or fail to return an unused payment to ODHS|OHA or the contractor;
- Inform their child care provider that they were not participating in authorized activities, therefore, ODHS|OHA is billed in error.

What is re-engagement?

Re-engagement is a process intended to determine good cause for failure to cooperate with necessary activities assigned by the SFPSS program, and to help participants and potential participants resolve disputes and misunderstandings. This includes disputes about case plans, SFPSS program support service payment amounts, irregular attendance at assigned activities, missed appointments and failure to participate in an activity.

Re-engagement is an opportunity offered to participants and is not a required activity. It can be requested by the participant, ODHS|OHA or a community partner. It is conducted by the family coach, disability analyst, and qualified-appropriate professional. It can be conducted by a face-to-face meeting or phone call between the participant and the conciliator or conciliation team.

Re-engagement includes informing the participant of their rights and responsibilities under the SFPSS program and informing them of the potential for removal from the program and return to the TANF/JOBS program. It may also include establishing good cause, modifying an individualized case plan or taking other remedial actions.

Re-engagement may end under any of the following conditions:

- A decision is made as to whether the participant had good cause for not cooperating with the requirements of the SFPSS program;
- ODHS|OHA and the participant agree on modifications to the disputed individualized case plan;
- No agreement is reached during the re-engagement call or at the re-engagement meeting;
- The participant expresses or otherwise clearly indicates the intent not to cooperate in the re-engagement process.

Re-engagement must end before a decision notice is sent. All re-engagement efforts and activities must be documented in TRACS using the Re-Engagement Page. Unresolved issues can be addressed through the hearing process only after the decision notice has been sent.

ODHS|OHA is required to review all noncooperation for known or unknown disability issues prior to applying a disqualification. This is done by a team consisting of the family coach, disability analyst and qualified-appropriate professional. The agency will document this information on the TRACS Re-Engagement Page.

SFPSS re-engagement review process

1. The SFPSS program arranges re-engagement meeting to discuss noncooperation.
2. The SFPSS program staff (family coach, disability analyst, qualified-appropriate professional) will use the following to determines if there is "good cause":
   (a) Review all evidence for good cause explained in items 1 (PSS F.1), 2 (PSS F.2), 3 (PSS F.3), and 4 (PSS F.4) of this section.
   (b) Review known disability issues for cause of noncooperation.
   (c) Review results of formal evaluations or assessments to determine if an aspect of a previously unknown medical, mental health, learning disability, cognitive, addiction issue, etc., caused the noncooperation.
   (d) Review accommodations and modifications for the following:
      i. Were all needed accommodations or modifications offered to the participant?
      i. Did the participant accept the accommodations or modifications?
      i. Were the accommodations or modifications appropriate?
      i. Are there alternative accommodations or modifications to consider?
   (e) If the SFPSS program staff review determines "good cause," the participant will remain in the SFPSS program.
   (f) If the SFPSS program staff review determines there was "no good cause" for the noncooperation, the participant will be removed from the SFPSS program. They will return to the TANF program as a JOBS-eligible participant and be engaged in a JOBS case plan.
   (g) Document all findings in TRACS using the Re-Engagement Page or TRACS Re-engagement Narrative, which is found on the TANF Staff Tools website under Re-engagement and Disqualification. Remember that certain A&D and mental health information narrated in TRACS needs to be placed in the A&D/MH narrative.

Remember, the participant has the right to ask for a hearing if a decision to remove them from the program was determined by the SFPSS staff review.

Chapter 4:
Working with families

Section 13: Long-term care (LTC) services case management

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Long-term care (LTC) services case management

Aging and People with Disabilities (APD) services

Service eligibility for long-term care (LTC) services through the APD waiver and K-State Plan amendment is determined by an APD or AAA case manager who also provides case management services.

Click here for more information on APD service eligibility and case management.

Intellectual/Developmental Disabilities (I/DD) services

Service eligibility for long-term care (LTC) services through the I/DD waiver and K-State Plan amendments is determined by an Office of Developmental Disabilities Services (ODDS) Community Developmental Disabilities Program (CDDP) eligibility specialist. Case management services may be provided by the individual's choice of either a CDDP service coordinator or a brokerage personal agent.

Click here for more information on I/DD service eligibility and case management.

Chapter 5: Temporary Assistance for Domestic Violence Survivors (TA-DVS) Program

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Chapter 5:

Temporary Assistance for Domestic Violence Survivors (TA-DVS) Program

Section 1: Intent and overview of program

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Intent and overview of program

Program intent

In 1997, the Oregon Legislature passed HB 3112, now ORS 411.117, as Oregon's response to the Wellstone-Murray Family Violence Amendment of the 1996 federal welfare reform law. The "Family Violence Option" provides an opportunity for states to certify standards and procedures to screen for and identify individuals affected by domestic violence.

The Temporary Assistance for Domestic Violence Survivors (TA-DVS) Program was created as a TANF-funded program intended to provide temporary financial assistance and support to families affected by domestic violence during crisis or emergent situations when other resources are not available. TA-DVS is used to help the domestic violence survivors and their children address their safety concerns and stabilize their living situation, thus reducing the likelihood of the survivor returning to the abuser. TA-DVS is intended to provide support to survivors of domestic violence and their children, not to the perpetrator.

The worker's role is to help determine eligibility for the TA-DVS Program, help the survivor identify safety risks, refer them to domestic violence advocates and community resources that may address those needs, and provide financial assistance to help the survivor and the children remain free from abuse.

Once the survivor is found eligible, an individualized case plan is developed with the participant that includes activities supporting the participant's goals related to safety and stabilization from the abuse; a plan to address how future housing costs will be covered; financial planning around the need for TA-DVS payments; as well as partner coordination and referral.

Oregon Administrative Rule(s)

461-001-0000 — Definitions for Chapter 461
461-135-1200 — Specific Requirements; TA-DVS

Program overview

The TA-DVS Program supports domestic violence survivors by providing temporary financial assistance to flee domestic violence (DV) and to help domestic violence survivors remain free of violence.

To be eligible for TA-DVS, a survivor must:

- Meet TANF eligibility requirements
- Have a current or future risk of domestic violence
- Be in a situation that meets the SSP definition of domestic violence.

Some examples of situations where TA-DVS approvals and payments could be used to meet a survivor's need:

- The domestic violence survivor and children are fleeing the abuser and need help to relocate to another state.
- The domestic violence survivor is unable to pay rent because of domestic violence. For example:
  - The survivor used all their available resources to move from the household held with the abuser and

cannot pay rent this month, or

- The abuser stole the money.

- In either case, TA-DVS would be used to stabilize the survivor's living situation so they are less likely to be forced to return to the abuser's household.
- The domestic violence survivor is in the process of fleeing domestic violence, is staying at a temporary shelter or is in a temporary living situation. The survivor needs financial help to get into an apartment and set it up.
- The domestic violence survivor wants to stay in their home and needs new locks to increase safety.
- The domestic violence survivor missed work due to the abuse and is unable to pay the rent.
- A roommate has been physically abusive, and the survivor and their partner want to leave the situation.
- The domestic violence survivor has fled to Oregon from another state after a recent abusive situation and has concerns the abuser will follow or knows where she/he has moved to.
- The domestic violence survivor needs to move because the abuser has located them and their children.
- The abuser was arrested. The case has not gone to trial. There has been no conviction and no jail release date has been set. Even though the abuser is in jail, the survivor has no way of knowing how long the abuser will be in jail. A potential safety risk still exists.
- The abuser was arrested and convicted of domestic violence. They will be in jail for one year. The victim wanted to stay in their home. The abuser's family has started making threats on behalf of the abuser saying the abuser was going to take care of them when they get out. The victim is afraid for themselves and the children and wants to move.
- The abuser has been in jail for five years and is being released. The victim is still living at the same address that was shared with the abuser. There is fear the abuser will make good on threats made prior to the arrest and incarceration. The survivor wants to move to protect himself or herself and their children.

Oregon Administrative Rule(s)

461-001-0000 — Definitions for Chapter 461
461-135-1200 — Specific Requirements; TA-DVS

SSP definition of domestic violence

Domestic violence is the occurrence of one or more of the following acts between family members, intimate partners or household members:

- Attempting to cause or intentionally, knowingly or recklessly causing physical injury or emotional, mental or verbal abuse.
- Intentionally, knowingly or recklessly placing another in fear of imminent serious physical injury.
- Committing sexual abuse in any degree as defined in Chapter 163 of the Oregon Revised Statutes.
- Using coercive or controlling behavior.

Qualifying relationships:

- Family member: Anyone related by blood, marriage or adoption;

- Household member: Individuals who are cohabitating or have cohabited with each other;
- Intimate partner: Anyone in either a current or past relationship of a romantic or intimate nature with the abuser (Intimate does not require sexual intimacy.)

These can include any of the following:

- Spouse
- Former spouse
- Individuals related by blood, marriage or adoption
- Individuals who are cohabitating or have cohabited with each other
- Individuals who have been involved in a sexually intimate or dating relationship
- Unmarried parents of a child.

A single or one-time instance of abuse or controlling behavior does not necessarily constitute a risk of further or future abuse. When there is a history of these behaviors, or when the behaviors have escalated in frequency or type, or if the survivor is concerned these behaviors will lead to physical abuse, there may be a higher risk of further or future abuse.

Click here for examples: SSP definition of domestic Violence.

Oregon Administrative Rule(s)

461-001-0000 — Definitions for Chapter 461

Policy unit contacts

For staffing of TA-DVS cases, please email the TA-DVS Policy Box at TADVS.Policy@odhsoha.state.or.us.

Chapter 5:

Temporary Assistance for Domestic Violence Survivors (TA-DVS) Program

Section 2: Application

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Application

Filing date

For the TA-DVS Program, the filing date is the date when an agency -approved application is received, or verbal filing date is established, and includes the applicant's name, address, and verbal signature captured in ONE.

Note: An agency approved application for TA-DVS includes the (DHS 0415F) or completion of data collection in worker portal.

To complete a verbal filing date, ODHS|OHA completes application registration making record of the applicant's name, address, request for TA-DVS, the date this occurred, and collecting the applicant's signature on call center software.

For more information on capturing a filing date in ONE, see the Establishing Date of Request/Filing Date QRG and the TA-DVS Handoff Process ETOP

Completing and signing the application

A parent or caretaker relative for the dependent child(ren) must complete the application process and sign the application. There is no authorized representatives in the TA-DVS Program.

Application process

To complete an application, the parent or caretaker relative must answer all questions on the application, provide information necessary to determine eligibility, and provide a signature. This information can be provided on an ODHS|OHA-approved application, including verbally.

Signature

A signature can be provided on an ODHS|OHA-approved application, or using the call center software to collect a verbal signature. There are no electronic signatures allowed in the TA-DVS Program.

Application time frames

ODHS must assess the emergent safety concern within eight working hours of receiving the application, including case noting and addressing any immediate safety concerns identified.

This must be done by offering to complete the TA-DVS Safety Screening (DHS 7802). If the survivor indicates they do not want to complete the safety assessment, ODHS case notes the conversation.

Eligibility must be determined within 16 working hours after receiving a filing date or completed signed application.

Exceptions to determining eligibility within 16 working hours of application:

- The application is not completed.
- The survivor does not show for the interview.

- The survivor requests a specific date outside of the 16 working hours.

If the survivor requests the intake appointment be made outside the 16 working hours:

- Check with the survivor to ensure they have a safe place to stay until the appointment can be scheduled.
- Schedule the appointment at the earliest date the survivor is available (and in time to meet any emergent needs).
- Case note that the appointment is being delayed based on a survivor request.

The 16 hours to determine eligibility would start from the scheduled intake date and time, if the survivor attends the intake. If the survivor does not attend the intake, the TA-DVS application is good for 30 days.

Click here for examples: Application time frames.

Oregon Administrative Rule(s)

461-115-0020 — Application Requirements

Certification period

The TA-DVS eligibility period is exactly 90 calendar days. The eligibility period begins the date the survivor is determined eligible for the TA-DVS Program.

There are no extensions in the TA-DVS Program, and TA-DVS 90-day eligibility periods may not overlap.

SSP is to be in frequent contact with the survivor to discuss safety planning and the survivor's needs throughout the eligibility period.

Click here for examples: Certification period.

Oregon Administrative Rule(s)

461-135-1230 — Benefits; TA-DVS

Incomplete application process

If an eligibility decision cannot be made because the survivor turned in an Application for Services (DHS 0415F) or established a verbal filing date, and did not show to the appointment, attempt to contact the survivor to reschedule either by phone or mail (if we have determined they have provided a safe address).

When leaving a voicemail for the survivor, leave a generic message and do not provide information about the TA-DVS application.

Before contacting the survivor via mail, the worker needs to determine the receiving mailbox is safe. If it is not determined the contact address is safe, ODHS will create the appropriate notice and store in a file with the application documents.

The application is held in pending status in ONE for 30 days. If no contact after the end of the 30 days occurs, ONE

will generate the appropriate denial notice denying the application, and will generate a task for support staff to notify the family coach that the notices needs to be provided.

If it is not known whether the address or phone number is safe, the notice would be kept in the electronic case file. Do not leave any detailed voice messages, and case note action taken and why.

For more information on see the TA-DVS Document Process ETOP.

Click here for examples: Incomplete application process.

When a new application is required

If an applicant has completed an agency approved application in the past 30 days and no eligibility determination was made, update the application as appropriate with current information. Do not have the applicant complete a new one.

If benefits were denied within 30 days and there has been no change of circumstances, the applicant can request a hearing.

If the applicant has had a change in circumstances, take a new application.

Note: An agency approved application for TA-DVS includes the (DHS 0415F) or completion of data collection in worker portal.

Click here for examples: When a new application is required.

Oregon Administrative Rule(s)

461-115-0020 — Application Requirements
461-135-1230 — Benefits; TA-DVS

Notices and required forms

Using a basic decision notice (see OAR 461-001-0000) is appropriate for approvals, denials and closures in the TA-DVS program. Notices should be sent to a safe mailing address or hand-delivered.

Exercise caution when issuing notices to DV households:

- When possible, hand-deliver in the office or at a safe meeting place with survivor.
- Verify with the participant that using the mailing address is safe.
- If unable to mail, narrate the notice and keep a copy in file.

TA-DVS required forms chart

Form	When required
DVS-077 Notice about your TA-DVS Eligibility	Automatically generated in ONE when TA-DVS eligibility is approved

DVS-068 TA-DVS Case Summary	Automatically generated in ONE for TA-DVS applications.
DVS-110 Notice of Action: TA-DVS	Automatically generated in ONE when TA-DVS eligibility is denied, payment is denied,
DHS 7802 TA-DVS Safety Screening	Within eight hours of filing date, at time of safety assessment
DVS-135 We Need Proof for TA-DVS Notice	Automatically generated in ONE for TA-DVS applications that must be pended
DHS 1543 Self-Sufficiency Domestic Violence Assistance Agreement	At TA-DVS eligibility determination
DHS 1543M Self-Sufficiency Domestic Violence Motel Use Agreement	At time of motel payment request

Oregon Administrative Rule(s)

461-175-0200 — Notice Situations; General Information

Approval notice – Notice about your TA-DVS eligibility (DVS-077)

When TA-DVS program eligibility is approved, the Notice about your TA-DVS eligibility (DVS-077) is automatically generated in ONE. This notice includes the dates of eligibility as well as information about how the program operates. The notice also explains participants' hearing rights.

If the program remains open for the entire 90 days, there is no additional notice generated at the end of the 90-day eligibility to close or end TA-DVS. The DVS-077 includes the program eligibility dates and, as such, meets the requirements of both an approval and closure notice.

Denial notice – Notice of Action -TA-DVS (DVS-110)

The Notice of Action- TA-DVS (DVS-110) is automatically generated for TA-DVS cases resulting in denial of program eligibility or payment(s). The document will include the reason for the denial.

When ending or closing the TA-DVS Program prior to the end of the 90-day period, the Notice of Action - TA-DVS (DVS-110) will be generated. Document in data collection and case notes the reason the program is ending early (e.g., no eligible child; moved out of state; reconciled with the abuser).

TA-DVS Safety Screening (DHS 7802)

Screening for domestic violence happens in several ways in Oregon. On all agency approved applications, generic questions on safety are asked. The TA-DVS Safety Screening (DHS 7802) asks questions on safety. Use the DHS 7802 to help determine immediate safety concerns, their level of safety, and if they may need a referral to the co-located DV advocate.

The TA-DVS Safety Screening (DHS 7802) is mandatory when a signed application for the TA-DVS Program is

received, and must be completed within eight hours of receiving a signed application or establishing a filing date.

Self-Sufficiency Domestic Violence Assistance Agreement (DHS 1543)

Click here for Safety plan.

In April 2004, the Self-Sufficiency Domestic Violence Assistance Agreement (DHS 1543) became a mandatory form for use in case planning with survivors of domestic violence who are currently experiencing domestic violence or who have been approved for Temporary Assistance for Domestic Violence Survivors (TA-DVS).

The DHS 1543 asks for the immediate plan to address safety concerns, as well as the plan to stay safe from abuse. These sections help guide the conversation in developing the required safety plan and increase stabilization.

The immediate plan should address the actions a survivor feels they need to complete to stay safe when leaving the office. Examples are calling family for resources, connecting with a DV advocate and getting copies of verification of pregnancy.

The plan to stay safe should include a more long-term concept of what is needed. Remember that long term could mean two weeks, two months, etc. Things needed could include locating a job, moving out of state or moving into a new housing situation.

Signature of both the worker and survivor is required on the Self-Sufficiency Domestic Violence assistance agreement (DHS 1543). When completing a phone intake, a verbal signature is acceptable and is documented in case notes that it was signed verbally.

Self-Sufficiency Domestic Violence Motel Use Agreement (DHS 1543M)

Click here for guidance on approving motels/hotels.

The Self-Sufficiency Domestic Violence Motel Use Agreement (DHS 1543M) was created in 2013 for guidance around access to motels.

The DHS 1543M must include the need for motel/hotel and the expected length of stay.

Payments should be paid directly to the motel as a vendor or dual payee check.

Signature is not required on the Self-Sufficiency Domestic Violence Motel Use Agreement (DHS 1543M) but is preferred. If you are unable to get a signature, have the conversation with the survivor and narrate the discussion that occurred.

Oregon Administrative Rule(s)

461-175-0200 — Notice Situations; General Information

Interviewing the survivor

In the TA-DVS Program, we are required to complete a face-to-face interview with the survivor.

The requirement to complete a face-to-face interview can be waived if there is a safety risk due to domestic violence, or if there is a hardship. Hardship follows the TANF rules and would be considered:

- Care of household member
- An individual's age, disability or illness
- A commute of more than two hours from the individual's residence to the nearest branch office
- A conflict between the individual's work or training schedule and the business hours of the branch office
- Transportation difficulties due to prolonged severe weather or financial hardship

In these cases, where there is a safety risk due to domestic violence or a hardship, we can complete the interview via phone, home visit or offsite appointment. The safety concern should be included in the narration.

If the interview is completed by phone, first ask the survivor if this is a safe time to talk. It is important to be mindful that, in a phone interview, we are not able to confirm who else is present during the intake. Listen to determine if there are others present and pay attention to cues from the survivor that they may not be safe to talk.

Note: Due to safety concerns, phone interviews are rare in the TA-DVS Program.

If completing an offsite appointment or home visit, confirm the abuser will not be at the visit. We cannot complete a home visit or offsite appointment if it is not safe for ODHS staff or the survivor. ODHS will not go on a home visit when the abuser still lives in the home. If determined it is safe to complete a home visit or offsite appointment, inform leadership in person and by email before leaving for the appointment; note your expected return time. You will be accompanied for these appointments by another ODHS staff member or partner.

Safety is our primary concern when interviewing an individual:

- Never ask the survivor about domestic violence in front of or within hearing of the alleged abuser.
- Build rapport, encourage conversations and support the survivor in their actions and decisions.
- Ask open-ended questions to facilitate the conversation.
- Express concern about bruises or other injuries (e.g., "That looks like it hurts. Do you need to go to the doctor?").
- If the survivor expresses positive feelings toward the alleged abuser, focus on the violence and controlling behaviors, not the abuser's personality.
- Express concerns for the survivor.
- Ask the survivor what she/he needs to feel safe.

The survivor is the best judge of their safety. Show support for the survivor's priorities. This will help in developing rapport and trust.

When working with survivors, have a conversation about their concerns and where they are at. Consider using the following questions:

- What support system does the survivor already have in place?
- What have they done in the past that worked well for their safety?
- Are there family or friends that have been helpful in the past?
- What do they feel is needed for their safety?
- What is their immediate need? What are some additional future needs?

Remember to take time listening to the survivor. Survivors may be experiencing varying forms of trauma. Sharing their story may not be easy. Interviews are more conversation based and built on creating rapport with survivors.

Oregon Administrative Rule(s)

461-115-0230 — Interviews

Narration Case Notes

Case notes for the TA-DVS Program are required for some elements not captured in data collection. We must case note all information pertaining to eligibility that is not captured in data collection, as well as all interactions, safety plan changes, payment request details, etc. These are considered legal records and must be kept. TA-DVS records are also audited and tracked; therefore, we must keep case notes for this purpose. The purpose of a case note is to be sure others can follow up and we have a record of what has happened. You must always case note, whether it is in the TA-DVS ONE case or kept in a hard file.

TA-DVS case notes are to be separate from all other programs, by ensuring they are put in the TA-DVS ONE case.

Eligibility case notes should include all financial and non-financial eligibility not captured in ONE, including:

- Appointment time/information
- Safety screening details
- Referrals made
- Interview hardship details*
- Case Composition*
  - Abuser in the home
  - Children out of the home
- Address details
  - Physical address details when in a temporary living situation
  - Mailing address details when there is no safe address
- Verification of domestic violence*
- Subsequent request*
- Domestic violence information
  - Abuser name (not an eligibility requirement)
  - Relationship to abuser
  - How the situation meets the SSP definition of DV
  - Current or future DV safety concerns
  - Referrals
- TA-DVS safety plan details
- Forms completed and how they were provided

- Mandatory report made - if applicable*

*Items only situationally required

For more details see the TA-DVS Case Note Guide QRG

Payment requests or ongoing conversations about their DV situation should be a separate case note.

Click here for examples: Narration.

Determining when it might not be safe to case note in ONE

When determining it might not be safe to case note in ONE, we need to establish what is unsafe about case noting. The safety reason must pose a risk of further domestic violence. We want to have a conversation with the survivor to explain the safety of our systems. Our systems have securities and protections already in place.

There are times when some information is unsafe, but it is still safe to case note in ONE. In these situations, the unsafe information can be protected in another way.

- Address is unsafe.
  - The address can be protected by coding DND in the system and have mailing address. We do not need to protect case notes for this reason.
- Naming abuser in case note is unsafe.
  - Keep hard file for name of abuser. The remaining eligibility and conversations can be case noted.
- Survivor is an ODHS employee.
  - See Domestic Violence Staff Tools for this process.

Situations when it may not be safe to case note in ONE:

- The abuser is an ODHS employee.
  - What is the likelihood the abuser will look in the system?
  - Will the abuser know the survivor has applied for TA-DVS?
  - Would they know how to find the information?
  - What is the safety concern if the information is located?
- The abuser is a community partner and has access to ONE or ODHS systems and other case files.
  - Have they looked before?
  - Do they have access?
  - Do they know to look?
  - Have they threatened looking?
  - What is the safety concern if the information is located?
- The survivor believes the abuser has access to any computer system. Either they are a hacker or other public figure.
  - Have they hacked or gained access to government systems before?

- Have they threatened to hack or gain access to government systems and have the ability to hack into the system?
- Have they hacked or gained access to systems to obtain survivor information before?
- What is the safety concern if the information is located?

How to store a hard file when not safe to case note in ONE

Manager holds file in a locked file for the 90-day eligibility period. Some offices may have a lead or district point hold these files.

Manager holds the file in a locked file for an additional 12 months (for review of the file for subsequent requests for the TA-DVS Program or for impact to other cases) after close of the 90-day eligibility period, so it can be reviewed if there is a subsequent request. Route to EDMS as restricted file. Do not secure in EDMS.

Case note in ONE to indicate the file location. There must be tracking in our systems of the TA-DVS intake. This is for survivor safety, to follow-up on the case and for covering workers or offices to support the survivor.

For example: " See hard file for case notes. File stored in Manager AJB's desk at branch 2001."

Confidentiality

Confidentiality is crucial in domestic violence cases. In some cases, how we case note and how we track information can affect a survivor's safety.

Be cautious sharing any information on DV cases, even within the branch. You may not be aware of family or community connections the abuser or survivor has. Abusers often try to use the system to manipulate or control the survivor.

Forms, notices or other information should be sent only when we know there is a safe address.

Click here for examples: Confidentiality.

Alias Identity Process

FFor a survivor to have a alias identity created, there must be a safety concern with their name and identity being in all ODHS systems.

Authorizing person alias is very rare and limited in the ONE system. This must be approved jointly by TA-DVS Policy and local management.

There are important considerations to follow when thinking about creating a alias identity case. We follow the alias identity process, as outlined in Alias Identity Process on Domestic Violence Staff Tools.

Here are some initial considerations to be reviewed with the survivor:

- What information is the concern? What is the safety concern with their real identity being in ODHS systems?
- All names and dates of birth of those in the eligibility determination group must change in the system.
- We must follow the process completely. There are no exceptions. We cannot change some names and not

others.

- All alias identity requests must be approved by policy and your management.

Subsequent requests

Store front offices are to jointly staff approval or denial of subsequent application requests for TA-DVS with a DV point, Co-located advocate (when you have a release of information to do so) Management, or TA-DVS Policy.

Subsequent request is considered as follows:

- The survivor received TA-DVS benefits in the last 12 calendar months and TA-DVS funds were issued; or
- It is the third or fourth request for TA-DVS in the last 12 calendar months, whether funds were issued, or not.

In this section, the "last 12 calendar months" means the end of the 90-day eligibility period fell in the last 12 months.

If there is ever a case with multiple requests over many years, or a case that the worker would like a second opinion on, you can always staff these cases with the above as well.

Number of requests in the last 12 months	Were funds used?	Requires staffing?
2nd request	NO	NO
2nd request	YES	YES
3rd request	YES or NO	YES
4th request	YES or NO	YES

When a survivor is in need of help to flee at any time, but especially multiple times throughout a year, it is important that time is spent to discover how SSP can best support this family in their plan to stay safe.

In order to get the best idea of how we can support the survivor, and what their ongoing plan is, the ODHS Subsequent Request Process form should be used in conjunction with your TA-DVS intake interview, staffing of the case and gathering all necessary information.

This form is intended to help guide conversation with the survivor and is to be used with the survivor to get the best idea of their safety as we make a new plan. Once the questions on the form are completed with the survivor:

- Staff the case and safety plan details on the form with any of the persons listed above, and have them sign off on the form.
- The completed form should be uploaded to the TA-DVS ONE electronic case file and staff should manually notify a Manager or TA-DVS policy for authorization.

Many times, survivors need to adjust their safety plan and request TA-DVS multiple times as they attempt to find what will work best to help them stay safe. The intent of having additional safety planning questions is to ensure survivors are supported and that SSP is helping to guide them to resources that can help them safety plan.

For more information see the TA-DVS Subsequent Request Authorization QRG

Difficult scenarios that may arise:

Shared children with the abuser: When there are children involved, often it can be hard for the survivor to separate themselves from legal obligations of visitation, etc. Abusers can coerce children into giving additional information about whereabouts, contact information, etc. It could be a strong plan to have an advocate talk with the survivor to aid in safety planning with the children around what to share and not to share. Other good resources would be school counselors, and mental health to support these conversations.

Hotel payments with TA-DVS funds: Often, survivors are hoping to use funds to flee their situation immediately. Sometimes, they may request the use of a hotel so they can better plan for their safety or have other reasons they may request to use their grant for this purpose. When this is part of a secondary request, it's important to have more conversation to create an in-depth plan for their ongoing safety. The hotel may still be a valid piece of their plan. Before issuing payments, additional resources are to be addressed and planning is to be adjusted to aid in long-term safety and stability. This is another good time to get a co-located DV advocate involved to help with ideas, resources, and additional support to the survivor.

Planning the use of the grant funds: Asking a survivor how they plan to use the TA-DVS grant can be helpful in moving forward with safety planning. This question provides an opportunity to discuss budgeting with their grant, looking at other resources to meet their needs, and preparing them for additional information that may be needed to provide payments (e.g. Proof of pregnancy). It can also help to determine what the grant can be used for and how to access it. For example, if they want to purchase a firearm with the grant, this is an opportunity for SSP to have a conversation with the survivor about restructuring the safety plan around what payments TA-DVS funds can help with.

Click here for examples: Subsequent Requests.

Authorized representatives and payees

Due to safety concerns, the TA-DVS Program does not allow authorized representatives or alternate payees.

If a survivor comes into an ODHS office and needs assistance with an application, payment request, etc., ODHS can have a conversation with the survivor to determine if an Authorization for Disclosure, Sharing and Use of Individual information (MSC 3010) is appropriate. The MSC 3010 can be used to share needed and relevant information regarding ODHS case information.

Have a conversation with the survivor about the information they want to share and with what individual they want to share. Determine if this is a safe person to be a contact for the survivor. If determined this is a safe person and sharing information would benefit the survivor, ODHS can complete the MSC 3010 detailing the purpose of the disclosure, the exact person receiving the disclosure and what information is being disclosed. Remember, we can refer survivors to co-located DV advocates for additional support. ODHS can also help survivors complete the application for TA-DVS.

Click here for examples: Authorized representatives and payees.

Oregon Administrative Rule(s)

461-115-0090 — Authorized Representatives; General

Chapter 5:

Temporary Assistance for Domestic Violence Survivors (TA-DVS) Program

Section 3: Eligibility groups

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Eligibility groups

Introduction

There are five eligibility determination groups (EDG): household, filing, financial, need and benefit.

Who is included in each of these groups may affect program eligibility, whose assets are considered, whose non-financial criteria are reviewed, and who receives benefits.

To be eligible for TA-DVS, applicants must meet the TANF eligibility determination group requirements. However, there are some exceptions based on situations unique to domestic violence.

Household group

The household group is usually the people who live together, with or without a dwelling. For a residence to be considered separate, it must have access to the outside that does not pass through another residence. It also must have a sleeping area, bathroom and kitchen facility. The household group forms the basis for determining who is in the remaining eligibility groups.

"Homeless" means lacking a fixed regular and adequate nighttime residence and includes living in an emergency shelter; shared housing with others due to loss of housing or economic hardship; or staying in motels, cars, parks, public places, tents, trailers or other similar settings.

For homeless applicants, the household group consists of the individuals who consider themselves living together.

Individuals who live in more than one household group during a calendar month are members of the household group in which they spend more than half of their time.

No children in the household

To be eligible for TA-DVS, the survivor must have a dependent child in the household more than 50 percent of the time. If the survivor fled without their child due to domestic violence, review recent, current and ongoing household composition. Determine what the household composition was before fleeing, what the current living situation is, and what is anticipated to change in the next 90 days.

In some situations, the survivor flees without their children, or their children are placed in another household for safety reasons due to the domestic violence. If this is the only reason the children are not in the household at time of application, we consider them in the household if they were living with the caretaker more than half of the time before they fled, and they are anticipated to be living with the caretaker within 90 days of application.

Abuser in the household

For TA-DVS, the definition of household group is the same as TANF unless the abuser is in the same household as the survivor; in that case, we can exclude the abuser only from the TA-DVS case due to safety concerns. The abuser would not be listed on the TA-DVS case and would not have access to case notes or case records.

Living in domestic violence shelter

If the survivor is residing in a domestic violence shelter or safe home, the survivor and their children would be considered a separate household group from all others in the shelter.

Click here for examples: Household Group.

Oregon Administrative Rule(s)

461-110-0210 — Household Group

Filing group

The filing group consists of individuals from the household group whose circumstances are considered in the eligibility determination process. The filing group includes participants from the household group who choose to apply for benefits and those who must apply together because of their relationship or circumstance.

Pregnancy

For TA-DVS, if there is a safety concern related to domestic violence and the survivor is pregnant and has no other children, the pregnancy does not have to have reached the first of the calendar month prior to the month in which the due date falls. Verification of pregnancy is not required for initial TA-DVS eligibility, but verification is required before payments can be made.

If there is an emergent need for payment without pregnancy verification (e.g., for a bus ticket to get to shelter on the day of intake) and the survivor does not have verification of pregnancy, local management can make a determination to waive the verification for the payment. Verification of pregnancy is needed for ongoing payments.

For details on how to override the request for information, see the Program Payments and Supports QRG.

Click here for examples: Filing Group.

Oregon Administrative Rule(s)

461-110-0310 — Filing Group; Overview

Financial group

The financial group includes all individuals in the filing group whose income and resources count in determining eligibility and benefits. Everyone in this group will have their income and resources reviewed to determine whether they are countable or excluded, unless otherwise specified in rule.

Oregon Administrative Rule(s)

461-110-0530 — Financial Group

Need group

The need group includes individuals from the financial group whose basic and special needs are used in

determining eligibility and benefit level, unless otherwise specified in rule.

Oregon Administrative Rule(s)

461-110-0630 — Need Group

Benefit group

The benefit group includes individuals from the need group who meet all non-financial eligibility requirements except:

- A fleeing felon
- Individuals violating a condition of state or federal parole, probation or post-prison supervision

Fleeing felons; probation and parole violators

For TA-DVS, a fleeing felon is not eligible for the TA-DVS program, however the rest of the benefit group remains eligible, if all other TA-DVS eligibility is met.

Payment may not be made to the ineligible felon and/or probation and parole violator and can be used only to support those who are not felons in the benefit group.

Specific payment instructions:

- Payments may not be written to the felon and/or probation and parole violator
- Payments may not be written to the children
- All payments must be payable to a third-party
- Payments that help the felon to flee the state, county or area they are legally obligated to stay in should be denied.

Oregon Administrative Rule(s)

461-110-0750 — Benefit Group

Chapter 5:

Temporary Assistance for Domestic Violence Survivors (TA-DVS) Program

Section 4: Individual information

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Individual information

Introduction

When applying for benefits, individuals must provide certain information about themselves and any other applicants. They have the right for this information to be treated with respect and confidentiality; and they have the responsibility to provide true, complete, legal and accurate information.

Some information must be verified, and other information can be accepted as stated by the applicant. If safety is a concern, arrangements can and should be made to provide an extra level of protection for individuals and their information in ODHS systems.

Oregon Administrative Rule(s)

461-105-0010 — Rights of Clients
461-105-0020 — Responsibilities of Clients
461-135-1200 — Specific Requirements; TA-DVS

Name/identity

All benefit applications request the name(s) of the applicant and any other person for whom benefits are being requested. Applicants need to provide their true legal identity/name(s), which for SSP purposes is the name registered with the Social Security Administration (SSA). SSP calls this the person's legal name and this name is used in the system to identify the person.

If an individual has legally changed their name through Oregon courts but SSA shows a different name, SSP will continue using the primary name and refer the person to the SSA to complete the name change. Changing a name through Oregon or other state courts does not change the person's name registered with the SSA.

Click here for Confidentiality.

Date of birth (DOB) and age

Recipients must provide their date of birth for themselves and all other applicants. Age is important for many programs and can affect who is considered when determining eligibility, as well as for which program(s) they may be eligible.

To be eligible for TA-DVS, the dependent child must be under age 18, or age 18 and enrolled in school. The caretaker relative(s) may be any age.

Minors who are married, married and legally separated or legally emancipated do not qualify as a dependent child.

If the caretaker relative is under age 18, SSP needs to determine there are no other adult relatives to care or be responsible for the well-being of the applicants, and the applicants are living in a safe environment.

Oregon Administrative Rule(s)

461-120-0510 — Age Requirements for Clients to Receive Benefits
461-135-1200 — Specific Requirements; TA-DVS

Social Security number (SSN)

Not all programs require applicants to provide SSNs. The SSN is used to verify income and other assets; and to match with other state and federal records such as those for the Internal Revenue Service (IRS), Medicaid, child support, Social Security benefits and unemployment benefits.

For TA-DVS, the survivor must provide their SSN if they have access to this information. It is not required if accessing this information creates a safety concern.

Oregon Administrative Rule(s)

461-120-0210 — Requirement to Provide Social Security Number (SSN)
461-135-1200 — Specific Requirements; TA-DVS

Address

Addresses are an important part of communicating with survivors. If a mailing or physical address is out of state, it is essential to review residency in depth during the interview.

For TA-DVS, SSP must ensure survivors have provided a safe address when sending any correspondence regarding this program.

Although individuals are not required to have a fixed mailing address, they must provide a location to get notices from SSP. This mailing address cannot be the branch address. A mailing address may be General Delivery or the address of a shelter or a friend.

Note: If the survivor is staying in a domestic violence shelter, do not ask for the location of the shelter. It is not safe or confidential to receive the address of the domestic violence shelter.

If an unacceptable address is provided on an application, ODHS accepts this for establishment of a filing date and collects a useable address during the interview.

Address fields for all programs should be reviewed and updated when a change of mailing and/or physical address is reported.

Some individuals will have special ways of coding in data collection that will be used for their physical address, due to their unique situation(s). These specific situations are:

- Without a permanent address:
  - This will be used only for participants who state they do not have a “fixed address.” This would be used for anyone who claims they are houseless, staying in a shelter (this includes domestic violence shelters), living with a friend, couch surfing, living in an RV or any place they feel is not their permanent home address.

- DND – Do Not Disclose:
  - DND is for safety purposes only and not for individuals who, for reasons other than safety, simply do not want to provide an address.
  - DND will only be used for cases with a safety concern, including but not limited to domestic violence and trafficking. ODHS will code the Address Line 1 with DND and the city and ZIP code of current residence; the safe mailing address will continue to be the address where they want their mail delivered.
  - Below are the reasons ODHS would code DND:
    - » The abuser is an employee of ODHS, or
    - » The abuser is a community partner or contractor and has access to DHR, ACCESS, MMIS, ONE or TRACS, or
    - » The abuser is in the EDG and has access to case information, or
    - » The survivor believes the abuser may have gained, or be able to gain, access to case information in ODHS systems.
- ACP – Address Confidentiality Program:
  - ACP is only used for individuals who participate in ACP. Participants will have an ACP ID card issued to them, with the ACP PO Box and their recipient number.
  - In ONE, choose 'Yes' to "Participating in Address Confidentiality Program" and input the ACP number shown on the card.
  - Best practice is to view the ACP card or confirm the number with the participant to ensure accuracy of the ACP number. Whenever possible, view the card when adding an ACP address, and case note the card was viewed.
  - We can email or call to verify ACP enrollment at acp@doj.state.or.us or via phone at 503-373-1323. This is also helpful if the survivor does not know their participant number.
  - Important: Delivery of mail to ACP addresses takes additional time. While the ONE system ensures enough time is given when notices are generated, if mailing notices outside the system, allow an additional 5 business days (see OAR 461-175-0050 and OAR 461-175-0206).

For information on how to code ACP and DND addresses in ONE, see the ACP and DND Address Coding QRG.

Oregon Administrative Rule(s)

461-105-0020 — Responsibilities of Clients
461-001-0000 — Definitions for Chapter 461
461-135-1200 — Specific Requirements; TA-DVS

Citizenship

Click here for Non-citizens.

Different programs have different United States citizen requirements.

For TA-DVS. The citizenship requirement can be waived if there is a safety concern related to domestic violence.

For non-citizens receiving TA-DVS benefits, use the payment type 'TA-DVS Citizenship Waived' for all payments.

Oregon Administrative Rule(s)

461-120-0110 — Citizenship and Noncitizen Status Requirements
461-120-0125 — Noncitizen Status
461-135-1200 — Specific Requirements; TA-DVS

Residency

To be eligible for benefits, an individual must be a resident of Oregon. An individual is a resident of Oregon if the individual lives in Oregon. If an individual is in Oregon solely for a vacation, that individual is not a resident. An individual continues to be a resident of Oregon during a temporary period of absence if the individual intends to return when the purpose of the absence is completed.

For TA-DVS, there is no minimum amount of time the survivor must live in Oregon to be a resident. If the survivor intends to move out of Oregon because of domestic violence, they do not need to intend to continue residing in Oregon.

Click here for examples: Residency.

Oregon Administrative Rule(s)

461-110-0210 — Household Group
461-120-0010 — Residency Requirements
461-135-1200 — Specific Requirements; TA-DVS

Relationship

The relationship (responsibility, age, legal and biological) between individuals in the same household can affect eligibility in many ways.

It is important to gather each person's relationship to every other person on the application and in the home. During the interview, SSP will inquire about roommates or significant others. It is important that ODHS knows who is living together; this can be important in the future, if not now, especially if there is a pregnancy or common children.

If there are minor children in the home, it is important to determine who has care and control of the children.

In the TA-DVS Program, survivors may be living in temporary living situations. It is very helpful to determine who they are living with and the relationship. This helps identify potential resources, safety concerns and confidentiality.

Oregon Administrative Rule(s)

461-135-1200 — Specific Requirements; TA-DVS

Chapter 5:

Temporary Assistance for Domestic Violence Survivors (TA-DVS) Program

Section 5: Financial eligibility

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Financial eligibility

Introduction

Income is money or other benefits an individual receives from work, business, investment, etc. ODHS gathers all information regarding income in the financial group, which is used to determine program eligibility.

TA-DVS applicants must still meet TANF financial eligibility requirements, except as follows:

- TANF countable income standard is compared to the net income, not gross income, after coding appropriate deductions and unavailable income. Staff can use the Temporary Assistance for Domestic Violence Survivors (TA-DVS) Eligibility and Benefit Calculation Worksheet (DHS 1542) as an optional tool, however must complete the TA-DVS Deductions and income screens in ONE to capture the information.

  Note: Always enter gross income into the TA-DVS ONE case. For ONE to calculate NET income, enter a deduction to capture payroll/tax deductions in the TA-DVS Deductions Screen.

- The income standard for TA-DVS is the TANF countable income standard. However, the income of the financial group includes only the income immediately available for the group to meet the emergent needs of the domestic violence survivor and the children.
- Consider income unavailable if the abuser controls the income or if pursuing the income would put the survivor or the children at risk.
- Do not count income that is unavailable due to circumstances beyond the domestic violence survivor's control:
  - For example: theft, income controlled by the abuser or money left behind when the survivor fled. This is captured as Unavailable Income on the income screen in the TA-DVS ONE case.
- Do not count income that is unavailable due to being needed to escape the abuse:
  - For example: Having to use the income for unexpected needs, temporary housing to flee, car repair. This is captured on the TA-DVS Deductions Screen in the TA-DVS ONE case.
- TANF grants are not considered income for survivors fleeing domestic violence but can be considered in determining the level of benefit issued. Staff should add a case note detailing Oregon TANF income as it cannot be entered on the TA-DVS ONE case.
- There is no requirement for domestic violence survivors to pursue assets. Do not require survivors to pursue income if doing so would increase the risk to their safety.
- Exclude resources when determining eligibility but consider liquid (cash) resources as part of case planning to meet emergent need.
- SSI income is countable, if available in time to meet the emergent need of the survivor.

Oregon Administrative Rule(s)

461-140-0040 — Determining Availability of Income
461-135-1230 — Benefits; TA-DVS
461-135-1200 — Specific Requirements; TA-DVS

Countable income

Income calculation is determined at time of intake. Follow the process below at intake for the last 30-day period. When payments are requested, we evaluate income available at that time.

Determining financial eligibility:

What income has the survivor received in the last 30 days? Only consider liquid (cash) resources. Input all liquid resources on the applicable income screens in ONE at their gross amount.

Income is considered unavailable if:

- It is controlled by the abuser.
- The survivor does not have access to it.
- It creates a risk of further domestic violence for the survivor to access these funds.
- It is considered unavailable for the TANF program, following TANF rules.

TA-DVS Deductions are considered funds that:

- Were, or will be, used to flee or stay free from domestic violence or intended to be used in their safety plan.
- Were, or will be, unavailable in time to meet the emergent need.

TA-DVS Deductions may include but are not limited to:

- Rent/Mortgage
- Utilities
- Child Care
- Medical Expenses
- Food
- Amount used to address safety issue
- Telephone
- Transportation Costs
- Payroll/Tax Deductions
- Other Expenses already made or obligated to be made
    - For all ‘Other Expense’ types, add a case note with details of the expense.

Income is considered countable when:

- Available in time to meet the emergent need, and
- Not being used to stay free from the domestic violence, and
- Does not present a safety risk in accessing it (e.g., child support).

If countable income is below the TANF countable income standard, the survivor meets the financial eligibility for TA-DVS.

Using finances to help with safety planning

It can be helpful to determine with survivors what resources and income are available to meet the needs of their safety plan. Work with survivors to consider the following:

- What funds does the survivor have immediately available to meet their needs?
- What funds, if any, will the survivor receive within the 90-day eligibility period? When will the income be received? Do not delay addressing safety concerns based on potential future income.
- What part of this income is available to meet part of the survivor's needs? If any, plan with the survivor what part of their needs they can take care of and what we will help with. Document agreed upon expenditures in the Self-Sufficiency Domestic Violence Assistance Agreement (DHS 1543).

Click here for examples: Countable Income.

Oregon Administrative Rule(s)

461-135-1200 — Specific Requirements; TA-DVS
461-140-0040 — Determining Availability of Income
461-135-1230 — Benefits; TA-DVS

Resources

Each program has specific limits to how much in resources an individual can have access to, both at application and for ongoing eligibility.

For TA-DVS, there is no resource limit for initial eligibility. For payment requests, SSP will need to determine what resources the survivor has available for safety needs. For example, a survivor may have a savings account, which would not be considered at the time of intake, but we will discuss using the savings at the time of payment requests.

Oregon Administrative Rule(s)

461-140-0020 — Availability of Resources
461-001-0000 — Definitions for Chapter 461

Pursuing assets

In some programs, applicants are required to actively pursue any income or resource to which they have a legal right or claim. This is called pursuit of assets. For programs that require pursuit of assets, benefits may not be opened until the individual has made a good faith effort to pursue the asset.

For the TA-DVS Program, there is no requirement to pursue assets including, but not limited to, pursuit of Social Security, unemployment and child support.

Chapter 5:

Temporary Assistance for Domestic Violence Survivors (TA-DVS) Program

Section 6: Non-financial eligibility

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Non-financial eligibility

Introduction

To be eligible for TA-DVS, a survivor must meet certain TANF non-financial eligibility requirements, as well as TA-DVS specific requirements, such as the need to meet the SSP definition of domestic violence and have a current or future safety concern related to domestic violence.

Requirement to live with a caretaker or caretaker relative

To be eligible for TA-DVS, a child must live with a caretaker relative. A caretaker relative is the individual, regardless of age, who is responsible for the care, control and supervision of the dependent child and who is related to the child in any of the following ways:

- A biological parent
- An individual who legally adopts the child and any individual related to the individual adopting the child, either naturally or through adoption in OAR 461-120-0630
- Any blood relative, including those of half-blood and including first cousins, nephews, nieces and individuals of preceding generations as denoted by prefixes of grand-, great- or great-great-
- Stepfathers, stepmothers, stepbrothers or stepsisters
- Is or was a spouse of anyone listed above.

A stepparent or stepsibling may be considered a caretaker relative even if the marriage to the biological or adoptive parent ended in death or divorce. When a caretaker relative of one child applies for another child in the same household, the groups must be combined. A dependent child can be in only one filing group at a time.

Need to meet SSP definition of domestic violence

For the TA-DVS Program, the situation must fit into the following definition of domestic violence.

The SSP definition of domestic violence is the occurrence of one or more of the following acts between family members, intimate partners or household members:

- Attempting to cause or intentionally, knowingly or recklessly causing physical injury or emotional, mental or verbal abuse
- Intentionally, knowingly or recklessly placing another in fear of imminent serious physical injury
- Committing sexual abuse in any degree as defined in Chapter 163 of the Oregon Revised Statutes
- Using coercive or controlling behavior

Definitions of relationship:

- Family member: Anyone related by blood, marriage or adoption
- Household member: Individuals who are cohabitating or have cohabited with each other;
- Intimate partner: Anyone in either a current or past relationship of a romantic or intimate nature with the

abuser (Intimate does not require sexual intimacy.)

These can include any of the following:

- Spouse
- Former spouse
- Individuals related by blood, marriage or adoption
- Individuals who are cohabitating or have cohabited with each other
- Individuals who have been involved in a sexually intimate or dating relationship, or
- Unmarried parents of a child.

A single or one-time instance of abuse or controlling behavior does not necessarily constitute a risk of further or future abuse.

When there is a history of these behaviors, or when the behaviors have escalated in frequency or type, or if the survivor is concerned these behaviors will lead to physical abuse, there may be a higher risk of further or future abuse.

Click here for examples: Need to meet SSP definition of domestic violence.

Oregon Administrative Rule(s)

461-001-0000 — Definitions for Chapter 461

Verification of domestic violence

Survivor statement is acceptable for verification of domestic violence and safety concern.

There are only two situations where ODHS will need additional information to make an eligibility decision:

- Two individuals apply against each other in the same eligibility period, or
- You learn an individual applying for TA-DVS has been arrested for, or was convicted of, an act of domestic violence in the past. You are uncertain whether the individual applying is currently a victim of domestic violence.

In these situations, ONE will pend the case for verification of domestic violence. ONE will consider our processing time frames when generating a pending notice. The timeframe for the pend will begin once the worker has provided the pending notice to the survivor via local print.

If two individuals have applied against each other and their eligibility periods are overlapping, each case is pended for verification. The open case is pended with a We Need Proof for TA-DVS Notice (DVS-135) by ONE for verification listed below for 10 days. Survivors may ask for more time; SSP can extend for a reasonable amount of time. No payments can be made without verification. If the verification is never received, the case will close and generate the appropriate closure notice. Once verification is received, enter the verification into ONE and rerun eligibility, then move forward with payments.

The new application for TA-DVS is to be pended with a We Need Proof for TA-DVS Notice (DVS-135) by ONE for 16

hours. If the survivor requests more time, this time can be extended for up to the 30-day application time frame. No eligibility determination can be made without verification. If the verification is not received by the due date, the case will be denied and appropriate notices generated. If the verification is received, the case will be opened from the date eligibility is cleared in ONE, and payments can be made.

You cannot tell them they have applied against each other. It is a confidentiality and safety concern to tell survivors someone else has applied against them. Instead, let them know we have received additional information on their situation, and we need some additional verification. This can be a hard conversation; you may want to have a lead worker, DV point or DV advocate with you.

Acceptable verification of domestic violence

A statement or letter that the individual is not a perpetrator of domestic violence or is a self-defending survivor is to be received from a third party. Third party verification can come from:

- A law enforcement officer
- A district attorney
- The court
- A batterer intervention program (BIP)
- A victim's advocate
- A Child Welfare worker
- A mental health provider
- A health care or other medical provider
- A member of the clergy; or another professional from whom the individual has asked for help to address the domestic violence.

Contact TA-DVS Policy to determine other types of acceptable verification.

At times, survivors of domestic violence are arrested because, at the time the police arrive, they believe them to be the aggressor. Sometimes there are mutual arrests because the police officer is unable to determine who is the primary or predominant aggressor. It may be found later that the person was a self-defending survivor, or the injury to the survivor was not apparent at the time of the arrest. In some cases, the perpetrator may be the one to call 911; they may access a restraining order before the survivor, or there may be mutual restraining orders. It is also common for abusers to claim to be the victim.

TA-DVS cases have only 16 working hours to determine eligibility. Case note in ONE how long the survivor has stated they need to verify the information if:

- The survivor states they need more time to verify an eligibility requirement, and
- Verification is necessary or the case will be denied.

Provide the pending notice, We Need Proof for TA-DVS Notice (DVS-135) generated by ONE.

Abusive situations not meeting TA-DVS policy

TA-DVS cannot meet the needs of all victims of abuse. If an applicant does not appear to meet the TA-DVS eligibility

criteria, consider the following options:

- Crime Victim's Compensation for survivors of crime may be available, whether or not it is domestic violence
- If there are no dependent children, offer a referral to the local domestic violence service provider or the Victims Assistance Program through the county district attorney's office
- If there are no current safety issues related to domestic violence and the individual is facing homelessness not as a result of domestic violence, offer a referral to local housing resources such as the Housing Stabilization Program through the local community action agency or program.
- If the survivor decides not to leave the abusive situation and remains in the household with the abuser, offer a referral to the local DV service provider for safety planning:
  - Do not issue a TA-DVS payment while the survivor is living in the household with the abuser. Explain that ODHS is a resource and TA-DVS can be issued when the survivor is ready to leave.
  - If the survivor is currently with the abuser but intends to flee within the next 90 days, TA-DVS may be opened and a payment made when the survivor is ready to flee.
- A parent is being abused by their minor teenage child. Options might include referring to counseling or law enforcement, or connecting with school counselors.
- If they applied for TA-DVS because the roommate called them names and they want to move, but there has been no past abuse and they do not feel it is likely to happen again — offer them other housing options in the community.
- If they were threatened or assaulted by a neighbor who is not related, not an intimate partner and not a household member, offer a referral to the domestic violence service provider and/or law enforcement.
- A couple is living with her parents. Her parents tell her they do not like how she disciplines her kids, or they want her to pay rent, or they want money back she borrowed. These circumstances alone would not constitute a safety risk, but if there are threats of violence or if there has been violence in the past and they are afraid her parents will hurt her or her children, there could be a safety risk.

Elder abuse

- If you suspect abuse, neglect or financial exploitation of an elderly person or an adult with physical disabilities, report abuse or neglect to the ODHS services office in your area or call 855-503-SAFE (7233) to make a report.
- If you suspect abuse, neglect or financial exploitation of an adult with developmental disabilities, report abuse or neglect to your county developmental disability program.
- If you suspect abuse, neglect or financial exploitation of an adult with mental illness, report abuse or neglect to your county mental health program.
- You may also call 855-503-SAFE (7233). This toll-free number allows you to report abuse or neglect of any child or adult to the Oregon ODHS.
- Use the Guide for mandatory reporters.
- For information about abuse of the elderly and vulnerable adults, see: Adult Abuse Investigation and Prevention.

Child abuse

- If you suspect a child under the age of 18 is being abused or neglected, report abuse to the Oregon Child Abuse Hotline, 855-503-SAFE (7233). This toll-free number allows you to report abuse or neglect of any child or adult to Oregon ODHS.
- Guide for mandatory reporters.

Oregon Administrative Rule(s)

461-115-0610 — Verification; General
461-135-1200 — Specific Requirements; TA-DVS

Safety concern

An eligibility requirement for the TA-DVS Program is there must be a safety concern related to domestic violence.

We must determine the current or future risk of domestic violence. By asking the questions in the next section, we can determine what the relationship was like to help the survivor explain the safety concern.

Assessing the safety concern

SSP should identify the risks the survivor and their family face.

Questions that can foster this discussion include:

- Are you in immediate danger?
- Where is the abuser (use their name) now?
- What do you think the abuser (use name) will do if you …?
- Do you think police intervention would be helpful?
- What do you think your abuser is capable of?
- Do you think your abuser will injure you? What makes you think the abuser will or will not injure you?
- Tell me about the time you were most afraid of your abuser.
- Has your abuser's pattern of behavior changed recently? If so, has it changed for the better or worse?
- What was the relationship like when it first started? What is different now?
- Has this ever happened before? What happened last time?
- Has the abuse been getting worse? Are you afraid for your life?

Has your abuser ever:

- Used or threatened to use weapons against you?
- Choked or attempted to strangle you?
- Stalked you?
- Hurt or threatened to hurt you or your children?

Remember: Domestic violence is a pattern of abuse. Understanding the pattern can help determine why a survivor

may be concerned for their safety. If someone reports they are afraid for their life, we want to be sure to address the concern. We want to review the case with management and try to get advocacy services for the survivor.

As you assess the survivor's safety concerns, listen to the survivor and provide validating messages such as those listed below:

- You don't deserve this. There is no excuse for domestic violence.
- I am concerned for your safety.
- This is complicated. Sometimes it takes time to figure it out. Would you like to meet with an advocate to help you?
- You are not alone in figuring this out. There may be some options. I will support your choices.
- I care. I am glad you told me. I want to work together to keep you as safe as possible.
- Stopping the abuse is the responsibility of your abuser (use name), not your responsibility.

Click here for examples: Safety Concern.

Oregon Administrative Rule(s)

461-135-1200 — Specific Requirements; TA-DVS

Safety plan

A safety case plan is required before issuing TA-DVS Program benefits. ODHS and the survivor jointly create the safety plan to address their safety concerns. The survivor is the best judge of their safety.

All safety plans must be documented on the Self-Sufficiency Domestic Violence Assistance Agreement (DHS 1543) and case noted in ONE. The DHS 1543 is a working document. The safety plan can change as the survivor's situation changes. If the survivor determines they need something else for their safety, we update their plan. This can be a helpful tool for survivors. SSP will always offer a copy of the safety plan to the survivor.

Creating the safety plan begins with a conversation about what the survivor needs.

ODHS creates safety plans based on:

- Resources the survivor has available or needs (financial, a car, community resources, etc.)
- Support systems in place or needed (friends, family, advocates, mental health, law enforcement, etc.)
- What is needed for stabilization (housing, support groups, change in locks, bill support)
- What community resources are being accessed or are being referred (co-located DV advocates, housing/community action agencies, etc.)

Remember that no safety plan guarantees safety. We want to evaluate what resources they need, what support is needed and how to access their grant.

Things to consider:

- Immediate concerns: What is most important to increase their safety? Examples include changing phone number, meeting with the advocate, getting the neighbor's number to call, talking with the landlord, changing

routes to work or school, etc.

- Long-term plan: Examples include moving into a new home using TA-DVS funds, moving out of state, getting into counseling for continued support in moving forward, joining a support group, etc.
- What has worked before and what has not worked: For example, survivor has been in the relationship and already taken steps to keep themselves and their children safe. Consider what has already been working and what has worked in the past to keep moving toward maintaining safety. For things that are not working, come up with creative ideas and new ideas with the survivor on what can be done differently or what resources are needed. Co-located domestic violence advocates can help in this conversation.

Note: There is a difference between a TA-DVS Safety Plan and DV step on a TANF JOBS Plan. For more information on the DV step and using JOBS Support Services, see the Program Payments and Supports QRG.

Click here for Co-located domestic violence advocates.

Click here for examples: Safety Plan.

Oregon Administrative Rule(s)

461-135-1230 — Benefits; TA-DVS
461-190-0151 — Case Planning; JOBS, Pre-TANF, REP, SFPSS, TA-DVS

Engagement

In TA-DVS, there is no requirement to engage in any employment program, including, but not limited to:

- TANF JOBS Program
- SNAP Employment programs
- ABAWD
- Partner Employment Programs.

When engaging DV survivors, we should be creating safety plans to meet the family where they are at and regularly check in with the family.

Whether someone applies for TA-DVS or discloses they are affected by domestic violence, we should be checking in weekly for support, resource referral and plan changes.

For TA-DVS: Create a safety plan and update as the situation or needs change:

- Include resources, referrals and to-dos on the safety plan.
- Update the Self-Sufficiency Domestic Violence Assistance Agreement (DHS 1543) to align with updated plan changes.
- Contact survivor regarding their plan regularly. Regular follow-up helps give additional support to an individual experiencing trauma. Do not leave detailed messages on voicemails. Email only needed information if you know it is safe to do so.

Things to consider in TA-DVS safety plan:

- Acknowledge supports: This includes supports a survivor has available — friends, family, churches, support groups, co-workers, etc.
- Acknowledge financial supports: This includes savings account, employment income, SSI, family that can loan or gift money, etc.
- Consider immediate concerns: What are the most important items to increase safety? Examples include changing phone number, meeting with the advocate, getting the neighbor's numbers to call, talking with the current landlord.
- Consider the long-term plan: Examples include moving into a new home using TA-DVS funds, moving out of state, getting into counseling for continued support in moving forward, joining a support group.

Problem solving and resources

Many of the challenges survivors face take specialized work and resources SSP accesses through community partnerships. We want to use subject matter experts as resources for domestic violence survivors. Refer survivors to domestic violence service providers, aid organizations Family Support and Connections, housing, mental health providers, victim's services, alcohol and drug services or other specialized services when issues arise.

Your local domestic violence or sexual assault service provider is the expert on resources for survivors of DV and sexual violence. They can assist with safety plans for home, work, school and travel. They may also offer referrals for survivors of trauma.

Click here for Co-located domestic violence advocates.

Oregon Administrative Rule(s)

461-130-0305 — General Provisions; Employment Programs
461-135-1230 — Benefits; TA-DVS
461-190-0151 — Case Planning; JOBS, Pre-TANF, REP, SFPSS, TA-DVS

Name of abuser

Though getting the name of an abuser is not an eligibility factor, it is important to know who the abuser is. There are benefits to the survivor in establishing the abuser's relationship with the victim and/or children:

- In consideration of good cause for noncooperation with child support if the abuser is an absent parent on the TANF case
- Effective safety planning in subsequent applications for TA-DVS when the person has re-abused
- Potential for the abuser to try to use the system against the victim (e.g., false report to Child Welfare or to SSP alleging fraud)
- Important safety consideration if that person comes into the office or tries to access confidential information about the survivor.

Click here for examples: Name of abuser.

Chapter 5:

Temporary Assistance for Domestic Violence Survivors (TA-DVS) Program

Section 7: Waiving eligibility requirements

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Waiving eligibility requirements

Introduction

To be eligible for TA-DVS, a survivor must meet TANF eligibility requirements. Some of these requirements can be waived for TA-DVS applicants.

The intent of waiving certain TANF requirements is to keep the survivor safe from domestic violence or the threat of domestic violence, and to ensure the safety of the survivor and their children.

What requirements can be waived

The TANF requirements waived for all TA-DVS applicants if there is a risk of domestic violence are:

- Citizenship/SSN, and
- Requirement to be in month prior to ninth month of pregnancy.

Some TANF requirements are not requirements in the TA-DVS Program. The following TANF requirements are not TA-DVS Program requirements:

- Pursuing assets
- Cooperating with the Division of Child Support
- Participating in any employment programs
- Addressing employment separation good cause
- Regular school attendance for dependent child
  - Child must be enrolled in school but, in many situations, attendance is disrupted due to domestic violence situation.

All waivers or TANF requirements that are not requirements for TA-DVS, should still be captured during data collection in the Eligibility Waiver screen to ensure correct TA-DVS program eligibility.

For example: If no good cause for employment separation is captured in data collection, apply Employment Separation Requirement is Waived on the Eligibility Waiver screen.

Click here for examples: What requirements can be waived.

What requirements cannot be waived

The following requirements cannot be waived:

- The requirement to be an Oregon resident
  - For TA-DVS, if the survivor does not intend to stay in Oregon and the reason for leaving is due to their current domestic violence situation, they still meet the residency requirement.
- TANF countable income limit. Click here for Financial eligibility.
- The requirement to be a dependent child, caretaker relative or parent

- The requirement that a dependent child live with a caretaker relative, unless:
  - The child is out of the home due to safety reasons related to the domestic violence situation, or the caretaker is homeless because of the domestic violence situation, and
  - The child is expected to return within the 90-day eligibility period.

Check with the Child Welfare worker to determine when the child will likely be returned to the survivor if

- The only child is in Child Welfare custody due to domestic violence in the household, and
- The parent does not have care, control and supervision of the child.

At intake – Attempt to connect with Child Welfare to determine if it is likely that the child will be returned to the survivor's care within the 90-day eligibility period.

Child Welfare is not trained in TA-DVS eligibility. It's important to ask questions in a way that gathers the information needed to determine eligibility. Keep in mind that the worker may not be able to verify or confirm that the children will be back in the survivor's care during the timeframe provided as often it is dependent on the survivor stabilizing and becoming safe.

If Child Welfare states it is likely the children will be returned within the 90-day eligibility period, consider the dependent child part of the household for initial eligibility.

If Child Welfare is unable to say it is likely the child will be returned within the 90-day eligibility period, deny TA-DVS. Let the survivor know they can reapply when the child is returned or is close to being returned. Refer the survivor to other appropriate resources, including the local co-located domestic violence advocate.

Click here for Co-located domestic violence advocates.

There may be times that Child Welfare cannot be reached to confirm at intake. When this happens, take the survivor's statement of when they anticipate the child to be returned to their care, and consider the dependent child part of the household for initial eligibility.

At TA-DVS payment request –Confirm with Child Welfare that the child has returned or that the child will be returned upon payment. (e.g. Child Welfare intends to return the children once the survivor finds safe housing. We would approve payment for safe housing, based on Child Welfare confirmation that the children will be returned). Explain this to the survivor during the intake so they can safety plan and prepare for this when they request payment.

Click here for examples: What requirements cannot be waived.

Oregon Administrative Rule(s)

461-135-1200 — Specific Requirements; TA-DVS

Chapter 5:

Temporary Assistance for Domestic Violence Survivors (TA-DVS) Program

Section 8: Payments

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Payments

Introduction

TA-DVS benefits are intended to support survivor and family safety. The funding for TA-DVS is considered emergency assistance and intended to:

- To help meet emergent and safety needs related to the domestic violence situation, and
- To help stabilize the family so they can stay free from domestic violence.

AAgreed-upon payments address the specific crisis situation or specific need related to stabilization from the domestic violence. Payments are documented on the Self-Sufficiency Domestic Violence Assistance Agreement (DHS 1543) as well as in the Other Payments module in the TA-DVS ONE case.

TA-DVS payments can be issued to meet the family's needs for shelter, relocation and other factors contributing to safety and stabilization. TA-DVS payments can also be used to meet other needs that will promote safety or independence from the abuser.

Payments cannot be made that would benefit the abuser. For example, payment cannot be made for past due rent or utility bills if the abuser is on the lease or bills.

If a payment is denied, modified or reduced under the TA-DVS Program, enter the payment into the Other Payments module in the TA-DVS ONE case, and ensure the generated Notice of Action: TA-DVS (DVS-110) is provided to the survivor.

Payment processing timeframe

TA-DVS payment requests should be processed immediately, or as soon as possible, as determined by the receiving office. TA-DVS payment requests should be processed with priority over all other program documents as the TA-DVS program is considered emergency assistance.

Always enter requested payments in the TA-DVS ONE Other Payments module upon receipt of the request to ensure correct notices are generated.

Oregon Administrative Rule(s)

461-135-1230 — Benefits; TA-DVS
461-135-1200 — Specific Requirements; TA-DVS

Payment limit

TA-DVS benefits are limited to the minimum amount necessary within the 90-day eligibility period to meet their safety needs. TA-DVS benefits are up to $1,200 within the eligibility period for services needed to stabilize families who are fleeing domestic violence, or who need assistance to remain free of violence. Program benefits are not intended to meet ongoing or recurrent needs.

TA-DVS Program benefits will:

- Not exceed $1,200 in the 90-day eligibility period
- Address a specific episode of crisis or need
- Be related to their domestic violence safety plan
- Pay the minimum amount necessary.

If the survivor has income available during the 90-day eligibility period, consider it when determining appropriate benefit level at each payment request. Payment of program benefits should not be delayed based on pending income if doing so would put the individual at increased risk of domestic violence.

Alternate community resources, if they exist, should be pursued prior to issuing TA-DVS payments unless doing so would cause a delay that could affect the survivor's safety.

At this time, staff will not write IOUs, promissory letters or use the SPOTS card for any payments.

TA-DVS benefits can only be used during the 90-day eligibility period.

ODHS cannot make payments past the 90-day eligibility period unless all needed verification was received by ODHS prior to or on the 90th day and ODHS was unable to make payment due to agency error. All payments must be issued within 10 days after the final date of the eligibility period.

Note: The payment request date in ONE Other Payments module must be the date the payment request is received and a date that falls within in the 90-day eligibility period.

Examples of agency error:

- There was no financial clerk in the office to make payment at the time of request.
- ODHS called the landlord before the end of the eligibility period and got a return call after business hours.
- There was no staff with an authorization role available to authorize the payment in ONE.
- All information was received, and ODHS did not have available staff to review and authorize before the end of business day.

Click here for examples: Payment Limit.

Oregon Administrative Rule(s)

461-135-1230 — Benefits; TA-DVS

Payment verification

Verification is needed for every TA-DVS payment request. The required verification will vary based on what is being requested. Verification must be case noted and kept in the electronic case file.

When a survivor requests a payment, gather the needed verification. If we do not have all the information we need, pend the payment request and generate a pending notice in ONE.

Examples of appropriate verification:

- **Request for move-in costs at rental home:** Verify information such as property ownership (can use

assessor and tax records) to determine appropriate benefit level or for dual payee purposes; verify details such as who is listed to be in the home and rental payment terms. A rental agreement or lease is not required as verification, but it is always encouraged that the survivor obtain a written agreement for their living situation.

- **Request for truck/trailer rental:** Verify the cost of the rental, the number of miles to be driven and the estimated cost of gas. Request information about how many trips the survivor believes they need to make to cover costs.
- **Request for lock change:** If renting, verify if the landlord can change the lock, verify the cost of the locks with a printout from the store, etc.

If ODHS does not receive all required verification, or the verification was not accurate, the payment request is denied. Denied payments must be notified by providing the system generated Notice of Action TA-DVS (DVS-110).

Only mail the notice if there is a safe address. If there is no safe address, case note. A copy is kept in the electronic case file.

Click here for examples: Payment Verification.

Oregon Administrative Rule(s)

461-115-0610 — Verification; General
461-135-1230 — Benefits; TA-DVS

Issuing payments

All TA-DVS payment requests must be entered into the TA-DVS ONE other payments module and require supervisor authorization before they will be issued.

TA-DVS benefits cannot be paid with the VISA SPOTS card or by adding TA-DVS benefits to the EBT cards.

Payments are issued as vendor or dual-payee whenever possible. Payments are issue by mail whenever possible. If there is an emergency, a check may be Benefits issued are intended to support the survivor and their situation. Once benefits are issued, they are unrestricted and do not require accountability for individual expenditure. This means that the money is intended to support the survivor and the intended use. Survivors may use the funds how needed to support family safety. This also means that once ODHS issues a check, there is no longer a commitment by ODHS for further payment, and the payment is now considered the survivor's money.

For all TA-DVS payments, use the corresponding payment type , unless payments are for individuals with citizenship waiver:

- For payments where citizenship is waived, always use payment type of TA-DVS Citizenship Waived.

For more information on coding see the Program Payments and Supports QRG

Click here for examples: Issuing Payments.

Oregon Administrative Rule(s)

461-165-0010 — Legal Status of Benefits Payments
461-135-1230 — Benefits; TA-DVS

Allowable payments

The TA-DVS Program benefits are intended to support survivors with their safety plan. There are many payments the program can make using the funds.

Shelter and relocation needs

When issuing shelter-related payments, the survivor's immediate safety concerns must be addressed. Make all attempts to help the survivor access affordable housing.

Make sure to verify landlord information in TA-DVS cases for the purpose of issuing a dual payee or vendor payment. Contact your local county taxation and assessment to verify ownership of the property.

It is inappropriate for landlords to ask for more money from survivors than from other potential renters. In this type of situation, you would inform the landlord you are only able to pay the same amount they would ask of other prospective renters.

If the landlord continues to ask for more money, notify the survivor of the maximum we can pay (what the landlord asks from other prospective renters) and that the landlord is requesting them to pay more. The survivor has the option of paying any additional amount requested. The survivor may want to contact a legal aid organization to see what rights they may have in this situation.

The following are shelter and relocation need costs that can be potentially paid through TA-DVS funds, if they align with their safety plan:

- Initial month's rent or first and last if required to secure safe housing; mortgage and utility costs, including basic payments, connection charges and deposits
- Rent, if the inability to pay rent is related to domestic violence
- Moving and relocation costs
- Transportation to another area of residence within or out of state
- Transportation costs to look for housing during the 90-day eligibility period if no other resources are available
- Repairs to provide safe housing Note: One-time house, electrical and plumbing repairs are allowed if essential to the health and safety of the occupants and if less costly than moving to other quarters. This can include repairs necessary for health and safety when damage was done by the abuser.

Past due costs should only be paid if:

- Money/payment was withheld or taken by the abuser, or the money was used to help the survivor stay safe
- The payment enhances safety or decreases risk of further domestic violence and a lesser cost alternative is not available.

If rental/housing costs are above the survivor's demonstrated ability to pay, this is not an automatic reason for denial. If the monthly housing costs are above future available income levels, a plan to address how the survivor will meet future housing costs should be discussed and documented on the DHS 1543. A discussion about what the survivor is doing to make this happen should take place:

- If the survivor states they plan to get a roommate, has the survivor placed ads in the newspaper, posted roommate requests on bulletin boards, gotten a potential roommate lined up, etc.?
- If the survivor indicates they are going to get a job, what are they doing to make this happen? Have they registered with the Employment Department, contacted temporary agencies working with the JOBS program, have a job offer pending, etc.?
- If the survivor indicates they are working with housing, who are they working with? What are the time frames for accessing a housing subsidy?

Whenever possible, vendors should return TA-DVS funds directly to the survivor. Once a check is issued, it is considered the property of the survivor. We often receive checks for security deposits, reimbursed when the survivor moves at the end of their lease. We should encourage landlords to return the funds to the tenant.

If the local office receives a return check that was not cashed from a landlord or business entity, contact TA-DVS Policy or Business Security for directions on how to handle.

Roommates

When a survivor and people (18 and older) not in the filing group are moving into a new home together, the people moving with the survivor are expected to pay an equal or representative portion of the move-in costs.

In rare circumstances, if the person the survivor is moving in with is unable to pay an equal portion of the move-in costs, we need to discuss what sort of agreement is being made between the survivor and roommate. If the survivor is moving in with a friend and the survivor will have two out of three bedrooms in the house, the survivor may have an agreement with their friend to pay more of the ongoing rent costs. This plan should be discussed and documented.

Motels/hotels

TA-DVS funds address-specific crisis situations where safety is at risk due to domestic violence. TA-DVS funds cannot be used to meet ongoing or recurrent needs such as ongoing rent and utilities. This includes ongoing use of a motel.

A payment for use of a motel is intended to meet temporary safety concerns when no other suitable public or private housing is available. More than 50 percent of the TA-DVS allocation should rarely be used to pay for motels. It is recommended that payments over 50 percent of the TA-DVS allocation be staffed with a manager, lead worker, or TA-DVS policy. Consider the following when agreeing to make a motel payment:

- What other housing options are available to the survivor?
  - Domestic violence shelters (in the area or outside of the area)
  - Other community shelters where appropriate (i.e., sober living, safe home, etc.), community programs that provide motel/hotel vouchers

- Staying with family or friends
- Bus or train tickets to family and friends out of town.

Any funds the survivor has available should be used prior to ODHS agreeing to pay for a motel.

Once SSP approves a hotel stay, the Domestic Violence Assistance Agreement (DHS 1543M) can be completed to help in the discussion. The 1543M must include the need for motel/hotel and the expected length of stay.

Remember:

- Approvals should be limited to the minimum necessary nights to keep someone safe. If a survivor has additional safety concerns, further nights (within the financial limits noted above) can be approved.
- The survivor must actively seek permanent safe housing. If this does not occur, a continued motel/hotel stay request should be denied.
- No person except the survivor and their children should be staying overnight in the motel room.
- The survivor is responsible for following the motel rules and for any fees or additional charges such as smoking fees, pet fees, damage to the room or theft of motel property.

If TA-DVS funds are still available, a branch can decide to use the remaining TA-DVS funds to pay for repairs or minor damage in order to maintain good relationships with the motel.

If the survivor has applied for and received TA-DVS in the past 12 months and the funds were used for a motel/hotel, the safety plan (DHS 1543) should not include further motel/hotel stays except in an emergency situation. If approved, payments are for minimum necessary nights. It is recommended these payments be staffed with a manager, lead worker, or TA-DVS Policy. Whenever possible, payments should be paid directly to the motel as a vendor or dual payee check.

Methods of travel

ODHS can authorize payments for relocation costs, including but not limited to:

- Train tickets
- Bus tickets
- Gas money for relocation
- Air travel and baggage costs.

For support with planning for travel, see the Travel Checklist on ODHS Self-Sufficiency Domestic Violence Staff Tools.

For all air travel, ODHS contracts with an outside agency to purchase flights. All flights must be purchased through the contractor.

For process and current contractor information, refer to the ODHS Self-Sufficiency Domestic Violence Staff Tools web page.

Food needs

Payment for food needs are to be related to the domestic violence situation and are not intended to replace SNAP program benefits. Food costs are to be specific to an emergency situation related to domestic violence; payments for food should be rare. Remember other community resources such as food banks, community dinners, and shelters. Food payments are most often issued as part of relocation costs.

Medical needs

TA-DVS funds can be used for medical needs in the following situations:

- Medical care for situations that appear to be life threatening at the time of occurrence (Accept the participant's statement for verification.)
- Medical care necessary to prevent medical problems from becoming life threatening
- Medical care determined necessary by the branch office.

Explore medical benefits offered through other programs before issuing under the TA-DVS Program. TA-DVS Program benefits are to be used after we have determined there is no other available medical coverage.

For any medical payments made using the TA-DVS funds, workers must use the payment type Medical Assistance.

Other payment situations

The following are additional situations when TA-DVS funds may be used:

- When a survivor requests items necessary to set up a household (e.g., beds or other basic furniture needs) that were left behind when fleeing abuse, and these items are not available through other community resources.
- When a survivor requests an initial fee and month of storage and it would be less expensive than replacing items they would be forced to leave behind. Payment of ongoing storage costs is not appropriate because it is a recurrent ongoing fee.
- When a survivor requests payment for other needs that will contribute to the safety of the family (e.g., new locks, motion detectors, security cameras, a post office box, etc.).
- When a survivor requests payment to replace personal items that were left behind when fleeing the abuse (e.g., clothes for both the survivor and the child, hygiene items, etc.), and these items are not available through other community resources.
- Limited child care costs to attend support group or to complete activities listed on the domestic violence assistance agreement during the 90-day eligibility period, if TA-DVS funds are available after emergent needs have been addressed.

Click here for examples: Allowable payments.

Oregon Administrative Rule(s)

461-135-1230 — Benefits; TA-DVS

Non-allowable payments

TA-DVS funds, while intended to meet needs related to domestic violence, are not intended to cover items such as:

- Purchase of a car (including making car payments) or purchase of a recreational vehicle, including a travel trailer
- Purchase of a gun or other weapons
- Payment of legal fees or attorney fees (refer the participant to your local legal aid organization)
- Payment of fines or other penalties
- Purchases of a pet (this includes animals designated as guard animals)
- Payment of pet fees (unless the pet is a service animal, and only when the service status has been verified by a medical or counseling professional)
- Purchases of new furniture:
  - Unless the furniture was left behind when the participant fled domestic violence, and
  - The furniture is essential to setting up a household (such as beds, dressers, dining room table and chairs, a couch), when those items are not available through a community resource or lower-cost alternatives are not available
- Payment of outstanding or past due costs such as rent or utilities when the participant does not intend to stay in the residence and/or the need for payment was not related to the current domestic violence situation
- Payment for moving household or personal belongings from another state
- Nonessential items such as a television or a computer or services such as cable, satellite, internet, even if such items or services were left behind when the participant fled the domestic violence
- Payment of a request that included inaccurate information
- Payment requests without verification of the costs and/or the payment information.

Click here for examples: Non-allowable payments.

Oregon Administrative Rule(s)

461-135-1230 — Benefits; TA-DVS

Reimbursements

Normally ODHS will not reimburse payments on behalf of or by the participant that were not pre-approved by the ODHS worker. Workers will need to add to the DHS 1543 or case notes that they have agreed to a payment. If there is no prior approval, reimbursements will not be approved.

Click here for examples: Reimbursements.

Oregon Administrative Rule(s)

461-135-1230 — Benefits; TA-DVS

Chapter 5:

Temporary Assistance for Domestic Violence Survivors (TA-DVS) Program

Section 9: Co-located domestic violence advocates

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Co-located domestic violence advocates

Who is a co-located domestic violence advocate?

The ODHS co-located domestic violence advocate is a certified domestic violence advocate that is not a Oregon Department of Human Services (ODHS) employee. The advocates are contracted to be co-located in ODHS Child Welfare and Self-Sufficiency program offices.

"Certified advocate" means a person who has completed at least 40 hours of training in advocacy for victims of domestic violence, sexual assault or stalking that meets the minimum training requirements and is currently employed by a qualified victim services program.

"Qualified victim services program" means a nongovernmental, nonprofit, community-based program receiving moneys administered by the Oregon Department of Human Services or the U.S. Department of Justice that offers safety planning, counseling, support or advocacy services to victims of domestic violence, sexual assault or stalking.

The advocates are from your local nonprofit domestic violence sexual assault (DVSA) organizations. The primary purpose of an advocate is to support survivors of domestic violence (DV). The advocates can provide confidential advocacy services for survivors and ODHS staff. Advocacy services can include but are not limited to:

- Safety planning
- Referrals and help with accessing other community resources
- Help with restraining orders
- Attending court with survivor
- Attending ODHS home visits with Self-Sufficiency, and
- Other confidential services for survivors of domestic violence with or without children.

These services apply to all survivors. Employees of ODHS may also access services provided by the co-located domestic violence advocates.

Domestic violence advocates' confidentiality and privilege

Co-located DV advocates have specific confidentiality rules called advocate privilege. This means the information shared with an advocate is not shared elsewhere. Co-located DV advocates have very strict confidentiality standards as a condition of their federal grant funding from the Family Violence Prevention and Services Act (FVPSA) and the Violence Against Women Act (VAWA). The standards state the advocates cannot disclose any information without the survivor's consent that can personally identify an individual or any individual information or reveal information of individuals who are accessing services.

Why is confidentiality important?

- It enhances survivor safety.
- It preserves the dignity of survivors.
- Survivors may be more willing to access services.

- Survivors may disclose the true nature of abuse or assault to allow effective safety planning and responses.

What does advocate privilege mean?

Advocate privilege is legal protection that protects all communication between a certified advocate from a qualified victim's services program and a survivor. This means the survivor gets to decide whether any communication shared with the advocate is shared with a third party. Without the survivor's approval, the information cannot be disclosed.

Advocate privilege also means the co-located DV advocates are not mandatory reporters. This allows open and honest communication for effective safety planning and support.

For more information on advocate confidentiality and privilege, see the Working Together guide on ODHS SSP Staff Tools.

How is the advocate plan different from the ODHS safety plan?

There are differences in safety plans between Self-Sufficiency, Child Welfare and the co-located DV advocate.

For example, when someone is approved for TA-DVS, ODHS reviews what the survivor intends to do with their TA-DVS grant: how they intend to spend the funds, what other agencies they are working with and what next steps they plan. The plans are based around actionable items, what resources are available to them and what support they need.

When a co-located DV advocate creates a safety plan with the survivor, the plan addresses but is not limited to:

- Survivor's physical and emotional safety
- Helping survivor plan how to get safe and stay safe
- Each plan being specific to the survivor's needs and their situation
- Identifying which community resources are available: food, financial assistance, housing, child care, parenting classes, DV support groups, etc.
- Addressing the current physical safety threat, including lethality assessment.

An advocate safety plan may not include protection orders because they are not always an effective tool for keeping people safe. Sometimes protection orders could put the survivor in more danger. Safety plans may be more complex depending on the survivor and their needs.

Safety plans from both co-located DV advocates and ODHS Self-Sufficiency staff are fluid. They may stay the same or change over time. It is normal for safety plans to change frequently.

Release of information (ROI)

Self-Sufficiency needs a completed and signed (Hardcopy signature only, cannot be accepted verbally or electronically) Authorization for Disclosure, Sharing and Use of Individual Information (MSC 3010) before ODHS can share any domestic violence information with advocates or anyone else. This includes identifying information with the co-located DV advocates including referrals, names, phone numbers, etc.

It is recommended that the ROI is completed for the shortest time needed, no longer than the 90-day eligibility period.

Below we have included some examples of how to complete the MSC 3010 that can be helpful. Reminder, these are examples, and each release should be specific to the situation and never standard or "canned" language for domestic violence.

ROI for Co-Located DV Advocate Referral	• For section titled "Purpose of the disclosure, sharing, and use" ◆ Example language: Referral to advocacy agency for services. Referral information includes name, date of birth, phone number, address, and children's names • For section titled "Date of Records" ◆ Select "other" and enter the 90-day eligibility period OR the time frame the survivor is comfortable with • For section titled "Release TO" ◆ Include the contact information for the domestic violence advocacy agency you are sharing information with. Include the advocate's name under "contact person"
ROI for general case staffing	• For section titled "Purpose of the disclosure, sharing, and use" ◆ Example language: TA-DVS eligibility, safety planning, and conversations • For section titled "Date of Records" ◆ Select "other" and enter the 90-day eligibility period OR the time frame the survivor is comfortable with • For section titled "Release TO" ◆ Include the contact information for the domestic violence advocacy agency you are sharing information with. Include the advocate's name under "contact person"
ROI for survivor contact information (Potential to use when sharing with other partners such as Child Welfare)	• For section titled "Purpose of the disclosure, sharing, and use" ◆ Example language: Home address and phone number • For section titled "Date of Records" ◆ Select "other" and enter the 90-day eligibility period OR the time frame the survivor is comfortable with • For section titled "Release TO" ◆ Include the contact information for the domestic violence advocacy agency you are sharing information with. Include the advocate's name under "contact person"

Give the co-located DV advocate information to the survivor to make contact if they choose. Let the survivor know Self-Sufficiency cannot share any information with the co-located DV advocate until an MSC 3010 is signed.

Once ODHS has a signed MSC 3010, ODHS is permitted to share the specific information listed in the release with the co-located DV advocate. The signed ODHS release does not mean the advocates are able to share information with ODHS. The advocates can take in the information ODHS shares and can answer hypothetical questions.

Due to privilege and federal funding, co-located DV advocates are not able to share information with ODHS or

anyone without their own completed release of information, meeting requirements below. Informed release of information ensures survivor consent in how their information is shared.

The Violence Against Women Act (VAWA) federal requirements mandate the co-located DV advocates to have releases that are:

- Signed in person, with the survivor and the advocate present
- Time sensitive (usually 30 days)
- Specific:
  - Must include what specific information is to be shared.
  - Must include with which specific individual(s) the information can be shared.

The co-located DV advocates must use their own release. ODHS releases will not cover the requirements for the advocates.

The survivor can revoke a release at any time. If this happens, the advocate cannot share any information, including the fact that the release was revoked.

Engaging together with the advocate and survivor

The co-located DV advocate is available for hypothetical conversations, when ODHS would like another opinion, and to be engaged in ODHS employees' conversations with survivors. The advocates can be a part of staff meetings for DV expertise on questions and can be invited to join conversations with survivors.

There are many ways to open the conversation to engage an advocate and help enhance support and resources for survivors:

- Invite the advocate into safety planning conversations with the survivor.
- Ask hypothetical questions when struggling to create a safety plan.
- Engage the advocates during case reviews or meetings.
- Begin the discussion when a survivor is approved or denied for TA-DVS.
- Start the conversation anytime a survivor would like support.

It is a best practice for ODHS to meet with the survivor and the co-located DV advocate together. This opens the door for more support, having domestic violence expertise and giving a warm hand-off for the survivor. Do not forget to ask the survivor first if they are okay having an advocate present.

After the joint conversation, provide a confidential location for the survivor and the advocate to further the safety plan.

It is important to remind the survivor that ODHS employees are mandatory reporters and the co-located DV advocates are not mandatory reporters. ODHS should tell survivors, "You have the right to an advocate." This can empower survivors by informing them of their right to access confidential services including further support and domestic violence expertise on safety planning.

ODHS can always ask questions and engage with advocates. If a survivor does not want to engage in advocacy

services, advocates are still a resource to ODHS for general questions, hypothetical scenarios, to help get safety planning ideas, get general information and get resources from the domestic violence experts.

Example of how ODHS can hypothetically speak with an advocate without breaking confidentiality:

“I am working with a survivor who applied for the TA-DVS grant, but she is not ready to talk to the advocate. She is planning to leave this weekend, but I am concerned about her abuser still being in the home. What are some ideas I can talk to her about to be safer while making this plan?”

Our collaboration with co-located advocates helps to support survivor safety and increases resources available to families.

Chapter 5:

Temporary Assistance for Domestic Violence Survivors (TA-DVS) Program

Section 10: Program integrity

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Program integrity

Hearings

Domestic violence survivors applying for TA-DVS on an agency approved application, have the right to an expedited hearing for the following reasons:

- If their request for TA-DVS is denied
- If TANF rules that put the participant at further risk of domestic violence or that would prevent them from escaping domestic violence were not waived or modified as allowed in OAR 461-135-1200
- If they disagree with the payment amount.

Oregon Administrative Rule(s)

461-135-1200 — Specific Requirements; TA-DVS
461-135-1235 — TA-DVS; Right to Hearing

Overpayments

Overpayments for the TA-DVS Program should be pursued in cases when:

- There was an intentional program violation; and
- The overpayment was not caused by coercion or intimidation by the abuser, and
- It is safe to pursue without putting the participant at greater risk of domestic violence.

Examples of when it may not be safe to pursue an overpayment:

- A survivor who is living with the abuser might be subject to further abuse if wages or tax returns are garnished.
- A survivor who is in the process of fleeing may need all their financial resources to escape the abuse.

A survivor's written or verbal explanation of why pursuit of repayment would endanger the physical safety of the survivor or minor children in the survivor's care is sufficient to establish good cause for not pursuing the overpayment.

Intentional program violations

In the TA-DVS Program, a person commits an intentional program violation by intentionally and without coercion from the abuser:

- Concealing information that would have made them otherwise ineligible for TA-DVS
- Knowingly providing false documentation or statements such as invalid rental agreements, notes from landlords, statements related to children being in the home, proof of pregnancy.

Oregon Administrative Rule(s)

461-195-0601 — Intentional Program Violations; Defined
461-195-0621 — Intentional Program Violations; Penalties and Liability for Overpayments

Fraud

If there is a belief that someone is committing fraud in the TA-DVS Program, ODHS needs to ask more questions to clarify the safety situation. There is a safety factor in every TA-DVS case or domestic violence situation. The reason for the fraud may be related to the domestic violence and may be a way for a survivor to remain safe.

Contact TA-DVS Policy when there are questions regarding fraud.

Click here for examples: Fraud.

Chapter 6: Non-citizens

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Chapter 6:
Non-citizens

Section 1: Introduction

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Non-citizens

Introduction

Most ODHS programs require that individuals meet citizenship requirements to be eligible for benefits. If the individual isn't a U.S. citizen or U.S. national, then the individual must meet certain immigration requirements. Federal policy is not consistent across all programs, so each program has their own specific immigration requirements.

The matrix below tells you which of the immigration statuses meet the immigration requirements for each program – and are therefore potentially eligible for benefits.

If the non-citizen has an immigration status that is not on the list, then they are not eligible. For clarification on any status listed below, please contact ODHS central office through the policy box for the program in question.

As a side note, the term 'alien' is an antiquated legal term used at the federal level to identify an individual who is not a citizen or national of the United States. Oregon law uses the term 'non-citizen'. This is the term that will be used in the Oregon Programs Eligibility Notebook when referring to individuals who are not citizens or nationals of the United States instead of "alien".

Immigration statuses

Immigration status	Typical documents	SNAP	TANF/ TA-DVS/ ERDC	REF/ REFM	Medical under age 19	Medical age 19 and over
Lawful Permanent Resident (LPR)	• "Green card" (form I-551) or earlier versions; • Form I-327 (Reentry permit); • Foreign passport stamped with machine-readable immigrant visa (MRIV) to show temporary evidence of LPR or "I-551" status; • Reciept from USCIS indicating that an I-90 application to replace LPR card has been filed; • Memorandum of Creation of Lawful Permanent Residence with approval stamp (I-181); • Form I-94 or I-94A with stamp indicating admission for lawful permanent residence; or • Order issued by the Department of Homeland Security (DHS), an immigration judge, the BIA (Board of Immigration Appeals), or a federal court granting registry, suspension of deportation, cancellation of removal, or adjustment of status. **NOTE:** An individual may enter with one immigration status and then adjust to LPR. The individual generally keeps their original immigration status for purposes of eligibility. If a document has one of the following COAs, please refer to the statuses below: AS6, AS7, AS8, CH6, GA6, GA7, GA8, HA6, HB6, LA, RE6, RE7, RE8, RE9, ST6, ST7, ST8, ST9, or ST0.	See footnote 1 for additional requirements	YES	NO	YES	See footnote 2 for additional requirements
Iraqi/Afghan SIV holder (LPR)	• Iraqi or Afghan passport with an immigrant visa stamp noting that the individual has been classified under IV (Immigrant Visa) Category SI1, SI2, SI3, SQ1, SQ2, or SQ3 and DHS stamp or notation on passport or I-94 showing date of admission • Afghan passport or printed page on Customs and Border Protection letterhead with their Form I-94, Arrival Departure Record noting Special Immigrant (SQ/SI) Parolee per section 602(b)(1) AAPA/Section 1059(a) NDAA 2006 • DHS Form I-551 with an IV (immigrant visa) code for category SI6, SI7, SI9, SQ6, SQ7, or SQ9	YES	YES	YES	YES	YES

Immigration status	Typical documents	SNAP	TANF/ TA-DVS/ ERDC	REF/ REFM	Medical under age 19	Medical age 19 and over
Refugee	• Form I-94 or I-94A Arrival/Departure Record or passport stamped "refugee" or "§207 of the INA" or paroled as a refugee under §212(d)(5); • Form I-94 with admission code RE-1, RE-2, RE-3, RE-4, or RE-5; • Form I-766 with code A04 or A03; • Form I-730 Approval Letter (for derivatives); • Visa 93 (or V-93) on the I-94; or • Refugee travel document (I-571) **NOTE:** If adjusted to LPR status, I-551 may be coded RE6, RE7, RE8, or RE9.	YES	YES	YES	YES	YES
Asylum (Granted)	• Form I-94, I-94A, or passport stamped "asylee" or "§208 of the INA" or paroled as an asylee under §212(d)(5) • Form I-94 with admission code AS-1, AS-2, or AS-3 • Order granting asylum under § 208 of the INA, issued by an immigration judge; • Asylum Approval Letter from USCIS Asylum Office; • Written decision from the Board of Immigration Appeals (BIA); • Form I-766 with code A05; • Form I-730 Approval Letter (for derivatives); • Visa 93 (or V-93) on the I-94; or • Refugee travel document (I-571) **NOTE:** If adjusted to LPR status, I-551 may be coded GA6, GA7, GA8, AS6, AS7, or AS8.	YES	YES	YES	YES	YES
Deportation being withheld - section 243(h) and 241(b)(3) of the INA	• Form I-94 stamped "§243(h)" or "§241(b)(3); • Order granting withholding of deportation/ deferral of removal from DHS, US Immigration and Customs Enforcement (ICE), immigration court, BIA, or federal court; • Form I-688 coded "8 CFR §274a12(10) (withholding of deportation)" or A10; or Form I-766 coded "8 CFR §274a12(10)(withholding of deportation)" or A10	YES	YES	NO	YES	YES

Immigration status	Typical documents	SNAP	TANF/ TA-DVS/ ERDC	REF/ REFM	Medical under age 19	Medical age 19 and over
Cuban/Haitian Entrants Indivdiual granted parole as a Cuban/ Haitian Entrant (Status Pending)	• Form I-94 with stamp indicating "Cuban/ Haitian Entrant (Status Pending)". Could refer to §212(d)(5) • Form I-94 showing parole on or after April 21, 1980 (Cubans only) or on or after October 10, 1980. Could refer to §212(d)(5) • Cuban or Haitian passport with §212(d)(5) stamp dated on or after October 10, 1980 **NOTE:** Individuals who have adjusted to LPR status may have I-551 cards or temporary I-551 stamps in foreign passports coded CH6.	YES	YES	YES	YES	YES
Cuban/Haitian Entrants A national of Cuba or Haiti who was paroled into the US and has not acquired any other status under the INA and with respect to whom a final, non-appealable, and legally enforceable order of removal, deportation or exclusion has not been entered	• Form I-94 showing paroled in the United States. Could refer to §212(d)(5) • Form I-788 with code A04 or C11 **NOTE:** Individuals who have adjusted to LPR status may have I-551 card or temporary I-551 stamped with HB6.	YES	YES	YES	YES	YES

Immigration status	Typical documents	SNAP	TANF/ TA-DVS/ ERDC	REF/ REFM	Medical under age 19	Medical age 19 and over
Cuban/Haitian Entrants A national of Cuba or Haiti who is the subject of removal, deportation, or exclusion proceedings under the INA and with respect to whom a final, non-appealable, and legally enforceable order of removal, deportation or exclusion has not been entered	• DHS Form I-221 (Order to Show Cause and Notice of Hearing) • DHS Form I-862 (Notice to Appear) • DHS Form I-220A (Order of Release on Recognizance) • DHS Form I-122 (Notice to Applicant Detained for a Hearing Before an Immigration Judge) • DHS Form 221S (Order to Show Cause, Notice of Hearing and Warrant for Arrest) • Form I-589 date stamped by the Executive Office for Immigration Review (EOIR) (Application for Asylum and Withholding of Removal; Individual is subject to removal, deportation, or exclusion proceedings) • Form I-485 date stamped by EOIR (Application to Register Permanent Residence or to Adjust Status; Individual is subject of removal, exclusion, or deportation) • Form EOIR-26 (Notice of Appeal from a Decision of an Immigration Judge, date stamped by the Board of Immigration Appeals) • Form I-766 with code C10 • Other applications for relief that have been stamped by EOIR • Other documentation pertaining to an applicant's removal, exclusion, or other deportation proceedings	YES	YES	YES	YES	YES
Cuban/Haitian Entrants A national of Cuba or Haiti who has an application for asylum pending with the DHS/USCIS or with an EOIR Immigration Court or the Board of Immigration Appeals and with respect to whom a final, non-appealable, and legally enforceable order of removal, deportation, or exclusion has not been entered	• USCIS receipt for filing Form I-589 (Application for Asylum and Withholding of Removal) • Form I-766 with code C08 **NOTE:** Individuals who have adjusted to LPR status may have I-551 card or temporary I-551 stamped with HA6.	YES	YES	YES	YES	YES

Immigration status	Typical documents	SNAP	TANF/ TA-DVS/ ERDC	REF/ REFM	Medical under age 19	Medical age 19 and over
Parolee (non-Cuban/ Haitian) - paroled into the US for at least one year. NOTE: Not that the individual has been in the US for at least one year, but that the date on their document indicates that there is one year from entry.	• Form I-94 or I-94A indicating "parole" or "PIP" or "212(d)(5)," or other language indicating parole status; or • Form I-688B or I-766 EAD coded 274a12(c)(11), A4, or C11. **NOTE:** If subsequently adjusted to LPR status, may have I-551 card (for Lautenberg parolees, these may be coded LA).	See footnote 1 for additional requirements	YES	NO	YES	See footnote 2 for additional requirements
Conditional Entry	• Form I-94, I-94A, or other document indicating status as "conditional entrant," "Seventh Preference," §203(a)(7), or P7	See footnote 1 for additional requirements	YES	NO	YES	See footnote 2 for additional requirements
Battered Spouse or dependent child Must have a pending petition for an immigrant visa, either filed by a spouse or a self-petition under the Violence Against Women Act (VAWA), or an application for suspension of deportation or cancellation of removal. The petition or application must either be approved or, if not yet approved, must present a prima facie case.	• Receipt or other proof of filing I-130 (visa petition) under immediate relative (IR) or 2nd family preference (P-2) showing status as a spouse or child; • Form I-360 (application to qualify as abused spouse, child, or parent under the VAWA); • Form I-797 Notice of Action referencing pending I-130 or I-360 or finding establishment of prima facie case; • Receipt of other proof of filing I-485 Application for Adjustment of Status of basis of an immediate relative or family 2nd preference petition or VAWA application; • Any documents indicating a pending suspension of deportation or cancellation of removal case, including a receipt from an immigration court indicating filing of Form EOIR-40 (Application for Suspension of Deportation) or EOIR-42 (Application for Cancellation of Removal); • Form I-688B or I-766 EAD coded 274a.12(a)(10) or A10 (applicant for suspension of deportation) or 274a.12(c)(14) or C14 (individual granted deferred action status); • Form I-688B or I766 EAD coded 274.a.12(c)(9) or C9 (applicant for adjustment) or 274a.12(c)(10) or C10 (applicant for suspension of deportation) or 274a.12(c)(14) or C14 (individual granted deferred action status) or C31 (individual with approved VAWA self-petition)	See footnote 1 for additional requirements	YES	NO	YES	See footnote 2 for additional requirements

Immigration status	Typical documents	SNAP	TANF/ TA-DVS/ ERDC	REF/ REFM	Medical under age 19	Medical age 19 and over
Victim of Trafficking	• Certification Letter, Eligibility Letter, or Interim Assistance Letter from ACF Office On Trafficking in Persons (OTIP). **NOTE:** To confirm the validity of the Certification Letter, call the trafficking verification line at (866) 401-5510. Letters do not expire. Some older letters will be from the Office of Refugee Resettlement. **NOTE:** If adjusted to LPR status may have I-551 card or temporary I-551 stamped with ST6.	YES	YES	YES	YES	YES
Certain family members of a Victim of Trafficking (Derivative)	• Form I-797 with code T-2, T-3, T-4, T-5, or T-6 • Form I-94 with code T-2, T-3, T-4, T-5, or T-6 **NOTE:** Derivative status holders will not receive a letter. **NOTE:** If adjusted to LPR status, may have I-551 card or temporary I-551 stamped with ST7, ST8, ST0, or ST9.	YES	YES	YES	YES	YES
Amerasian (LPR)	• Form I-94 with code AM-1, AM-2, or AM-3 • Form I-551 with code AM-6, AM-7, or AM-8 • Vietnamese Exit Visa with code AM-1, AM-2, or AM-3 • Vietnamese passport with code AM-1, AM-2, or AM-3 • US passport with code AM-1, AM-2, or AM-3	YES	YES	YES	YES	YES

Immigration status	Typical documents	SNAP	TANF/ TA-DVS/ ERDC	REF/ REFM	Medical under age 19	Medical age 19 and over
An American Indian born in Canada - section 289 of the INA (50%)	• Form I-551 with code 513, S1-3, or S-13 • Temporary I-551 with code 513, S1-3, or S-13 in a Canadian passport • Form I-94 with code 513, S1-3, or S-13 • Evidence of birth in Canada and a document indicating the percentage of American Indian blood **NOTE:** Documents indicating the percentage of American Indian blood include a birth certificate issued by the Canadian reservation, a Blood Quantum Letter, card, or other record issued by the tribe (each tribe provides some type of evidence). The Blood Quantum Letter may use the following verbiage: at least 50% Aboriginal blood, at least 50% Indigenous blood, at least 50% North American Indian blood, or at least 50% American Indian blood. Do not accept a Certificate of Indian Status card ("Band" card) issued by the Canadian Department of Indian Affairs, information from any internet sites, or any other document not directly issued by the individual's tribe.	YES	YES	NO	YES	YES
An enrolled member of an Indian Tribe - section 4(e) of the Indian Self-Determination Education Act	• Membership card or other tribal document demonstrating (i.e., tribal card), membership in U.S. federally recognized Indian tribe under Section 4(e) of the Indian Self-Determination and Education Assistance Act and satisfactory evidence of birth outside the U.S.	YES	YES	NO	YES	YES
A citizen of a Compact of Free Association State (i.e., Federated States of Micronesia, Republic of the Marshall Islands, and the Republic of Palau) who has been admitted to the U.S. as a non-immigrant and is permitted by the Department of Homeland Security to reside permanently or indefinitely in the U.S.	• Form I-94 or passport noted as "CFA/RMI" or "CFA/FSM" or "CFA/PAL"; or • Form I-688B or I-766 coded (a)(8) or A8	NO	NO	NO	YES	YES See footnote 3

Footnote number	Additional requirements

1	Individual meets the non-citizen status requirements if the individual meets one of the following conditions: • Has been legally residing in the US for at least five years • Is under the age of 18 • Has a disability (according to the SNAP definition of disability - OAR 461-001-0015) • Elderly - was born on or before August 22, 1931 who lawfully resided in the US on August 22, 1996 • Has a minimum of 40 verified qualifying quarters under Title II or can be credited with at least 40 verified qualifying quarters under Title II • Active Duty or veteran of the US Armed Forces who was discharged and meet requirements of 38 USC 5303A(d) (including the spouse, unremarried surviving spouse, or unmarried dependent child of a member.) • A lawfully residing member of a Hmong or Highland Laotian tribe at the time the tribe rendered assistance to US personnel by taking part in a military or rescue operation during the Vietnam era (as defined in 38 USC 101) (including the spouse, the unremarried surviving spouse, or un unmarried dependent child of the tribe member.)
2	Individuals who are over 19 meet the non-citizen status requirements if they meet one or more of the following: • They have been in the US for at least five years following the date on which they obtained the qualified non-citizen status • They entered the United States before August 22, 1996; • The individual, their spouse (alive or deceased), or their parent is an honorably discharged veteran or active duty member of the US military.
3	With the passing of the Consolidated Appropriations Act of 2021, COFA citizens are considered Qualified Non-Citizens who are not subject to the 5-year bar and meet the Non-Citizen requirement for Medical benefits only. This policy is effective 12.28.2020.

If an individual enters the US under one of the statuses below, but has adjusted to LPR - please see LPR

Immigration status	Typical documents	SNAP	TANF/ TA-DVS/ ERDC	REF/ REFM	Medical under age 19	Medical age 19 and over
An noncitizen currently **in temporary resident status** pursuant to section 210 or 245A of the INA (8 USC 1160 and 1255a)	• Form I-688 Temporary Resident Card; • Form I-688B or I-766 EAD coded 274a.12(a)(2) or A2; or with other evidence indicating eligibility under INA §210 or 254A; • Form I-688A EAD; or • Form I-698 Application to Adjust from Temporary to Permanent Residence under INA §245A	NO	NO	NO	YES	No See footnote 4
An noncitizen currently under **Temporary Protected Status (TPS)** pursuant to section 244 of the INA (8 USC 1229b)	• Form I-688B or I-766 EAD coded 274a.12(a)(12) or A12: or • Form I-797 Notice of Action showing grant of TPS status	NO	NO	NO	YES	No See footnote 4
Cuban-Haitian, as defined in section 202(b) Pub. L. 99–603 (8 USC 1255a), as amended.	• I-766 EAD • Any verification from the USCIS, DHS, or other authoritative document.	NO	NO	NO	YES	No See footnote 4

Immigration status	Typical documents	SNAP	TANF/ TA-DVS/ ERDC	REF/ REFM	Medical under age 19	Medical age 19 and over
Family Unity beneficiaries pursuant to section 301 of Pub. L. 101–649 (8 USC 1255a), as amended	• Form I-797 Notice of Action showing approval of I-817 Application for Family Unity; or • Form I-688B or I-766 EAD coded 274a.12(a)(13) or A13	NO	NO	NO	YES	No See footnote 4
An noncitizen currently under **Deferred Enforced Departure (DED)** pursuant to a decision made by the President	• Form I-688B or I-766 EAD coded 274a.12(a)(11) or A11	NO	NO	NO	YES	No See footnote 4
An noncitizen currently in **deferred action status** pursuant to Department of Homeland Security Operating Instruction OI 242.1(a) (22)	• Form I-797 Notice of Action or other form showing approval of deferred action status; or • Form I-688B or I-766 EAD coded 274a.12(c)(14) or C14, (c)(33) or C33	NO	NO	NO	YES	No See footnote 4
An noncitizen who is the spouse or child of a United States citizen whose visa petition has been approved and who has a pending application for adjustment of status.	• Any documentation showing a filing or pending status of Form I-485 • I-766 EAD • I-797 receipt for application for EAD based on C09- Adjustment of status applicant • I-512 authorization for parole, indicating applicant for adjustment of status • Any verification from the USCIS, DHS, or other authoritative document	NO	NO	NO	YES	No See footnote 4
An individual in **non-immigrant** classifications under the INA who is permitted to remain in the U.S. for an indefinite period, including those individuals as specified in section 101(a)(15) of the INA (8 USC 1101)	• Form I-94 Arrival/Departure Record in foreign passport • I-766 Employment Authorization Document • B-1/B-2 Visa/Border Crossing Card (BCC) • Form I-95 - Crewman's Landing Permit	NO	NO	NO	YES	No See footnote 4

Immigration status	Typical documents	SNAP	TANF/ TA-DVS/ ERDC	REF/ REFM	Medical under age 19	Medical age 19 and over
A noncitizen in **non-immigrant** status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission.	• Any verification from the USCIS, DHS, or other authoritative document.	NO	NO	NO	YES	No See footnote 4
Noncitizens who have been **granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24)**.	• Any documentation showing a filing or pending status of Form I-485 • I-688B or I-766 employment authorization document (EAD) coded 274a.12(c)(9) or C9 or C9P (applicant for adjustment) or 274a.12(c)(10) or C10 (applicant for suspension of deportation) or 274a.12(c)(20), (c)(22), or (c)(24) or C20, C22 or C24 • I-512 authorization for parole, indicating applicant for adjustment of status • I-687 Application for Status as a Temporary Resident Under Section 245A of the INA • Notice showing release under supervision • Form I-687 Application for Temporary Residence under INA § 245A; • Passport, with stamp or writing by USCIS/ DHS officer, indicating pending §245 application; or • Any verification from the USCIS, DHS, or other authoritative document.	NO	NO	NO	YES	No See footnote 4
A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days.	• Receipt or notice showing filing or pending status of Form I-589 Application for Asylum and Withholding or CAT; or • Form I-688B or I-766 EAD coded 274a.12(c)(8) or C8	NO	NO	NO	YES	No See footnote 4

Immigration status	Typical documents	SNAP	TANF/ TA-DVS/ ERDC	REF/ REFM	Medical under age 19	Medical age 19 and over
An noncitizen who has been **granted withholding of removal** under the **Convention Against Torture**.	• Order granting withholding of deportation or removal under CAT, issued by an immigration judge, the BIA, or a federal court; or • Form I-688B or I-766 EAD code 274a.12(c)(8) or C8	NO	NO	NO	YES	No See footnote 4
A child who has a pending application for **Special Immigrant Juvenile** status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J)).	• Form I-797 Notice of Action Special Immigrant Juvenile Receipt Notice; • Form I-797 Notice of Action Special Immigrant Juvenile Approval Notice; • Form I-797 Welcome Notice/Approval of I-485, "Other Basis of Adjustment SL6"' or • Form I-551 coded SL6	NO	NO	NO	YES	No See footnote 4
SSI Recipients	• Non-citizen status is verified and documented by SSA. Once SSI is verified, no further verification is needed for Medicaid benefits.				YES	YES
No immigration status (Undocumented) including Deferred Action for Childhood Arrivals (DACA)	• Individuals who do not have an immigration status do not meet the noncitizen requirements for ODHS|OHA programs. **For medical programs only**, individuals who do not have an immigration status, but meet all other financial and non-financial eligibility requirements are eligible for Healthier Oregon medical benefits if aged 19 through 25 or 55 and older, or if under 19 Cover All Kids, or if not eligible for Healthier Oregon, or Cover All Kids, individuals will be evaluated for CWM or CWM Prenatal (pregnancy related) coverage.					

Footnote number	Additional requirements
4	For medical programs only, individuals who meet all other financial and non-financial eligibility requirements will be evaluated for Healthier Oregon medical benefits if aged 19 through 26 or 55 and older, if not eligible for Healthier Oregon, individuals are evaluated for CWM, or CWM Prenatal (pregnancy-related) coverage.

Class of Admission (COA)

Class of Admission (COA) is a three-digit designation (usually two letters and one number) given to individuals (both immigrant and non-immigrant) when the individual enters the country. Generally, it aligns with the initial visa type that was granted upon entry. The COA can be found on many different immigration documents, including the I-94 and I-551.

Immigrant COA's: https://www.DHS.gov/immigration-statistics/lawful-permanent-residents/ImmigrantCOA

Non-immigrant COA's: https://www.DHS.gov/immigration-statistics/nonimmigrant/NonimmigrantCOA

Qualified

From time to time you might hear the term 'qualified' or 'qualified non-citizen' when discussing non-citizen eligibility. The term qualified was created with the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) on August 22, 1996.

The term can be a bit confusing. On the surface, it seems to imply a qualified individual automatically meets the non-citizen requirements for DHS programs. This is only half right. After the enactment of PRWORA, only those individuals

who were listed as 'qualified' could be considered for eligibility. Some qualified individuals will meet the requirements outright, but others will need to meet additional requirements in order to meet the non-citizen requirement.

Note: For medical programs (with the exception of REFM), Oregon has additional State Plan waivers that allow individuals with non-qualified statuses to meet the non-citizen requirement.

There is another term that you may hear, it's 'lawful presence.' Lawful presence encompasses all the immigration statuses in the matrix – both the first and second sections. Lawful presence is a term only relevant to Medical programs (excluding REFM). The top portion of statuses in the matrix are considered either qualified or those who are to be treated as qualified. The bottom portion of the matrix includes the remainder of statuses that are considered under lawful presence, but are not qualified or treated as qualified. You will note that all qualified non-citizens are considered lawfully present, but not everyone who is lawfully present is considered qualified.

Remember, if someone is not on the list at all – they are not eligible.

Qualified statuses (Treated as Qualified)

These statues are considered qualified or are treated as qualified:

Lawful permanent residents (LPR)

A lawful permanent resident is a non-citizen who has been granted authorization to live and work in the United States on a permanent basis. As proof of that status, a person is granted a permanent resident card, commonly called a "green card."

People enter the U.S. under different visas. This would include, but not limited to, family sponsored visas, diversity visas, or returning resident visas. The following are also considered to an LPR:

Iraqi and Afghan

Individuals who have entered the U.S. with a Special Immigrant Visa (SIV) under section 101(a)(27) of the Immigration and Nationality Act. During the wars in Afghanistan and Iraq, the U.S. government employed many Afghans and Iraqis as interpreters, translators, and other roles to assist in the war effort. Congress created three special immigrant programs to allow such qualified non-citizens to immigrate to the United States with their families. This special immigrant category applies to a:

- Special immigrant Afghanistan or Iraq national who worked with the U.S. armed forces as a translator;
- Special immigrant Iraq national who was employed by or on behalf of the U.S. government; and
- Special immigrant Afghanistan national who was employed by or on behalf of the U.S. government or in the International Security Assistance Force (ISAF) in Afghanistan.

With the U. S. evacuation of Afghanistan, in addition to the SIV holders mentioned above, there are two other statuses that Afghan individuals could enter the U. S.:

- Special Immigrant – Parole (SQ/SI). These individuals are Afghan nationals who are in the process of becoming SIVs, but their applications have not been completed; therefore, they were paroled. For purposes of eligibility, we treat them like SIVs.
- Paroled – These individuals are Afghan nationals who are paroled into the U. S. and are not SIVs. Please see

"Paroled" status below if they have been paroled for at least one year. If they have been paroled for less than a year, they are not qualified non-citizens.

Amerasians

Amerasians from Vietnam as defined in section 584 of the Foreign Operations, Export Financing and Related Programs Appropriations Act of 1988. These are individuals who were fathered by a U.S. citizen and born in Vietnam after January 1, 1962, and before January 1, 1976.

Refugees admitted under section 207 of the INA

A refugee is someone who has fled one's home country and cannot return because of a well-founded fear of persecution based on religion, race, nationality, political opinion or membership in a particular social group.

Asylees admitted under section 208 of the Immigration and Nationality Act (INA)

These are individuals who are already in the U.S., but are unable to return to their country of origin due to a well-founded fear of persecution based on religion, race, nationality, political opinion or membership in a particular social group. It's important to remember that this doesn't include asylum applicants.

Conditional entrant under section 203(a)(7) of the INA

Conditional entrants are granted conditional entry into the United States because of fear of persecution in the home country due to race, religion, political opinion, or because of a natural catastrophe. Note: This was the immigration status used for refugees prior to the Refugee Act of 1980.

A non-citizen whose deportation is being withheld under section 243(h) or under section 241(b)(3) of the INA – amended (also Withholding of Removal)

Both 243(h) and 241(b)(3) allow the U.S. to not deport individuals to countries in which they could be subject to persecution based on race, religion, nationality, membership in a particular social group, or political opinion.

Paroled under section 212(d)(5) of the INA for at least one year

An individual who is ineligible to enter the US as a refugee, immigrant, or non-immigrant may be ''paroled'' into the US by the Secretary of Homeland Security. These individuals shouldn't be confused in any way with criminal parole. They are not being released from prison. Also, the "…for for at least one year" is a reference to the parole period marked on their immigration documentation. It must allow them to be in the U.S. for at least one year – it has nothing to do with their actual time in the U.S. prior to applying for benefits.

Cuban/Haitian entrants (as defined in section 501(e) of the Refugee Education Assistance Act of 1980)

These are individuals who are from Cuba or Haiti and have been:

- paroled into the U.S.,
- granted any other special status for those from Cuba or Haiti**, or
- who is not subject to a final, non-appealable and legally enforceable removal order and:

- » is in removal proceedings under the INA; or
- » has an application for asylum pending with USCIS

Battered non-citizens

These are individuals (including children) who are victims of domestic violence and have been approved or have a petition pending which sets forth a prima facie case under:

- Clause (ii), (iii), or (iv) of section 204(a)(1)(A) of the INA;
- Clause (ii) or (iii) of section 204(a)(1)(B) of the INA;
- Suspension of deportation under section 244(a)(3) of the INA;
- Status as a spouse or child of a U.S. citizen pursuant to clause (i) of section 204(a)(1)(A) or 204(a)(1)(B) of the INA; or
- Cancellation of removal pursuant to section 240(b)(2) of the INA

Certified victims of severe forms of trafficking – including some family members

These are individuals who have been brought to the U.S. and have been placed into forced servitude, usually sex work or labor. These individuals are considered modern day slaves.

American Indians born in Canada to who section 289 of the INA applies

These are individuals who are American Indians who were born in Canada and have "…at least 50 per centum of blood of the American Indian race."

Non-citizens who are members of a Federally recognized Indian tribe under section 4(e) of the Indian Self-Determination and Education Assistance Act

"Indian tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C. 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Compact of Free Association (COFA) are three nations: the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau. With the passing of the Consolidated Appropriations Act of 2021 on December 27, 2020, these individuals are now considered to be qualified non-citizens, **for medical only**, not subject to the 5-year bar and meet the non-citizen requirements for full OHP Plus benefits, Medicare Savings Program, Long-Term Care, and medical through the Hospital Presumptive Process. This federal change only applies to Medicaid and CHIP medical programs and is effective December 28, 2020.

Adjustment of status

Many times, individuals who enter the US with one immigration status can adjust to another immigration status after a period of time. For example, an individual who enters the US as a refugee can adjust their status to LPR after one year. Someone who enters as a student can request asylum or some other status. How this affects their eligibility is based on what immigration status they started with and what they have now.

The following individuals retain their original status when determining eligibility for DHS programs, even if they have adjusted their status to LPR. They are not subject to the five-year bar of federal benefits:

- Refugee
- Asylee
- Cuban or Haitian Entrant
- Victim of Human Trafficking and certain family members

Iraqi and Afghan Special Immigrant Visa (SIV) holders and certain Vietnamese Amerasians are technically LPR's, but they are not subject to the five-year bar.

If you have a question about an immigration change, please contact DHS Central Office via the program policy box.

Citizens and nationals

The following individuals are considered either U.S. citizens or U.S. nationals and therefore do not have to meet the non-citizen requirements for ODHS programs (with the exception of REF/REFM). Individuals who were born in:

- Puerto Rico
- Guam
- Saipan, Tinian, Rota, or Pagan of the Northern Mariana Islands
- The U.S. Virgin Islands
- Swains Islands
- American Samoa

Victims of abuse or crime

Individuals who have been victims of abuse or other crimes can sometimes be granted a legal status that allows them to reside in the United States.

- **T Visa: Immigration Relief for Survivors of Sex or Labor Trafficking**

  T non-immigrant status is a temporary immigration benefit that enables certain foreign-born victims of a severe form of human trafficking to remain in the United States for up to 4 years if they have assisted law enforcement in an investigation or prosecution of human trafficking. T non-immigrant status is also available for certain qualifying family members of trafficking victims. T non-immigrants who qualify may also be able to adjust their status and become lawful permanent residents (obtain a Green Card).

- **U Visa: Immigration Relief for Survivors of Domestic Violence and Other Crimes**

  The U non-immigrant status (U visa) is set aside for victims of certain crimes who have suffered mental or physical abuse and are helpful to law enforcement or government officials in the investigation or prosecution of criminal activity.

- **VAWA: Immigration Relief for Survivors of Domestic Violence and Other Crimes**

  The VAWA provisions in the INA allow certain spouses, children, and parents of U.S. citizens and certain spouses and children of permanent residents (Green Card holders) to file a petition for themselves, without the abuser's

knowledge. This allows victims to seek both safety and independence from their abuser, who is not notified about the filing.

Click here for Comparison Chart of U visa, T Visa, Violence Against Women Act (VAWA) Self-Petition, Special Immigrant Juvenile Status (SIJS), and Deferred Action for Childhood Arrivals (DACA).

Note: This document is for informational comparison of different types of statuses and is not to be used for determining eligibility.

SNAP

Individuals who are victims of trafficking, **T Visa**, can be eligible for SNAP benefits without having to meet any additional immigration criteria stated on the matrix.

Individuals who have a **U visa** are not eligible for SNAP benefits until they have become an LPR and can meet one of the additional criteria on the matrix.

Individuals who are self-petitioning under **VAWA** can be eligible for SNAP benefits if they meet the additional criteria stated on the matrix.

TANF and **ERDC**

In the TANF and ERDC programs, individuals who are at risk of domestic violence or are fleeing domestic violence may waive the non-citizen requirement. However, if domestic violence is not a factor, then only VAWA self-petitioning and Trafficking Victims meet the non-citizen requirement. U visa holders must gain another status, usually LPR, prior to becoming eligible for TANF or ERDC.

VAWA Self-Petitioning (When there are no domestic violence considerations): Based on federal regulations, if an individual has been approved or has a DS-360 self-petition pending that sets forth a prima facie case, the individual meets qualified non-citizen status.

To maintain TANF and ERDC eligibility during this self-petitioning process, the parent or children who have been "battered and subjected to extreme cruelty" cannot live in the same household as the abuser.

The need for benefits would have a substantial connection to the battering or extreme cruelty. A substantial connection means the benefits are needed to enable the applicant, the applicant's child and/or (in the case of an non-citizen child) the applicant's parent:

- To become self-sufficient following separation from the abuser,
- To escape the abuser and/or the community in which the abuser lives or to ensure the safety of the applicant, the applicant's child or the applicant's parent from the abuser,
- To alleviate loss of financial support resulting from the separation from the abuser, or
- To alleviate finances due to a reduction in earnings or job loss related to the battery or cruelty and/or the applicant or applicant's parent (who is not the abuser) had to leave a job for safety reasons.

And the abuse needed to have happened in the United States.

REF

Only victims of trafficking can be considered for REF and REFM. U visa holders and VAWA self-petitioning are not eligible.

MSP Individuals with a T visa may not have to meet the 5-year requirement:

- T1 visa holders have to present a Certification Letter from the U.S. Department of Health and Human Services (HHS) in order to meet an exception from the 5-year bar requirement.
- All other T visa holders are excluded from the 5-year bar requirement.

Individuals with a U Visa meet the non-citizen requirements if they are under age 19. Individuals with a U Visa who are 19 and older, do not meet the non-citizen requirement.

OSIPM Individuals with a T visa may not have to meet the 5-year requirement:

- T1 visa holders have to present a Certification Letter from the U.S. Department of Health and Human Services (HHS) in order to meet an exception from the 5-year bar requirement.
- All other T visa holders are excluded from the 5-year bar requirement.

Individuals with a U Visa meet the non-citizen requirements if they are under age 19. Individuals with a U Visa who are 19 and older, do not meet the non-citizen requirement.

HSD Individuals with a T visa may not have to meet the 5-year requirement:

- T1 visa holders have to present a Certification Letter from the U.S. Department of Health and Human Services (HHS) in order to meet an exception from the 5-year bar requirement.
- All other T visa holders are excluded from the 5-year bar requirement.

Individuals with a U Visa meet the non-citizen requirements if they are under age 19. Individuals with a U Visa who are 19 and older, do not meet the non-citizen requirement.

Verifying 40 work quarters

SNAP Lawful Permanent Residents (LPRs) with 40 quarters of work experience may be eligible for SNAP benefits. A quarter of coverage is any calendar quarter as follows:

- Jan. 1 to March 31
- April 1 to June 30
- July 1 to Sept. 30
- Oct. 1 to Dec. 31

The individual must have a specified amount of wages or self-employment income in each quarter to count that quarter.

Amount of earnings needed to earn one quarter of coverage					
Year	**Quantity of earnings**	**Year**	**Quantity of earnings**	**Year**	**Quantity of earnings**
1978	$250	1993	$590	2008	$1,050
1979	$260	1994	$620	2009	$1,090
1980	$290	1995	$630	2010	$1,120
1981	$310	1996	$640	2011	$1120

1982	$340	1997	$670	2012	$1,130
1983	$370	1998	$700	2013	$1160
1984	$390	1999	$740	2014	$1,200
1985	$410	2000	$780	2015	$1,220
1986	$440	2001	$830	2016	$1,260
1987	$460	2002	$870	2017	$1,300
1988	$470	2003	$890	2018	$1,320
1989	$500	2004	$900	2019	$1,360
1990	$520	2005	$920	2020	$1,410
1991	$540	2006	$970	2021	TBD
1992	$570	2007	$1000	2022	TBD

Note: If the individual from whom quarters are being borrowed is not in the filing group, SSP will need the "Consent for Release of Information" (SSA-3288) before requesting any information about the individual's work quarters. SSP cannot use any quarter claimed after Dec. 31, 1996 if the LPR received any assistance from a federally means tested program, as defined below, during the quarter.

The following are federal means-tested programs for purposes of determining qualifying quarters:

- SNAP
- Temporary Assistance for Needy Families (TANF)
- SSI
- Medicaid
- State Child Health Insurance Program (CHIP), and
- Nutrition Assistance Program (NAP) in Puerto Rico, American Samoa and the Northern Marianas (CNMI)

An applicant may make a self-declaration as to working 40 quarters, but SSP must verify this with one of the following:

- A current employer-prepared statement of earnings
- W-2, W-2c, employer-prepared wage statement, or an IRS copy of the individual's tax return
- A timely filed tax return for a self-employed individual

Note: A timely filed tax return must show proof of filing, canceled check, money order or copy of IRS schedule C form bearing the IRS time stamp. The IRS time stamp must indicate the return was filed within three years three months and 15 days after the end of the year in which the self-employment income was derived.

- Other evidence of self-employment that allows SSP to determine business did exist and a profit was earned. Comparison of bills, payment vouchers and receipts are examples of evidence SSP might use to make a determination
- Records of employment agencies in Oregon or any other state
- Any other evidence of earnings including pay envelopes, pay vouchers, union records, or an individual's copy of a federal or state tax return

- Social Security Administration records of a non-recipient

Note: If the individual states they can claim work quarters from a spouse or a parent who worked before the non-citizen turned 18, SSP can request that the individual obtain verification from the non- recipient individual, spouse or parent. If the non-recipient individual, spouse or parent refuses to cooperate, the information can be obtained from SSA by using a Request for Quarters of Coverage History Based on Relationship (SSA-513) form. This form is not available online and the non-citizen must contact SSA for more information.

- Social Security records for recipient individuals can be requested from the Social Security Administration (SSA) through the TPQY screen. To initiate a request SSP should complete the following steps from the TPQY screen:
- Enter a Y in the QQ HIST field.
- Enter their branch number.
- Enter their worker I.D.
- Hit F9 to send the request.
- Check response via W1TR screen the next day.
- Exclude any quarters that the non-citizen received SNAP, TANF or Medicaid (federally means- tested benefits).

TANF The use of 40 quarters in TANF is only used to determine whether income and resources are deemed from a sponsor. Please see the section on Sponsors and Deeming.

ERDC and REF

The use of 40 quarters is not used in the determination of eligibility for ERDC, REF or REFM.

Determining and calculating benefits for eligibility groups with ineligible non-citizens

In ONE, income of individuals who are ineligible due to their immigration status will have their income automatically Prorated for some programs. The eligibility worker does not have to do any calculations.

TANF To determine TANF eligibility and payments for filing groups that include ineligible non-citizens, do the following:

Step 1-Determine eligibility groups and total gross income

- Determine the need group and the benefit group.
- Add all gross countable income of members in the need group. This includes ineligible non-citizens. Determine if the total income is less than the countable income limit

Step 2 -Adjusted income test

- Apply a 50% deduction to all of the earned income. After the deduction, prorate only income (earned and unearned) received by the ineligible non-citizens in the financial group.

- To do this, take all of the ineligible non-citizen income and divide it by the number in the need group. Then multiply that by the number of individuals in the benefit group.

  Example: Mom, dad, and child. Mom is an ineligible non-citizen. Mom has earned income of 300.00 a month.
  300 – 50%=150.00 150/3x2=100.00 total for adjusted income test.
- Income of those who meet non-citizen status is counted without prorating. Only apply 50% deduction to earned income and then use the total without proration.
- If the total amount is under the adjusted income limit with an adult for the need group size, then the worker can proceed to determine payment amount.

Remember: If there is no adult on the case that meets the non-citizen requirements then you will need to compare the adjusted income to the No-Adult Payment Standard for the benefit group to determine the adjusted income limit and payment amount.

If adjusted income equals or exceeds the Payment Standard, the benefit group is not eligible.

For example, Michonne is in the office needing to apply for TANF for herself and her two kids. Michonne and her oldest child are ineligible non-citizens. Her youngest child is a U.S. citizen. Michonne states that she is working at a bakery. The worker will need to take her pay verification of $250.00 a month and determine eligibility using the countable and adjusted income test for the need group.

Step 1: Countable income test for need group
Earned income 250
Countable income limit for persons in **NEED** group **616**
Since $250.00 is under the countable income limit, move to step 2.

Step 2: TANF adjusted income test for need group
Earned income 250
Minus 50% earned income deduction 125
Adjusted income limit for persons in **NEED** group **482**
Since $125 is under the adjusted income limit, move to step 3.

Step 3: Calculate the prorated income of the ineligible non-citizen
Earned income 250
Divide by number in the need group /3
Multiply by number in the benefit group x1
Prorated earned income 83.33
Minus 50% earned income deduction **41.66**
Result: total adjusted income **41.66**
Payment standard for **BENEFIT** group **180**
Since $41.66 is under the payment standard, move to step 4.

Step 4: Determine TANF grant amount 180
Payment standard for BENEFIT group
Minus adjusted income above: 41.66
Result: TANF grant 138

If you are working in ONE, you will not be manually coding this. The computer system will do this calculation once all the information is entered. In DHR, this still needs to be manually entered. To enter on UCMS, the worker will code Michonne NO and add TNC on the C/D line; the N/R line will have EML C $83.33. Judith will be a CH and the second child would be a NO.

Note: Do not code ineligible non-citizens as IA; this is medical coding. Code ineligible non-citizens in-grant code NO and a C/D of TNC.

ERDC To qualify for ERDC, there must be at least one child with a childcare need who meets the non-citizen status requirements (unless the caretaker relative has a current safety issue related to domestic violence). The filing group must meet all other eligibility requirements. To determine eligibility for ineligible non-citizens with a child who meets non-citizen status requirements:

- Treat the entire filing group as if all members meet non-citizen status when conducting the income tests.
- Compare their countable income to the ERDC Gross Monthly Income Limit Chart.
- If the countable income exceeds the gross income limit, the filing group is not eligible.
- If the countable income is equal to or below the gross income limit, calculate the copay from the number in the benefit group. If the copay amount is more than the childcare benefit (subsidy) amount, the family is not eligible for ERDC.

REF Because a filing group for REF or REFM will have all individuals in a legal status, it's highly unlikely that there would be an ineligible non-citizen. However, if there is a group with an ineligible non-citizen, please follow the income calculation mentioned above in TANF.

Treatment of income, resources and deductions of certain ineligible household members – SNAP

Overview

SNAP has special rules and procedures for handling the income and resources of ineligible household members living with other eligible members. There are two main groups of ineligible individuals. Each group requires different treatment of their income, resources and deductions when residing with other eligible members.

The first group is composed of people who have been penalized due to:

- Intentional Program Violations (IPVs),
- Fleeing Felons/Parole Violators; and
- Work requirement sanctions (LVs).

Income, resources, and deductible expenses of these ineligible household member(s) count in their entirety, and the entire household's allowable earned income, standard, medical, dependent care, child support, homeless shelter deduction, and excess shelter deductions apply to the remaining household members.

These ineligible members are not included in the household size to determine benefit level, standard deduction, and when comparing the monthly income with the income eligibility standards, or when comparing the household's

resources with the resource eligibility limits.

ONE identifies them with the reason not included in the benefits on the EDG Summary.

The second group of people is composed of the following individuals:

- Ineligible non-citizens
- Persons disqualified for failing to obtain or provide a Social Security Number;
- An ABAWD ineligible for exceeding the SNAP time limits.

Note: If a person is unwilling to disclose their citizenship status, treat them as ineligible non-citizens.

Most income, resources and deductible expenses of these individuals are subject to the use of proration when determining how their presence impacts benefit levels for the eligible household members. Proration refers to counting only the portion allotted for the eligible individuals based on a simple calculation.

To prorate, the amount in question (income or deduction type) is divided evenly among all household members, including eligible and ineligible members. The result is then multiplied by the number of eligible individuals so that only their share is counted in the case. The pro rata share belonging to the ineligible household member is not considered countable for the filing group.

Treatment of income

The following details the calculation of countable income for ineligible household members. ONE Prorates the ineligible member's countable income based on the household size. It excludes the prorate share of individuals not in the benefit group by multiplying the pro-rata portion by only those who are eligible in the household. This income is countable income for the filing group. It is important to correctly identify the individual as an ineligible member in ONE to get the correct calculation.

Note: The countable income of ineligible members is eligible for the earned income deduction (20% of earned or self-employment) and an exclusion of 50% of self-employment income with costs.

For example, in a household with three citizens and one ineligible non-citizen person there are 4 persons in the household. If the ineligible person earns $1000 a month only the prorated portion available to the eligible members is counted. To prorate the income:

1. Divide the income by number of household members. $1000 divided by 4 household members is $250.
2. The equitable portion ($250) is multiplied times the number of eligible members (3), $250 times 3 = $750. The prorate amount to use in the calculations is $750.

Note: Income is calculated differently dependent on the citizenship status of each individual. An ineligible non-citizen's income is prorated as mentioned above. Eligible non-citizen's income is not prorated. It is important to correctly identify the citizenship status for each individual in ONE.

Proration of deductions

The costs for the following deductions are prorated if paid by an ineligible member. Only the benefit group's members prorated share is used for the deductions.

- TANF
- Shelter
- Child support
- Medical costs, and
- Dependent care

Note: The only exception to the rule above is the utility costs. Utility costs are not prorated.

For additional guidance and examples of when and how to enter prorated deductions in ONE see: SNAP Proration QRG

System requirements

The following tables show actions required by worker in ONE:

Type of income	ONE prorates
Most income (except TANF Grant)	YES – must have correct status

Type of income	ONE prorates
Shelter	NO – manual proration
Dependent care	YES – manual proration and code under adult making payment
Child support	YES – manual proration and code the portion on each person in the filing group
Medical deduction	YES – manual proration and code the portion on each person in the filing group
Utilities – never prorated	NO – always use actual type coded under the person who is responsible

Sponsors and deeming

What is a sponsor?
A sponsor is a person who has helped an immigrant become a lawful permanent resident (green card holder) by signing an "affidavit of support."

What is an affidavit of support?
An affidavit of support is a contract signed by the sponsor to show that the immigrant applying for a green card is not likely to become dependent on the government, or a "public charge."

Can immigrants whose sponsor signed an affidavit get benefits?
Yes. Do not withhold benefits because of an affidavit of support.

SNAP

Sponsor deeming overview

When a sponsored non-citizen applies for SNAP, a portion of the sponsors income and resources must be deemed to the sponsored non-citizen's SNAP household, regardless of the amount of actual support being provided by the sponsor. It is the responsibility of the sponsored non-citizen to provide income verification requested for their sponsor, including the sponsor's spouse. Failure to provide the sponsor's income and resources will result in a denial for SNAP unless the sponsored non-citizen chooses not to apply for SNAP, or they meet one of the exceptions listed below

Sponsor deeming

An eligible, sponsored non-citizen is subject to deeming rules unless at least one of the following exemptions apply:

- The sponsor has not signed a legally binding affidavit of support (USCIS Form I-864 or I-864A) or the affidavit of support was signed before 12/9/1997.
- The sponsor receives SNAP, SSI or TANF benefits.
- The sponsor is deceased (the estate of a deceased sponsor is not responsible for the non-citizen).
- The sponsored non-citizen does not meet "non-citizen" status requirements for the program for which they apply.
- The sponsored non-citizen becomes a naturalized citizen.
- The sponsored non-citizen can be credited with 40 qualifying quarters of work, or
- The sponsored non-citizen is under 18 years of age.

Non-citizens not subject to sponsor deeming

Deeming rules are not applicable to eligible sponsored non-citizens in these situations:

- The sponsored non-citizen is not required to have a sponsor under the INA, such as, but not limited to, a refugee, a parolee, an asylee or a Cuban or Haitian entrant.
- The non-citizen is sponsored by a public or private organization or group, or
- The non-citizen is living in the same SNAP filing group as the sponsor, or
- The sponsored non-citizen meet one of the exceptions to deeming, below.

Exceptions to sponsor deeming

At the option of a sponsored non-citizen, the income and assets of the sponsor are not required to be deemed for a period of 12 months if the sponsored non-citizen claims one of the following exceptions:

- Battered non-citizen exception: The non-citizen verifies they were was battered, and there is a substantial connection between the need for SNAP benefits and the battery (in the opinion of SSP).
- The sponsored non-citizen is a battered immigrant spouse, battered immigrant child, immigrant parent of a battered child or an immigrant child of a battered parent, as long as the battered non-citizen does not live in the same household as the person responsible for the battery.

Note: These exceptions can be reviewed and eligibility redetermined without deeming from a sponsor after the 12-month period if the non-citizen demonstrates that such battery or cruelty described above has been recognized in an order of a judge or administrative law judge or a prior determination of U.S. Citizenship and Immigration Services, and that such battery or cruelty has a substantial connection to the need for benefits.

- The sponsored non-citizen establishes indigence.

Indigence Determinations

The agency may determine that the eligible, sponsored non-citizen meets indigence criteria. This means the

household is not being provided sufficient support to meet basic needs. A SNAP household with a sponsored non-citizen may not be considered as indigent if the total income of the non-citizen's household (including in-kind income) plus cash, food, housing or other assistance provided by other individuals, including the sponsor, is over 130 percent of the federal poverty level.

Each indigence determination is effective for 12 months and may be renewed for additional 12-month periods.

Steps to complete the indigence determination:

- Determine if the total SNAP household income is below 130% FPL
- Explain indigence determination and purpose to the sponsored non-citizen or authorized representative. An individual may opt-out of the indigence process at any time:
  - If a sponsored non-citizen opts-out, they would no longer be requesting benefits for this individual.
  - Remove the SNAP benefit request for the individual and continue determining eligibility for any remaining household members.
- Staff make the final indigence determination by completing the Declaration of Indigence form (DHS 1058) with the sponsored non-citizen. This form should be signed by the sponsored non-citizen.
- The completed, signed form should be forwarded to SNAP policy.
- SNAP policy will submit to the Attorney General.

Note: The DHS 1058 serves as documentation that a sponsor is not complying with the legal obligation to provide adequate support to the sponsored non-citizen as a condition of entry. The form documents that the sponsored non-citizen meets indigence criteria and agrees with this determination. Explaining the process and reason will allow the sponsored non-citizen to make an informed choice in continuing with the indigence determination process.

Deeming countable income from a sponsor

Once verification of all earned and unearned income is received, follow these steps to determine countable deemed income:

1. Determine the sponsor(s)' household size. This includes the sponsor, their spouse and any dependents they claim on their federal taxes. Do not include any individuals they are sponsoring in this step. Use the household size to look up the countable income limit. It is the 130%FPL.
2. Calculate the monthly income of the sponsor and their spouse, including any earned, unearned or self-employment income.
3. Subtract 20 percent from earned income and/or self-employment with no costs (SEN). Subtract 50 percent from self-employment income with costs (SEC).
4. Subtract 130%FPL obtained in step 1 from the remaining income from step 3. This is the income subject to deeming.
5. Determine the number of people exempt from deeming related to sponsor and non-citizen. The people not subject to deeming include:

(a) Number of other non-citizens being sponsored by the same sponsor or their spouse, plus

(b) Number of children, under the age of 18, in the filing group of nonc-itizen requesting benefits (include both sponsored non-citizen children and citizen children).

6. Divide the income subject to deeming from step 4 by the number of people from step 5.

Note: The citizen and sponsored non-citizen children of the sponsored non-citizen are exempt from deeming. In order to exclude a portion of the deemed income for their needs, it is important to include them in step

Deeming countable resources from a sponsor

Determine the sponsors available resources and subtract $1500. The amount obtained is deemed to the non-citizen.

Sponsorship of more than one non-citizen

If an individual(s) has sponsored more than one non-citizen, the total monthly income and total assets of the sponsor(s) shall be prorated among all the sponsored non-citizens.

TANF Sponsorship and deeming is the same for TANF and SNAP. The only difference between the two programs is the calculation of the sponsor's income.

Taking into account any exceptions or exclusion mentioned above, when you need to calculate income for a sponsored non-citizen, all the sponsor and sponsor's spouse's income and resources should be counted as available to the sponsored non-citizen. Any earned income should receive a 50% deduction. The total should be counted as available to the sponsored non-citizen.

Note: "Opting Out" – Opting out means removing one's self from applying for benefits. A sponsored non-citizen can opt out of applying for benefits if they either do not want their sponsor being reported to USCIS as in the case of an indigent individual, or do not want to obtain the information from their sponsor for ODHS to determine their deemed assets. Non-citizens who opt out of the reporting to USCIS or the deeming process are considered not having their non-citizen status requirement met.

ERDC The assets of a sponsor and of a sponsor's spouse are not deemed to the sponsored non-citizen.

REF There is no deeming of assets if there is a sponsor involved with an individual in the REF program.

MSP The department is working on implementing sponsor deeming questions and calculations into the ONE system for medical programs. Until that time, this information is not collected for medical only cases

OSIPM The department is working on implementing sponsor deeming questions and calculations into the ONE system for medical programs. Until that time, this information is not collected for medical only cases.

HSD The department is working on implementing sponsor deeming questions and calculations into the ONE system for medical programs. Until that time, this information is not collected for medical only cases.

Public charge

UPDATE – March 2021

- As of March 9, 2021, the U.S. Citizenship & Immigration Services (USCIS) will no longer apply the August 2019 Public Charge Final Rule. The 2019 rule had expanded the definition of public charge and increased the number of programs used to determine public charge status. Instead, USCIS will now use the public charge policy described in the 1999 field guidance (published by the prior Immigration and Naturalization Service).
- Many immigrants are exempt from the public charge test.
- Many benefits don't count in the public charge test.
- Benefits received by and for children don't count against their parents.
- Testing, treatment and preventive care for COVID-19 will not be considered in the public charge test, no matter how it is paid.

Background

"Public charge" or the "public charge test" is used by immigration officials to decide whether a person can enter the U.S. under a new visa, renew/extend a visa or adjust their legal status to that of a lawful permanent resident (LPR). Reference the USCIS website to see what version of the public charge rule is being applied. This section is designed to provide an overview and list of facts about public charge so you may answer general questions. Remember, at no time should you give legal advice to a participant, nor should you influence their decision to request benefits or not.

The public charge test does not affect eligibility for public benefit programs. Public charge does not change whether someone is eligible for SNAP, TANF or HSD medical programs. Instead, the public charge rule makes it so that receiving public benefits may be considered when determining if these individuals may enter the United States or be granted lawful permanent residence.

Who is not subject to the public charge test?

USCIS will not consider public benefits received on behalf of another or receipt of a public benefit by one or more members of the applicant's household to the applicant, unless the applicant is also a listed beneficiary of the public benefit. In addition, the following individuals are not subject to public charge test, or are specifically excluded:

- U.S. citizens. This includes:
  - Those who are born in the United States, and
  - Those who have naturalized.
- Green card holders including:
  - People with green cards who are applying for U.S. citizenship, and
  - Those renewing their green card.

Note: Green card holders who leave the United States for 180 consecutive days or more are subject to public charge criteria when they return.

- Active military service members and their families
- Immigrants who are in the United States for humanitarian reasons. For example:
  - Refugees

- Asylees (including people applying for asylum)
- People with Temporary Protected Status (TPS)
- Violence Against Women Act (VAWA) self-petitioners
- T or U visa applicants or holders
- People with Special Immigrant Juvenile Status (SIJS)
- Certain parolees, and
- Other categories of non-citizens.

What public benefits are listed under public charge rule?

The 1999 rule is narrower in scope. Only a couple of programs may be used to determine public charge status. As written:

"USCIS may consider a non-citizen's use of the following in deciding whether to issue a green card:

- Cash Welfare, such as Supplemental Security Income (SSI), cash Temporary Assistance for Needy Families (TANF) and state General Assistance.
- Institutionalization for long-term care, such as residing in a nursing home or mental health facility at government expense."

Note: Acceptance of these forms of public cash assistance could make a non-U.S. citizen inadmissible as a "public charge" if all other criteria are met. However, the mere receipt of these benefits does not automatically make an individual inadmissible, ineligible to adjust status to lawful permanent resident or deportable on public charge grounds.

Which ODHS programs are not considered to determine public charge status?

The following ODHS programs are not included in the 1999 public charge test:

- Employment Related Day Care (ERDC)
- Employment and Training (E&T) programs
- Job Participation Incentive (JPI)
- Medicaid and CHIP (HSD and APD medical programs)*
- Refugee Cash Assistance (REF)
- Supplemental Nutrition Assistance Program (SNAP)
- Temporary Assistance for Domestic Violence Survivors (TA-DVS)

*The portion of Medicaid used to pay for long-term care is considered.

Which other public benefit programs may not be counted for public charge?

The following programs may **not** be taken into consideration by USCIS officials when making a public charge determination. Under the 1999 agency guidance, non-cash benefits and special-purpose cash benefits not intended for income maintenance are not subject to public charge consideration. Such benefits include:

- Cash payments that have been earned, such as Title II Social Security benefits, government pensions and

veterans' benefits, among other forms of earned benefits

- Educational assistance (such as attending public school), including benefits under the Head Start Act and aid for elementary, secondary or higher education
- Emergency disaster relief
- Energy assistance, such as the Low Income Home Energy Assistance Program (LIHEAP)
- Foster care and adoption assistance
- Housing benefits
- In-kind, community-based programs, services or assistance (such as soup kitchens, crisis counseling and intervention, and short-term shelter)
- Non-cash benefits under TANF such as subsidized child care or transit subsidies
- Nutrition programs, including the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), the National School Lunch and the School Breakfast programs, and other supplementary and emergency food assistance programs such as Pandemic-EBT/Summer-EBT meal programs
- Other child care services
- Unemployment compensation.

Note: Some of the above programs may provide cash benefits, such as energy assistance, transportation or child care benefits provided under TANF or the Child Care Development Block Grant (CCDBG), and one-time emergency payments under TANF. Because the purpose of such benefits is not for income maintenance, but rather to avoid the need for ongoing cash assistance for income maintenance, they are not subject to public charge consideration.

Does the rule change how eligibility is determined for public service programs?

No, the public charge rule affects the U.S. Department of Homeland Security for immigration purposes only. The USCIS rule change does not affect eligibility for ODHS programs.

What should I do when someone asks me how public charge will affect them?

When asked by applicants for advice or information about the effect of public charge due to receiving benefits, we can mention which programs are and are not used to determine public charge status. However, the best choice is to refer them to legal services. The following are reputable resources available for Oregonians with questions about public charge:

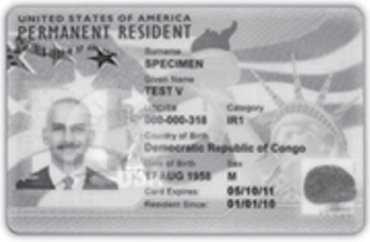
- Oregon Law Center and Legal Aid's Public Benefits Hotline: 800-520-5292
- Causa, Oregon's Latino Immigrant Rights Organization: 503-409-2473
- Immigration attorneys: https://oregonimmigrationresource.org/resources/

Verification and documentation

All lawfully admitted non-citizens given immigration documents by the U.S. Citizenship and Immigration Services (USCIS) are considered "documented". Individuals who have come to the United States without an USCIS document or stay without a valid visa are considered "undocumented."

Here is an example of documentation of legal permanent resident:

Permanent Resident Card (aka Green Card) (form I-551; earlier versions are the I-151, AR-2 and AR-3)



The redesigned Green Card (above) no longer displays the individual's signature on the front or an optical stripe on the back similar to the old-style card (below).

Card images credited to the USCIS website

Other examples of documentation include:

- Re-entry Permit (I-327)
- Foreign passport stamped to show temporary evidence of LPR or I551 status
- Memorandum of Creation of Lawful Permanent Residence with approval stamp (I-181)
- Order issued by the USCIS, an immigration judge, the Board of Immigration Appeals (BIA) or a federal court granting registry, suspension of deportation, cancellation of removal, or adjustment of status, or
- Any verification from USCIS or other authoritative document.

Verifying status

The immigration documents of each qualified non-citizen in the benefit group must be verified before eligibility for programs can be established. It is not necessary to verify the document of the non-citizen if the document has already been previously verified.

Applicants are responsible for providing proof of immigration status for all household members applying for benefits. If an applicant is unable or unwilling to provide documentation of immigration status for themselves or for any household member applying for benefits, SSP will:

- Classify that household member as an ineligible non-citizen, and
- Stop efforts to obtain any documentation for those members.

Most non-citizens will provide documentation from USCIS. However, acceptable documentation may also be issued by other federal agencies such as the Office of Refugee Resettlement (ORR), the Bureau of Indian Affairs (BIA), or a court.

Non-citizens who are lawfully present in the United States typically have documents issued that contain information about that individual's immigration status and the date that individual entered the country or adjusted to the status shown on the card.

Some eligible applicants may not have documents issued by USCIS and, in some cases, the date of entry or adjustment may not be necessary or required. Until acceptable documentation is provided, a non-citizen is ineligible for benefits unless:

- The worker has submitted a copy of a document provided by the household to USCIS for validation. Pending validation, do not deny, delay, reduce or terminate the individual's eligibility for benefits on the basis of immigration status,
- The individual provides documentation that SSA is conducting an investigation to determine if more quarters of work coverage can be credited. In this situation, workers must certify the individual, pending the results of the investigation, for up to six months from the date of the original determination of insufficient quarters, or
- The applicant or worker has submitted a request to a federal agency (other than USCIS) for verification of information applicable to the individual's immigration status. In this situation, workers must certify the individual, pending the results of the investigation, for up to six months from the date of the original request for verification.

Expired documents

Applicants sometimes present expired immigration documents. When expired documents are provided, complete each of the following steps:

- Accept the expired document for the initial certification/redetermination.
- Click on the "request additional verification" window of SAVE and complete questions. If there is not enough information on the document to permit use of SAVE, complete a form Document Verification Request (SAVE Agencies) (G 845) to validate non-citizen status. This form is also available on the DHS forms server that will link SSP to the USCIS website. AND
- Clearly narrate that expired documentation was accepted and the method (online or mailed form) used to request additional verification.
- If USCIS validates the document, it can be used to verify non-citizen status at the next recertification.
- If USCIS is not able to verify the document, the non-citizen must present current documents at recertification to continue to receive benefits.

It is important to narrate the response to the additional request for verification. SSP encourages applicants to contact USCIS to renew their status. There is a fee for renewal, but it may be waived due to destitution. Although DHS cannot help with the cost, some advocacy agencies may have funds available.

Quick reference chart - SSA

The following is a list of codes reported on by SSA and available to view on the non-citizen's SSA screens.

Note: An individual's non-citizen status must still be verified by the VLP interface via the ONE system (for medical), or SAVE (for all other programs).

SDX code	SDX description	Description
1	No status alleged	Undetermined
2	Valid non-citizen status alleged, but not proven	Undetermined
3	Amerasian immigrant	Vietnamese Amerasian
4	North American Indian	Citizen
A	Proven U.S. born-U.S. citizen	Citizen
B	Alleged U.S. born-U.S. citizen	Citizen
C	U.S. citizen born outside the U.S. Includes naturalized citizens and U.S. citizens born abroad to U.S. parents	Naturalized citizen
E	No citizenship or non-citizen status development undertaken; case denied for reason(s) other than citizenship/non-citizen status	Undetermined
F	Refugee status- Section 207 or 203 (A)(7) of the I.N.A.	Refugee
G	Parole status-Section 212(d)(5) of the I.N.A.	Parolee
J	Deportation has been withheld pursuant to section 243 (h) of the INA or meets one of the following criteria: • Deferred action status non-citizen • Residence of U.S. pursuant to an order of supervision • Properly filed an application with the U.S. Citizenship and Immigration Services for adjustment of status	Deportation withheld non-citizen
K	Non-citizen lawfully admitted to the U.S. for permanent residence	Legal permanent resident
L	Asylum status-Section 208 of the INA	Asylee
N	Identity and citizenship of the individual verified by the code interface (code was previously B); individual is a U.S. citizen	Citizen
P	Pre-Jan. 1,1972 non-citizen (presumably lawfully admitted for permanent residence)	Legal permanent resident
Q	Alleged born in the U.S.-allegation corroborated by a U.S. place of birth shown on the online code	Citizen
R	Lawful temporary resident-status granted as a result of the Immigration Reform and Control Act of 1986	PRUCOL

S	Lawful permanent residence-status granted as a result of the Immigration Reform and Control Act of 1986	Legal permanent resident
T	Non-citizen granted voluntary departure	PRUCOL
U	Unknown	Undetermined
V	Systems override applied following interface edit (obsolete code)	N/A
W	Non-citizen granted stay of deportation	PRUCOL
X	Cuban/Haitian Entrant	Cuban Haitian Entrant
Y	Legalized agricultural worker pursuant to the Immigration Reform and Control Act of 1986; granted permanent residence status	PRUCOL
Z	On whose behalf an immediate relative petition has been approved; or has an approved petition; or a petition pending with the U.S. Citizenship and Immigration Services that sets forth a prima facie case for one of the following: • Status as an immediate relative • Classification to immigrant status • Suspension of deportation and adjustment to LPR status	PRUCOL

Note: For SSA Codes 1, 2 and E, SSP must explore the citizenship/non-citizenship of the applicant.

"PRUCOL" or permanently residing in the U.S. under color of law – is not an immigration status, but a benefit eligibility category. The term generally means that immigration authorities are aware of a person's presence but have no plans to deport/remove him or her from the country. It is interpreted differently, depending on the benefit program and jurisdiction. Currently, DHS doesn't use this term.

Chapter 7: Worker guides

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Chapter 7:
Worker guides

Section 1: Multiple program worker guides

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Multiple program worker guides

Introduction

While the chapters within the Oregon Programs Eligibility Notebook are intended to cover all areas of eligibility, there may be miscellaneous pieces of information that do not fit into a single topic. The multiple program worker guides are available as a tool to accompany the rest of Oregon Administrative Rule and the Oregon Programs Eligibility Notebook for these areas.

TA-DVS worker guides are not included here at this time. Select here for Temporary Assistance for Domestic Violence Survivors (TA-DVS) eligibility manual.

Alternate formats, interpreters and translations

This worker guide exists to provide additional policy and process guidance around alternate formats, interpreter services, and translation services. Please click here for Assistance with applications.

Alternate formats

Alternate formats are documents that are made available through anything other than standard print. This includes documents in large print, Braille, audio tape, computer disk and oral presentation (phone or in person).

The Americans with Disabilities Act (ADA) is intended to protect persons with disabilities from discrimination in the services, programs or activities of all state and local governments. This includes accessing information about these services, programs or activities. ODHS must ensure that communications with applicants, participants and members of the public with disabilities are as effective as communications with others. ODHS|OHA policy states:

The intent of providing alternate formats is to ensure that ODHS|OHA communication with individuals with disabilities is as effective as that provided to individuals without disabilities. ODHS|OHA will use an individualized approach to respond to requests for alternate formats which may include the need for additional information or clarification. Agents of ODHS|OHA, in cooperation with individuals requiring alternate formats, will identify the most appropriate format. Primary consideration will be given to the individual's preferred format.

This document consolidates and revises previous instructions from Central Office regarding the availability, assessment and processing of alternate format requests. If you have any questions concerning these matters, contact your branch ADA coordinator or operations manager.

Availability of alternate formats (AF)

When an individual asks to receive information in an alternate format, the request provides ODHS|OHA an opportunity to learn more about and better serve that individual. In order for the individual to make a request, they must be aware of the availability of alternate formats.

Oral notification must also be given to applicants and recipients about the availability of materials in alternate format. If the Oregonian self-identifies this need in ONE, this requirement has been ment. If not, staff should address the question during the interview. The staff should document in ONE or the case narrative that such oral

notification was provided, the date provided and the initials of the staff providing the notification, e.g., "12/14/98 - Oral AF notice. Staff initials." Please also include such oral notification as a regular part of the individual/applicant orientation. If oral notification is not possible, e.g., no working telephone number for individual, no face-to-face appointments scheduled or kept by the individual, etc., document in the narrative any attempts to provide oral notification and/or the reason it was not possible and then send out a written notice of alternate format availability. You may use the supplement language for this purpose.

Assessing AF requests

ODHS|OHA will not assess whether an individual/applicant requesting materials in an alternate format is entitled to them under law. Rather, as a matter of customer service, ODHS|OHA shall provide agency materials in alternate formats (e.g., Braille, audio tape, computer disk, large print, oral presentation) upon request. However, the agency shall explore with the individual the best and most realistic format available given the individual's request, the available processing and other relevant considerations.

Remember that although ODHS|OHA will not assess whether a person is entitled to an alternate format under law, any request for an alternate format provides us with the opportunity to explore whether we have made available to the applicant/recipient a full array of services and resources to meet their individualized needs. This fits with our agency mission.

Processing alternate format requests

Once a request for alternate formats is made and you have worked with the individual to determine the best format given the circumstances: for cases in the legacy system, you need to enter the correct alternate format code on the CMS and FSMIS screens in the print (PRNT) fields. You need to enter the alternate format coding on both screens. Correct coding will allow for processing of most information in the alternate format by Central Office. However, some information must be processed at the branch level. See below. The codes can be found on the Help Window in the PRNT fields on FSUP and UCMS screens. For ONE, please refer to the ETOP: Alternate Format Request. The requestor should not have to make a request every time they need a document in an alternate format. Once coded the requestor should receive all ODHS|OHA documents in the appropriate format.

We currently have all of the forms available in large print on the Forms Server. If any form is needed in audio tape format, in Braille, or on computer disk, contact the Forms Unit in Central Office by email: DHS FORMS or facsimile at 503-373-7690, using the Alternate Format Request Fax Sheet.

If a core form is needed in a format other than Braille, audio tape or computer disk, follow the instructions below on processing alternate format requests.

Notice Writer/CMS/FSMIS

For cases that still reside in the legacy systems, this category covers most ODHS|OHA notices sent to applicants and individuals. If the correct code is entered into the print (PRNT) fields on CMS and FSMIS, these notices are automatically processed in the requested alternate format (except oral presentation) and mailed directly to the individual. If the individual is coded for oral presentation, the Forms Unit will forward the document to the appropriate staff for processing. The staff should document in the case narrative all attempts to contact the individual regarding the document, e.g., date of telephone call and staff's initials, and when and how contact is

made, e.g., date of person-to-person contact or message left on answering machine, and the staff's initials. If no presentation can be made within a reasonable time given the content of the notice, the staff should contact the Forms Unit in Central Office by facsimile at 503-373-7690 using the Alternate Format Request Fax Sheet to request that the document be place on audio tape and sent to the individual. If you are unclear what a reasonable time is in the situation, contact your operations manager.

Other

(E.g., local branch-created notices and documents)

There might be some documents created by the branch that are neither processed through the ODHS mainframe nor sent out by ODHS Forms and Distribution Unit and that are not core forms. One example is a form created and used by only one branch or district, or a letter drafted by staff and sent to the individual. Any such notices and documents must be processed manually by the branch and a notation placed in the case narrative identifying the document processed, the alternate format used, the date, and the staff processing or requesting process of the document. For example, "Ltr re: _____, LP (large print), 2/10/99, S. Iverson" or "MSC Form 415, DC (Computer Diskette), 2/10/99, rqst to D. Zeit (Central Office) by S. Iverson."

Requests for documents to be put in Braille or audio tape should be faxed to Central Office Forms Unit at 503-373-7690, using the Alternate Format Request Fax Sheet.

Documents to be put in large print should be processed by the branch either by enlarging the notice on the copy machine or by changing the font on the computer before printing to at least 16 point or 129 percent enlargement.

Branch or district documents to be put on computer disk should be processed by the branch in the version, e.g., ASCII, WordPerfect, MS Word, which is available at the branch. If the version needed by the individual is not available, and other formats have been explored with the individual, e.g., audio tape, oral presentation, etc., and found not to be effective, contact your operations manager for guidance.

Oral presentations of a document are the responsibility of staff. The staff should document in the case narrative all attempts to contact the individual regarding the document, e.g., date of telephone call and staff's initials, and when and how contact is made, e.g., date of person-to-person contact or message left on answering machine, and the staff's initials. If no oral presentation can be made within a reasonable time given the content of the notice, the staff should contact the Forms Unit in Central Office by facsimile at 503-373-7690 using the Alternate Format Request Fax Sheet and ask that the document be placed on audio tape and sent to the individual.

Interpreters and translations

ODHS|OHA prohibits discrimination on the basis of age, race, color, national origin, gender, religion, political beliefs, disability, sexual orientation and marital status. Some of this is also included in the Civil Rights Act of 1964. This act requires that services and benefits be provided in a consistent manner to all individuals. No person shall be denied an opportunity to participate in a program administered by ODHS|OHA because of their age, race, color, national origin, gender, religion, political beliefs, disability, sexual orientation and marital status. For more information, see https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/de0025.pdf.

Deaf and Hard of Hearing Services Program (ODHHS)

The ODHS-wide policy for Scheduling a Sign Language Interpreter/Real-Time Captioner (DHS-010-005-02) can be found at http://www.DHS.state.or.us/policy/admin/exec/010_005_02.htm.

Note: The faxed format is no longer available form ODHHS.

Use the Communication Service Request On-line Interpreter/Real-Time Captioner Request form. This is a Web-based form that is completed and submitted online (http://www.oregon.gov/DHS/BUSINESS-SERVICES/ODHHS/Pages/ECS.aspx).

Guidelines for staff who work with limited-English-speaking, hearing-impaired or blind individuals

In Oregon, you do not have to speak English, have good hearing or be sighted to apply for public assistance programs. The agency is responsible for ensuring a limited-English-speaking individual is communicated with in words they understand. (A limited-English-speaking household is one that does not have an adult member who is fluent in English.) The agency is also responsible for ensuring that individuals who have difficulty hearing or seeing are communicated with in a way they understand.

Oregon's confidentiality regulations apply to all individuals. Friends and family members of limited-English-speaking, hearing-impaired and blind individuals should have no more involvement in the individual's case than do friends and family members of English-speaking individuals, or individuals who are not hearing-impaired or blind.

The program delivery requirements for limited-English-speaking individuals and hearing-impaired and blind individuals are equal to those for English-speaking individuals. ODHSIOHA programs are accessible to all individuals and meet individual needs.

When a branch office has a caseload of 35 or more limited-English-speaking households that all speak the same foreign language, all forms and notices will be translated into that language (if they have not already been translated into that language). All branch offices with individuals who speak a language for which forms and notices have been translated must then provide forms, notices, and other documents in that foreign language.

All limited-English-speaking, hearing-impaired and blind individuals are entitled to oral or sign language interpretation services when they apply for or receive benefits from ODHS. Branches that meet the 35 or more standard described in part (4) above must also provide help through a bilingual worker.

Ask the individual which language they prefer to speak. If their preference is other than English, inform the individual at intake that they will be assigned bilingual staff member or an interpreter will be provided.

Friends and family members should not be used as interpreters because this violates the individual's right to privacy, and because ODHS cannot be assured of the accuracy of such translations.

If an individual refuses to use ODHS's interpreter, record the reason for the refusal in the case record. Always record who provided the interpretation each time an interpreter is used (unless the case has been assigned to a bilingual worker).

Remember to talk to the individual and not the interpreter. The individual will be answering all of the questions and

making all of the decisions.

When an individual completes a form with the help of an interpreter, both the worker and the interpreter should initial the form. Documenting this information is important if there should be a hearing or lawsuit at a later date.

Responsibilities of employees listed in the Interpretation Services Directory

To be listed in the Interpretation Services Directory, you must speak and understand the individual's language, also understand English, and be able to clearly present policy in the individual's language. If you are a sign language interpreter, you must be able to clearly present policy in sign language.

Bilingual staff and staff who can communicate in sign language will do a self-assessment of their foreign language or signing skills. They will be asked to sign the self-assessment form attesting to its accuracy. The self-assessment will be verified by the operations manager.

A staff person acting as interpreter has a passive role in the process of assisting workers and individuals. Their function is to translate word for word, or in words or signs that are as close as possible to the speaker's intended meaning. This is unlike a bilingual staff assigned full responsibility for a case, who will actively converse with the individual in the individual's language.

Interpreters provide a professional service to individuals that must be taken seriously. Interpreters are to work with individuals in ways that do not lead the individual to become overly dependent on their help.

Occasionally, staff will be called upon to act as interpreters for individuals being served by other branches. These services will usually be provided by telephone.

On rare occasions, staff will provide interpretation services to individuals who are being served by other agencies or providers. This will happen when the situation is considered urgent and other resources are not available. This type of service should also be approved by the operations manager or their delegate. In these cases, services will generally be provided by telephone.

ODHS will not "loan" staff to doctors, hospitals or the court system for use as medical or legal interpreters. These situations require special skills that ODHS|OHA staff are not expected to use in the routine performance of their job as interpreters. Additionally, there would be tort liability risks for the agency if ODHS|OHA staff were used as medical or legal interpreters.

ODHS|OHA staff giving services to limited-English-speaking or hearing-impaired individuals will ensure that these individuals receive information and services as quickly as would normally be received by English-speaking individuals and individuals who are not hearing-impaired. Our goal is to serve all individuals within the same timeframes.

Responsibilities of managers who supervise employees listed in the Interpretation Services Directory

- Review the self-assessment form of each bilingual employee and each employee with sign language skills. Ensure the accuracy of the self-assessment through discussion with the supervisor or employee as necessary. If you or the employee's supervisor are not fluent in the foreign language of the bilingual staff person, or are not fluent in sign language, take appropriate steps to verify the skill level of the employee.

This could take the form of identifying someone in the community with those skills and having them verify the staff person's level of competency. When a disagreement occurs between the level of competency the bilingual staff claims and the level of competency documented by the person doing the verification, the interpretation staff and operations manager will meet to resolve the discrepancy.

- Send a copy of the Interpretation Assessment Form to ODHS Administrative Services Unit when a new bilingual employee or an employee with sign language skills is hired. Send the copy after you have signed the Interpretation Assessment Form attesting to the employee's skill level.
- Ensure that an employee who is listed in the Interpretation Services Directory will be available to provide interpretation services at the skill-level indicated.
- Make decisions about bilingual and sign language staff availability and the type and extent of interpretation services to be provided.
- Use judgment about the level of interpretation skill needed to meet the individual's needs. If a individual's situation is complex, avoid using a low-skill-level interpreter. If a low-skill-level interpreter is used, explain to the individual that the interpreter is being used only to obtain basic information and to answer simple questions until someone with a higher skill level is available.
- Provide each employee at their annual review a copy of the Interpretation Assessment Form. Verify any new information provided on the evaluation forms and send a copy of the verified Interpretation Assessment Form to ODHS Administrative Services Unit.
- Ensure that individuals are informed at intake that an interpreter is available if they prefer to speak in a language other than English.
- Ensure that contacts and services are provided to limited-English-speaking and hearing-impaired persons within the same timeframes as English-speaking persons and persons who are not hearing impaired.

Procedures for branches where there are no bilingual or sign language staff

Use the Communication Service Request Interpreter/Real-Time Captioner Request form (https://www.oregon.gov/DHS/BUSINESS-SERVICES/ODHHS/Pages/ECS.aspx) to request communication services for individuals and/or individuals who are deaf or hard of hearing and require these services to participate in meetings, trainings, or other appointments. The email for Communication Services is request.odhhsp@dhsoha.state.or.us.

For all information related to bilingual or sign language assistance, see this link: Service Guide for language Access.

Citizen/non-citizen status

This worker guide includes definitions of terms used in citizen/non-citizen policy, and it gives information about the U.S. Citizenship and Immigration Services (USCIS) documents shown on the non-citizens charts.

Definitions

Amerasians: People who were born between 1/1/62 and 1/1/76 in Vietnam, who have an American father and a Vietnamese mother. Amerasians may enter the U.S. either as documented non-citizens or as citizens. If they apply for benefits within eight months of the date stamped on their entrant papers, they may be eligible for REF.

Amnesty Non-citizen: A non-citizen who was here illegally but obtained Temporary Resident legal status after

Congress passed a new immigration law entitled "Immigration Reform and Control Act of 1986." The non-citizen must apply for Temporary Resident status through USCIS.

Battered and subjected to extreme cruelty: An individual has been battered or subjected to extreme cruelty if the individual has been subjected to – I. physical acts that resulted in, or threatened to result in, physical injury to the individual; II. Sexual abuse; III. Sexual activity involving a dependent child; IV. Being forced as the caretaker relative of a dependent child to engage in nonconsensual sexual acts or activities; V. threats of, or attempts at, physical or sexual abuse; VI. Mental abuse; or VII. Neglect or deprivation of medical care. Based on federal regulations, if the person has been approved or has anI-360 self-petition pending which sets forth a prima facie case, the person meets qualified non-citizen status.

Citizenship Waived Emergent Medical (CWM): Emergency Medicaid for non-citizens who have a life- threatening need for medical help. To be eligible for CWM, a person must meet all the eligibility requirements of any medical program except for citizen/non-citizen status.

Deportation being withheld (DBW): Similar to asylee status, this category is for people whose lives or freedom would be threatened by a return to their home county. This non-citizen status includes eligibility for work authorization.

Immigration and Nationality Act (INA): The basic immigration law.

Immigration and Naturalization Service (INS): See USCIS.

Immigration Reform and Control Act (IRCA): In 1986, Congress passed the Immigration Reform and Control Act. This act allowed non-citizens who were currently residing in the United States to apply for legalization without the threat of deportation.

Immigrants: People who have been admitted to the United States for permanent residence and have the option of becoming naturalized citizens after five years of permanent resident status. This category includes some Amerasians.

Non-citizen: A person who is not a citizen of the United States.

Non-immigrants: People who enter the United States on non-immigrant visas. These people are admitted for specific purposes and limited periods of time. They include tourists, students, visitors, temporary workers, investors, dignitaries, etc.

Parolees: People not otherwise admissible who are sometimes granted entry into the U.S. at the discretion of the United States Attorney General.

Persons residing under color of law (PRUCOL): People who are known to the USCIS and who the USCIS has no intention of deporting.

Refugees/Asylees: People admitted because of a well-founded fear of persecution in their homeland due to race, religion or political opinion, as determined by USCIS.

1/1/82 Residents: Non-citizens who are being considered for amnesty under IRCA. These are non-citizens who were not previously lawfully admitted for residency but have proven to the USCIS that they have resided continuously in the United States since 1/1/82.

Special or seasonal agricultural workers (SAWs): Non-citizens who are being considered for amnesty under IRCA. These non-citizens have proven to the USCIS that they have performed seasonal agricultural services in the United States for the specific period of time established by the USCIS.

Undocumented non-citizen: A person who has overstayed a non-immigrant visa or who has entered the United States without inspection or valid immigration documents.

United States Citizenship and Immigration Services (USCIS): An agency within the United States Department of Homeland Security that is responsible for enforcing the immigration laws that set the conditions of admission and the duration of the stay for all non-citizens. The USCIS issues the appropriate documentation to those who enter the country legally.

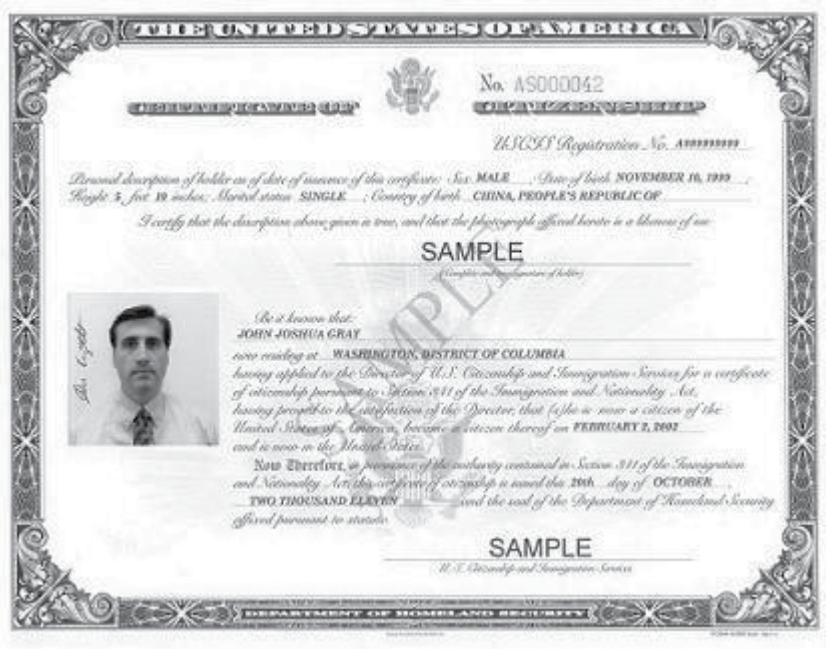
Citizenship

United States citizens are:

- A person born in the U.S; A naturalized citizen;
- A naturalized citizen;
- A person born outside of the U.S. but whose parents (both mother and father) are U.S. citizens;
- A person born outside of the U.S. who is over 18 years of age but who has at least one parent who is a U.S. citizen. The person must either have a certificate of U.S. citizenship or meet one of the following criteria:
  - Born on or after 12/24/52 and prior to 11/14/86, and their citizen parent was physically present in the U.S. or its outlying possessions for 10 years or more, at least five of which were after age 14;
  - Born on or after 11/14/86, and their citizen parent was physically present in the U.S. or its outlying possessions five years or more, at least two of which were after age 14.
- A child born outside of the U.S. who is under 18 years of age and has at least one parent who is a U.S. citizen. The child is residing in the U.S. in the legal and physical custody of the citizen parent after having been lawfully admitted into the U.S. as an immigrant for lawful permanent residence;
- A child lawfully adopted by U.S. citizens;
- A citizen of Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands (Saipan, Tinian, Rota and Pagan), American Samoa and the Swains Islands.

Long-time residence in the U.S. or marriage to a U.S. citizen do not by themselves confer citizenship on a non-citizens.

Although there have been many different revisions of the CERTIFICATE OF NATURALIZATION, there are two common versions. The present version has a green color background design and contains a gold embossed Great Seal of the United States in the top center portion. Earlier versions were gray or beige and did not contain the embossed seal. Regardless, all certificates of naturalization are printed on watermarked paper. The watermark design of the Department of Justice seal and the letters “USA” becomes visible when the document is held up to a strong light.



United States passport

AA UNITED STATES PASSPORT is a document that is issued by the State Department to persons who have established that they are citizens of the United States, whether it is by birth, naturalization or derivation. The primary purpose of the passport is to facilitate travel to foreign countries by establishing U.S. citizenship and acting as a vehicle to display any appropriate visas and/or entry/exit stamps that may be necessary.

Passports are also very reliable documents which may be used within the United States to establish citizenship, identity and employment authorization.

Note: There are approximately 15 different versions of the U.S. passport that are presently valid which vary from the 1994 version illustrated above.

Permanently residing under color of law (PRUCOL)

- Persons permanently residing under color of law are those who USCIS is aware of and has no intention of deporting. Persons residing under color of law do not meet non-citizens status for any self-sufficiency program.
- Citizens of the Federated States of Micronesia (Kosrae, Truk, Yap, Ponape), Republic of Palau and the Marshall

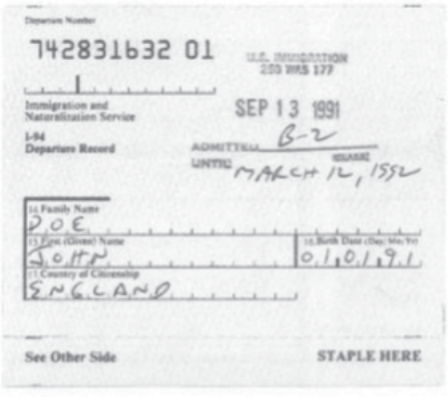
Islands (Republic of Bikini, Eniwetok and Kwajalein) are considered PRUCOL due to a Compact of Free Association. They are not required to have a visa/passport to travel between their country and the United States, but they may have an I-94 coded "CFA/FSM" or "CFA/MIS."

- Non-citizens s paroled into the United States under the Persian Gulf Evacuation Program.
- Non-citizens who are applying for admission to the United States may be considered PRUCOL while their application is being processed.
- Documentation of PRUCOL includes:
  - I-94 card coded "CFA/FSM" or "CFA/MIS."
  - Birth certificate.
  - Passport.
  - Visa.
  - Correspondence from USCIS .
  - I-94 or passport with designation of "Humanitarian," "Persian Gulf Evacuee" or "Hostage."
  - I-94 or other official USCIS documentation showing that the non-citizen:
    - » Has been granted indefinite voluntary departure status; or
    - » Has been granted an indefinite stay of deportation; or
    - » Is not under direct order or deportation; or
    - » Is awaiting a permanent residence visa.

INS form I-94

"Arrival-Departure Record"

When a non-citizen has been granted admission into the U.S. by an Immigration inspector at an authorized Port of Entry, he/she will be issued an I-94, ARRIVAL/DEPARTURE RECORD, which is stapled to a page in the passport. This document will explain how long the bearer may remain and the terms of admission.



I-94

- There are several versions of the I-94 card, and the type of card the non-citizen has will depend on where it

was issued (e.g., immigration office, Port of Entry, Processing Center);

- The I-94 card shows the immigration law under which the non-citizen entered the U.S. This will be indicated in the endorsement area;
- The following are some examples of section numbers of the immigration laws that appear on the I-94. Use the appropriate policy and/or the chart on Citizenship/Non-citizen Documents for specific section numbers for each program:
  - Section 207, Section 207(c), Section 203(a)(7), Section 249, Section 212(d)(5), Section 208, Section 101(a)(15), Section 243, Section 101(a)(20), Section 243(h)

The card may also show a duration-of-stay date and authorization. This information will also be indicated in the card's endorsement area.

Immigrants

Immigrants applying for benefits must obtain the I-94 card from USCIS. The card will be printed or stamped with the message:

Processed for I-551 Card
Temporary evidence of lawful admission for permanent residence
Valid until (date)
Employment Authorized

Refugees/asylees

For refugees/asylees, wording similar to the following will be printed or stamped on the I-94:

- Refugee pursuant to Section (number)
- Employment Authorized

A duration date is never entered because refugees and asylees generally stay in the U.S. indefinitely.

Parolees

For parolees or certain conditional entrants, wording similar to the following will be printed or stamped on the I-94:

- Paroled pursuant to
- Section (number) of the I & N Act to (a date or the word "indefinitely")
- Employment Authorized

Non-immigrants

Non-immigrants are ineligible for cash benefits and SNAP. For non-immigrants (tourists, students, dignitaries, etc.) wording similar to the following will be stamped on the I-94:

- U.S. Immigration 250 (date)
- Admitted (alphabet letter A-L and a one-digit number: for example, "B-1")
- Until (date)

Employment for non-immigrants is generally not authorized. If authorized, it will be included on the card in the stamped information, except for those cards coded with the letter "K." For those with the "K," employment is always automatically authorized.

Amerasians

For Amerasians, wording similar to the following will be printed or stamped on the I-94:

- Processed for I-551
- Temporary evidence of lawful admission for permanent residence
- Valid until (date)
- Employment Authorized

The back of the I-94 arrival card will be stamped with an admissions stamp and coded either AM1, AM2 or AM3. These codes identify the non-citizen as an Amerasian and mean the non-citizen has refugee status. Eligibility is generally through the Refugee Program.

Cuban/Haitian Entrants

Consider the non-citizen status requirement to be met for those Cuban/Haitian entrants who:

(a) Entered the U.S. between April 20 and June 19, 1980; and

(b) Have an I-94 or I-94S card stamped:

"*Cuban/Haitian Entrants (status pending). Reviewable January 15, 1981.*"

The I-94S is a pink and white laminated card containing both a photo and fingerprint. The card has been or is being reissued to all Cuban/Haitian entrants who possess I-94 cards.

I-94 marked "S-9"

An I-94 marked "S-9" is issued to the non-citizen when the application process is started outside of the United States for adjustment of status under the Special Agricultural Workers (SAWs) section of IRCA. The I-94 gives work authorization and is valid for 90 days. By that time, the non-citizen should have filed a complete I-700 (SAW) application at an immigration office. The expiration date is noted on the face of the document. The effective date on this document is not the date temporary residence is effective. Temporary residence is effective when the individual files their application at an immigration office.

I-94 marked "CFA/MIS"

An I-94 marked "CFA/MIS" is issued to citizens of the Marshall Islands. Holders of this card are considered persons residing under color of law (PRUCOL).

I-94 marked "CFA/FSM"

An I-94 marked "CFA/FSM" is issued to citizens of the Federated States of Micronesia. Holders of this card are considered persons residing under color of law (PRUCOL).

North American Indians

For North American Indians, wording similar to the following will be printed or stamped on the I-94:

- Processed for I-551
- Temporary evidence of lawful admission for permanent residence. Valid until (date)
- Employment Authorized
- Port of Entry
- (Date) of entry
- Classification (code)

Other documentation

Permanent Resident Card

The PERMANENT RESIDENT CARD, Form I-551, was introduced December 1997. Noticeable differences on the front of the card include: Change of card title from RESIDENT ALIEN CARD to PERMANENT RESIDENT CARD, three line machine readable zone and a hologram.

The Optical Memory Stripe contains encoded cardholder information as well as a personalized etching which depicts the bearer's photo, name, signature, date of birth, alien registration number, card expiration date and card number.

The RESIDENT ALIEN CARD, Form I-551, was revised in August 1989. This version was the first Alien Registration Card to contain an expiration date on every card. Usually, it is valid for 10 years from date of issue. The expiration date indicates when the card expires and must be renewed. It does not indicate that the non-citizen's status has expired. The card was modified in January 1992 when a white box was added behind the fingerprint.

The modified version is the card currently being issued.

Form I-551 (January 1992)

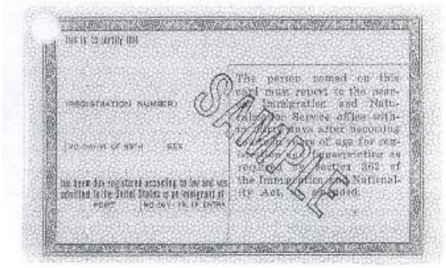
The RESIDENT ALIEN CARD, Form I-551, was introduced in January 1977 and phased in over a period of time. In addition to the photograph, the I-551 will contain the bearer's signature and fingerprint.

Form I-551

Alien Registration Receipt Cards

USCIS Forms I-151 and I-551, are issued to non-citizens who have been granted permanent resident status in the United States. They retain this status while in this country. The bearer is required to have this card in his/her possession at all times.

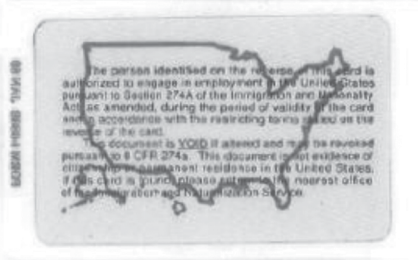
The first ALIEN REGISTRATION RECEIPT CARD, Form I-151, was introduced in 1946. Through 18 years of various revisions, it remained primarily green in color causing it to become known as a "green card". This term is still commonly used today although the cards have not been "green" since 1964. These cards contained no expiration date and were only required to be renewed if the recipient was under the age of 14 at the time of issuance, or if the card was lost or stolen.



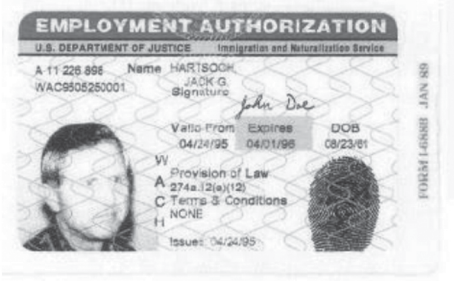
Note: As of March 20, 1996, the above form I-151 is no longer acceptable as evidence of permanent residence.

Employment Authorization Document

This EMPLOYMENT AUTHORIZATION DOCUMENT, Form I-688B, is issued to non-citizens who are not permanent residents but have been granted permission to be employed in the U.S. for a specific period of time. The card originally was produced with a Polaroid process similar to the I-688 and I-688A, but has the added feature of interlocking gold lines across the front.



In May 1995, some INS (currently USCIS) offices began issuing a modified I-688B. The most significant change was to the card stock which was changed from the Polaroid process to a synthetic material called Teslin on which the biometric and biographic data of the bearer are printed. Note that on this version, the name is printed on two lines.



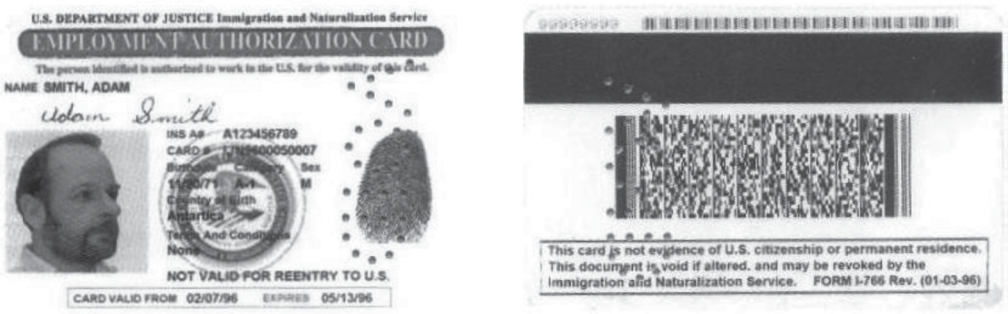
Form I-688B (May 1995)

In August 1995 changes were made to the software which prints the I-688Bs and the name reverted to the one line format similar to the original card.

Form I-688B (August 1995)

In January 1997, INS (currently USCIS) began issuing a new EMPLOYMENT AUTHORIZATION DOCUMENT, Form I-766. The new card is a credit card type of document. The front of the card contains a photo, fingerprint and signature of the rightful holder. The reverse contains a standard bar code, magnetic strip and a two-dimensional

bar code which will contain unique card, biographic and biometric data.

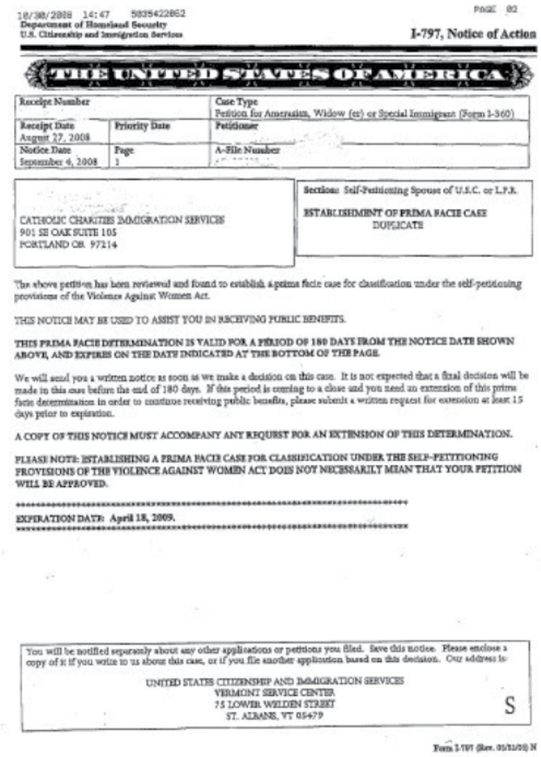


Form I-766 (January 1997)

Documentation required when a person meets qualified non-citizens status as a person who has been Battered or Subjected to Extreme Cruelty.

Documentation of a prima facie status or approved petition includes an I-707, Notice of Action that specifically states that the non-citizen is a: I-360 Self-petitioning spouse/child of USC (U.S. Citizen) or LPR (Legal Permanent Resident). The original notice of action will show an “Establishment of Prima Facie Case.” The status is valid for a period of 180 days from the date of the notice. An expiration date is given on the bottom of the notice. An I-797 may also indicate an “Extension of Prima Facie Case” with a new expiration date. An I-797, like the DHS 456,

is a decision notice. It can be used for other information that is provided to immigrants by immigration services. Only the I-797 with the specific information about the prima facie case or an approved I-et0 petition would be considered documentation.

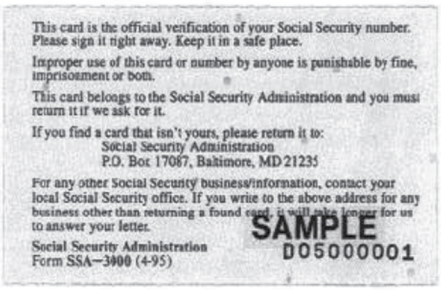


Social Security Cards

Although SOCIAL SECURITY CARDS are not immigration documents, they are mentioned here because they are often used as identification and to establish employment authorization.

Social Security cards have been issued since 1936 and have been revised more than 20 times. Originally, the seal on the social security card read Department of Health, Education and Welfare. In May 1980, it was changed to the Department of Health and Human Services. In April 1995, it was changed again to read Social Security Administration. Some counterfeiters have failed to notice these changes.

In October 1983, security features were added to the card. All social security cards issued since October 1983 have been printed with raised (intaglio) printing and the signature line consists of microline printing of the words "SOCIAL SECURITY ADMINISTRATION" in a repeating pattern.



The first three digits of the social security number indicate the state in which the card was issued:

Number	Issuing State	Number	Issuing State
001-003	New Hampshire	516-517	Montana
004-007	Maine	518-519	Idaho
008-009	Vermont	520	Wyoming
010-034	Massachusetts	521-524	Colorado
035-039	Rhode Island	525	New Mexico
040-049	Connecticut	526-527	Arizona
050-134	New York	528-529	Utah
135-158	New Jersey	530	Nevada
159-211	Pennsylvania	531-539	Washington
212-220	Maryland	540-544	Oregon
221-222	Delaware	545-573	California
223-231	Virginia	574	Alaska
232	North Carolina	575-576	Hawaii

233-236	West Virginia	577-579	Dist. Columbia
237-246	North Carolina	580-584	Puerto Rico/VI
247-251	South Carolina	585	New Mexico
252-260	Georgia	586	Am. Samoa/Guam
261-267	Florida	587-588	Mississippi
268-302	Ohio	589-595	Florida
303-317	Indiana	596-599	Puerto Rico
318-361	Illinois	600-601	Arizona
362-386	Michigan	602-626	California
387-399	Wisconsin	627-645	Texas
400-407	Kentucky	646-647	Utah
408-415	Tennessee	648-649	New Mexico
416-424	Alabama	650-653	Colorado
425-428	Mississippi	654-658	South Carolina
429-432	Arkansas	659-665	Louisiana
433-439	Louisiana	667-675	Georgia
440-448	Oklahoma	676-679	Arkansas
449-467	Texas	680	Nevada
468-477	Minnesota	681-690	North Carolina
478-485	Iowa	691-699	Virginia
486-500	Missouri	750-751	Hawaii
501-502	North Dakota	752-755	Mississippi
503-504	South Dakota	756-763	Tennessee
505-508	Nebraska	764-765	Arizona
509-515	Kansas	766-772	Florida

Hearings guide

What hearings are

A hearing is a formal proceeding about individual benefits when the individual has filed a hearing request and disputed a decision made by branch staff. The hearings process provides a "second look" to ensure that the benefit or overpayment decisions are correct. Hearings are also held to resolve other issues (see Individuals have a right to hearings). Administrative Law judges from the Office of Administrative Hearings (OAH) preside over each hearing, and ODHS|OHA's position in the hearing is explained by the ODHS|OHA representative, usually a Compliance Specialist (Hearing Rep). The hearing is conducted in accordance with state statutes (ORS 183.413 and following) and the administrative rules for hearings of ODHS|OHA and OAH. ODHS|OHA's rules are at OAR 461-025-0300 and following. The OAH rules are at OAR 137-003-0501 and following.

Individuals have a right to hearings

Individuals are given the right to a hearing by the U. S. Constitution, federal law, state statute and ODHS|OHA's administrative rules (see OAR 461-025-0310 for a list of nearly all situations in which a person has a right to a

hearing). Most but not all hearings are requested after an individual has received a notice that benefits will be denied, reduced, or closed. A person also has a right to a hearing when they dispute the level of benefits that have been approved, the effective date that their benefits began, when ODHS|OHA claims an overpayment, when it denies a listing requested by a child care provider or Home Care Worker (HCW), and when ODHS|OHA claims the individual committed an intentional program violation (IPV). See OAR 461-025-0316 for information on IPV hearing requests.

Resolving disputes

Many cases can be resolved informally, prior to the hearing, when staff explain the situation to the individual and review the policy that was used to make the decision in question. Hearing Reps often use informal conferences to resolve cases. When a case is resolved informally following a hearing request, specific steps must be taken (see below).

How staff become involved

Hearing Reps represent ODHS|OHA in most hearings, but staff will be responsible for some parts of the process. For instance, reviewing for expedited hearing criteriaExpedited hearings are is usually handled by designated staff (HSS4/HSS3 Lead/Community Resource Coordinator), see Expedited hearings below for more information. All staff need to be alert to an individual's need for translated material, for documents in alternative format, and for an interpreter. The Office of Administrative Hearings obtains interpreters for hearings. ODHS|OHA staff continue to work as appropriate with an individual who has requested a hearing, following applicable rules including those on individual confidentiality.

Before the hearing: Staff may become involved when an individual wants to request a hearing. The Administrative Hearing Request MSC 443 form is used to request a hearing. For SNAP and Medical programs, hearings may be requested orally or in writing, without the use of a specific form.

Staff should assist an individual in completing a hearing request as necessary, for instance by providing the individual the correct form, accepting a written request, or responding to an oral request as appropriate. For SNAP and Medical programs, where individuals may request a hearing orally, staff must complete the MSC 443 for that individual.

- When an individual makes an oral request for a SNAP or Medical hearing, staff should fill out the form completely, with the exception of the individual signature. Enter the date of the oral request in the boxes for both the "date of initial request" and the "date 443 received by ODHS or OHA." Forward the completed form to Central Office within 24 hours of the date the hearing was requested, as described below, and send a courtesy copy to the individual. Do not delay SNAP or Medical hearing requests by sending the individual a form to sign and return. A signed request is not required for SNAP and Medical programs;
- When an individual makes an oral request for a hearing in a program other than SNAP or Medical, mail or give the individual a blank MSC 443 form. Do not establish the Date of Request until a completed and signed MSC 443 is received by ODHS|OHA. When mailing the blank Form MSC 443, it is helpful if staff first complete the top line with the exception of the "date received" box (complete the "date of notice," "program," "cost center/ branch #," "case number" and "worker id" boxes);
- When an individual makes an oral request for a hearing for SNAP or Medical, along with one or more other

programs, fill out a completed MSC 443 for SNAP or Medical and process as described in this section. Send the individual both a courtesy copy of the completed MSC 443 and a blank form to fill out for other programs and submit the MSC 443 to Central Office for the SNAP or Medical request within 24 hours of the date the hearing was requested. When mailing the blank Form MSC 443, it is helpful if branch staff first complete the top line with the exception of the "date received" box (complete the "date of notice," "program," "cost center/ branch #," "case number" and "worker id" boxes).

Upon receipt of the completed MSC 443, review for Expedited criteria and Continuing Benefits (formerly known as Aid Paid Pending) requests, as follows (narrate all action in ONE):

Overrides

Describes the purpose, functionality, and use case for conducting an override. Includes a list of common situations that may justify an override. Provides steps for how to process an override. * * includes screenshots

Expedited

For all programs except non-MAGI, review the MSC 447 page 3,to determine if the request meets Expedited criteria. If Expedited criteria is met, the 443 must be submitted to SSP Hearings Unit via the CAF Hearings email address right away, as the hearing must be held within five days. The 443 will be assigned to a hearings representative , who will schedule and conduct the Expedited hearing. For non-MAGI, submit the MSC 443 to the appropriate hearings unit for determination and resolution.

If the claimant does not meet expedited criteria (see form 447, Part 3 – Can I have an expedited hearing?), their request is denied. When their request for expedited hearing is denied, the designated staff (HSS4/ Lead/Community Resource Coordinator), sends the denial notice, form 1115, located on the forms server. Follow the normal submission process to CAF Hearings.

Continuing Benefits (COB)

A lead worker or point person should review and determine eligibility according to OAR 461-025-0311. When eligible, benefits should be issued without unnecessary delay to the individual. A lead worker or case worker may determine eligibility, issue benefits and appropriate notices as needed.

- The request for continuing benefits is usually indicated by marking the box about two thirds of the way down the MSC 443 form, and reads "Do you want your benefits to stay the same (not be reduced or stopped) while you wait for the hearing?" However, requests are not required to be made in writing, nor are they required to be indicated on the MSC 443 to be valid. Staff must respond to a request for continuing benefits whether verbal or in writing;
- When approved, issue benefits as soon as possible, and send a Request for Continuing Benefits form (DHS 1114). When denied, send a Denial of Continuing Benefits Pending Hearing Decision form (DHS 5303) form (or NOTM form GS05303). The claimant has the right to request a hearing if denied, which must be processed as an Expedited Hearing. (See back of form DHS 5303 or MSC 443);
- The branch may contact their local Hearing Representative for assistance in this process.

All completed MSC 443 forms must be submitted upon receipt (same day/next day) as follows (narrate action in ONE):

- For Self-Sufficiency hearing requests – by email to CAF Hearings or by fax to 503-373-7492, along with the CAF-SSP Hearing Request Cover Sheet (DHS 443C). This is required even for those resolved at the local level, or for those being handled as Expedited. Please be sure to indicate this accordingly on the DHS 443C form;
- For HSD medical programs only – to CAF Hearings CAF.Hearings@dhsoha.state.or.us (Expedited and COB review not needed);
- For HSD medical service or procedure – to OHA Medical OHAMedical.Hearings@dhsoha.state.or.us (Expedited and COB review not needed).
- For APD Non-MAGI programs – Scan both pages (front and back) of the DHS 443 including the page about hearing rights, all pages of the notices issued that pertain to the hearing request, and email them to apd.hearings@state.or.us within 24-hours of receipt (same day when possible) using the APD hearing referral sheet. The cover sheet requires the names, phone numbers and email addresses of contact person, supervisor and program manager. The cover sheet also requires an explanation of why there is no notice attached, if there is no notice included with the 443. Hearings requests should NOT be sent directly to a hearing representative (Expedited and COB review not needed).

While some requests can be quickly resolved without a hearing, ODHS|OHA must comply with required processes and document its compliance. Even when resolved at local level an authorized Hearing Rep (or designated district point person for Expedited) must issue a dismissal order. When ODHS|OHA becomes aware that an individual has legal representation for the hearing, ODHS|OHA must involve the legal representative for the duration of the process. This includes sending the legal representative copies of decision notices and amended decision notices sent to the individual. Staff may be asked to testify at the hearing, provide assistance in assembling information needed for the hearing, and take care of some aspects of the prehearing process, such as making a room available for an informal prehearing conference and directing the individual and individual representative to this room.

During the hearing: Most hearings are conducted by telephone and handled by a Hearing Representative, though staff are occasionally asked to provide support or testimony in certain types of hearings. The individual may contact ODHS|OHA and request to use the office for the telephone hearing. Staff may assist by making a room available for the hearing and directing the individual, the individual's representative and witnesses to the hearing room. The participants may need a speaker phone with conferencing capability or a personal computer during the hearing.

After the hearing: Many individuals have an ongoing relationship with the agency during and after a hearing, and ODHS|OHA continues to serve them while some issues are being resolved through the hearing process. The final order issued after a hearing is sent to the ODHS|OHA representative and to the office so that appropriate action can be taken. If it is not clear to staff what action to take, the Hearing Representative can assist.

Individual's right to expedited hearings

Individuals have the right to expedited hearings in several situations. See OAR 461-025-0315 regarding these situations. ODHS|OHA is required to offer an expedited hearing when:

- The claimant's request for EA or TA-DVS is denied, ODHS|OHA fails to issue a timely decision on the request for EA or TA-DVS, or the claimant disputes the form or amount of an EA or TA-DVS payment.
- The claimant's request for continuation of benefits pending a hearing on the reduction, suspension or termination of public assistance or medical is denied.

- The claimant's request for expedited SNAP or DSNAP service is denied, or the claimant is aggrieved by an action of ODHS|OHA that affects the expedited participation of the household in the SNAP program.
- The claimant is denied a support services payment in the JOBS program or a payment for basic living expenses in the Pre-TANF Program (see OAR 461-135-0475).
- ODHS|OHA closes or reduces an ongoing JOBS support service payment.
- ODHS|OHA failed to issue a JOBS support service payment within specified timeframes.
- For OSIPM and MSPs, when following the final order timeline could jeopardize the individual's life, health, or ability to attain, maintain, or regain maximum function.
- A individual may have the right to an expedited medical hearing when the individual believes their medical or dental problem cannot wait for the normal review process. This type of hearing is handled by DMAP. See OAR 410-141-0265 regarding expedited medical hearings.

Retention of regular and expedited hearing files

Initial retention in a readily accessible location

Any staff responsible for a regular or an Expedited hearing must retain at a readily accessible location all hearing-related records and written communications for at least 90 days after the case closes.

Note: The earliest a case is considered closed for purposes of retention is the date of the final order or dismissal order issued by ODHS|OHA or by the Office of Administrative Hearings; but if there is a request for reconsideration or rehearing or an appeal, hold onto the file for at least 90 days after those matters close.

Long-term retention requirements

When the Office of Administrative Hearings has issued the final order in a case, the OAH file is the official hearing file. Any staff responsible for a regular or an expedited hearing must add the hearing request, any amended decision notices, the contested case notice, DHS Form 1114, Approving Continuing Benefits (if issued), and the OAH final order to EDMS (records may be sent electronically by email to 'EDMS Help') or send hard copies to Archives as directed below.

When ODHS|OHA has issued the final or dismissal order in a case, the ODHS|OHA file is the official hearing file. Any staff responsible for a regular or an expedited hearing must arrange for long-term retention of the hearing file.

The hearing file should contain copies of the hearing request, any amended decision notices, any contested case notice and the signed ODHS|OHA order, all documents sent between any two of the following: ODHS|OHA, the claimant or claimant's representative, the Office of Administrative Hearings. The retention of these records must be for a minimum of six years. Records may be sent electronically by email to 'EDMS Help.' Or you may send hard copies to Archives as directed below. Be sure to identify records as hearing files, requiring six-year retention, and be sure to narrate action taken.

Other procedures and requirements for long-term retention

Archives Policy, ODHS Archives

ODHS Archives Procedure: Sending Records for Storage

ODHS Addendum 1, Archives Storage Process Flow Chart

ODHS Addendum 2, Archive Box Label (DHS 6625) Instructions

Form: DHS 276, Shipping Log for Closed Case Records

Form: DHS 6625, Archive Storage Label

ODHS Archives Procedure: Requesting Records from Storage

ODHS Records Archive Document Request Form

ODHS Archives Procedure: Destruction of Records in Storage

Additional guidance for authorized Hearing Representatives (Hearing Representatives and district-designated staff who handle Expedited hearings) is available on the Hearings website at: Hearing Representatives.

Identifying and budgeting self-employment income

The purpose of this worker guide is to help staff identify self- employment, determine allowable costs and budget income correctly for all programs.

Self-employment is a category of earned income. Because most programs treat self- employment differently than wages, all earned income must be identified either as self- employment or as earnings.

Per OAR 461-145-0910, except as provided below, an individual is self-employed if they:

- Are considered an independent contractor by the business that employs them; or
- Meet four or more of the following criteria:
  - Are engaged in an enterprise for the purpose of producing income. For example, the person operates under their own business name, advertises or otherwise solicits for business;
  - Are responsible for obtaining or providing a service or product by retaining control over the work or services offered. For example, the person establishes their own hours, territory and methods of work and determines what services they will offer;
  - Has principal responsibility for the success or failure of the business operation by assuming the necessary business expenses and profit or loss risks connected with the operation of the business. This could mean providing the equipment, supplies and materials needed to do a job or to produce the income; risk of loss. This is principal responsibility for their own business. If, for example, the individual is a freelance tattoo artist, we would consider their own potential for gain or loss, not that of the tattoo parlors they work in;
  - Is not required to complete an IRS W-4 form for an employer or does not have federal income tax or FICA payments withheld from a pay check;
  - Is not covered under an employer's liability insurance or workers' compensation. Many definitions of self-employment hold this as an absolute test.

For SNAP, OSIPM, and MSPs, incorporated businesses are not self-employment. For all other programs, determine if the applicant meets at least four of the self-employment criteria listed above.

The SNAP Webtools page has links to Business Registries for California, Idaho, Oregon and Washington. The registries help identify the status of a business, its address, partners, etc. Recent activity showing current status also confirms that the individual has business income records.

For all programs:

- Home care providers paid by APD are not self-employed;
- Child care providers paid by DPU, realty agents and individuals who sell plasma, redeem beverage containers, pick mushrooms for sale or similar enterprises are considered to be self-employed for income categorization purposes;

  Note: individuals who sell plasma, redeem beverage containers, pick mushrooms for sale or similar enterprises are not considered self-employed for the purposes of meeting non-financial eligibility requirement to be employed for OSIPM-EPD. See Employed Persons with Disabilities for more information.
- If a financial group member actively manages property 20 hours or more per week, it is considered self-employment. If a financial group member does not actively manage property 20 hours or more per week, the income is counted as unearned after allowing costs per OAR 461-145-0920 (usually mortgage [interest only, if not for SNAP]), property taxes and homeowner's insurance).

In most cases, determining whether an individual earns money from an employer or through their own business is relatively simple. For example, sales associates working the cash registers at Target are undoubtedly employees of the corporation. Conversely, a person who works as a gardener, advertises his work, sets his own schedule and prices and is solely responsible for all business decisions is clearly self-employed.

However, many working individuals have a balance of responsibilities and freedoms that fall between these two extremes. The next section of this worker guide will walk through several case situations, using the tests tied to the rule above to answer the question: is this person self-employed?

Income

Describes all categories of income: Earned, Self-Employment, Unearned, Unpaid, and Specific. Includes general guidance on how to enter income verification and how to verify no income. Provides instruction on updating and terminating income, and when to update, delete, or add a record. Explains the 100% Annual Income screen and the pay frequency calculation factor. Includes FAQ on income.

Examples of individual work situations

1. A married couple has incorporated their tile installation business. They select the stock, set the process, hire their own employees and determine their own business methods. They take a salary from their business.
2. A glassblower makes beads, ornaments and other decorative items on demand for a local shop owner. The owner sets the prices and puts in orders according to current need. The glassblower purchases their own supplies. They only do business with one shop. They do not have tax withholding through the business and is not covered by their employee worker comp/liability policy because they consider them an independent contractor.
3. An individual works for a tax accounting business every January through April. They travel among three of the

business's offices as scheduled, and has a desk and computer set up at each location for use. They take as many individuals as they can each day, and is paid commission of 50 percent of what individuals are charged. The business has her fill out a W-4 and covers them under their liability policy. They tell us they are self-employed because they are not contractually obligated to work only for them.

4. An exotic dancer pays weekly rental for her "station" in the club. She is paid no salary but keeps all her tips. The club provides a DJ and expects her to work a minimum of 20 hours per week. She is responsible for providing her own outfits.

Number	Tile company	Glass blower	Accountant	Exotic dancer
Work = occupation	Y		Y	Y
Control over services	Y		N	Y
Resp. success/failure	Y		N	Y
No W-4 form	Y		N	Y
No workers comp	Y		N	Y
Self-employed?	Y	Y	N	Y

Reasons for these decisions:

Tile company. The couple owns the company and has total control. *They cannot be considered self-employed for SNAP, OSIPM, or MSPs because the company is incorporated.

Glassblower. The glassblower is considered an independent contractor, so there is no need to go through the five-criteria test.

Accountant. She is covered by the business liability policy, files a W-4 and is directed by the company. She is not self-employed.

Exotic dancer. The dancer is paid nothing by the club she works in; she merely pays a fee to be allowed to work there. The club is not her employer; they provide no income, no Workers Comp, no UC, no benefits. She is free to perform in multiple clubs. Although she has to work a minimum number of hours, she sets her own schedule.

Occupations that may be/not be self-employment

Below are some examples of occupations that are usually challenging. For each of these, an example of a self-employed individual vs. an employee is given, again using the test of meeting at least four out of the five criteria.

Ministers/religious leaders

- Minister A is selected by the local Methodist church to fill their vacancy. The church provides housing, a living stipend and insurance for the minister and his family, but no salary. The church reports his compensation and covers him with the liability policy. The minister takes his other living expenses out of the love offerings (membership donations/pledges) made at the end of each service and for officiating at other ceremonies (e.g., weddings and funerals) as required.
  Decision: He is not self-employed. He meets none of the tests.
- Minister B has started his own small church. It is not affiliated with or authorized by any existing religious organization. He has total control over how he presents his theology and over the content of his

communication with parishioners. He is supported by donations, plus income from yard sales, bake sales, etc.
Decision: He is self-employed. The church and the person are one. He meets all five tests for self-employment.

Hairstylists

- Hairstylist A rents out a station in a local salon. Her station rental pays for the chair, her share of electricity, use of the salon towels, sinks, etc. She purchases all her own hair products, sets her own hours and prices, decides which services she will offer. She is not on the salon's payroll.
  Decision: Because of the costs incurred, the lack of employee status through taxes and her freedom to make decisions, she is self-employed.
- Hairstylist B works at a chain salon. She is hired for an hourly rate, plus tips. Her hours, services offered and the cost of those services are set by the company. She files a W-4 and is covered by liability.
  Decision: She is not self-employed.

Taxicab drivers

- Cab driver A uses a car that the cab company provides. The company pays the insurance on the vehicle and he pays for gas and maintenance. His gross income is a percentage of his fares and is based on a sliding scale. He also receives tips, but they are separate from the fare percentage. He has chosen to work nights; he determines which fares he will accept and the geographic area he will serve. He uses a Schedule C for his taxes.
  Decision: He is self-employed.
- Cab driver B works for a medi-cab company. She rents her cab and pays gas and maintenance. Her pay is a percentage of the fares, plus tips. She can only pick up fares given to her by dispatch. She does not control her territory or hours.
  Decision: She is not self-employed.

Newspaper carriers

- Newspaper carrier A picks up copies of the Oregonian each morning at 3:00. He puts each copy into a plastic bag before he delivers them to the subscribers. When the subscriber's monthly fee is due, the carrier encloses the bill with the newspaper. The subscribers will mail him the payments which average about $2,400 a month. He sends them to the Oregonian. He pays for gas, insurance, and maintenance of his vehicle, cost of the papers, plastic bags and rubber bands. The Oregonian considers him an independent contractor but will reimburse him for gas. He uses a Schedule C for his taxes.
  Decision: He is self-employed. His gross income is $2,400.
- Newspaper carrier B works for the Healthy Food Weekly (HFW). He drives a car that the company provides. The company pays the insurance on the vehicle and reimburses him for gas. He delivers the weekly paper to a paper stand every Monday so that they can be available to readers each Tuesday morning. He is paid on a weekly basis on the number of deliveries he makes each week. HFW pays him $.75 for each delivery to the paper stand and his average weekly pay is $100. Federal and state income taxes are being deducted from his pay check. HFW also offers a health insurance policy for him at a reduced rate since he is not a full-time employee.
  Decision: He is not self-employed. His income will be counted as EML.

Examples of self-employment situations

- Real estate agents;
- Selling Avon, Mary Kay, Party Light, Pampered Chef, etc.;
- Selling blood plasma;
- Collecting and redeeming beverage containers;
- Picking mushrooms, collecting firewood, picking brush, etc. for sale; Running a franchise (e.g., McDonald's).

Examples of non-self-employed jobs

- Beautician hired by salon;
- Jobs in which the person receives both wages/salary and commission; Incorporated businesses (SNAP, OSIPM and MSP only).

Verifying self-employment status and income

Independent contractor status should be verified. Acceptable verification includes:

- A signed contract specifying this;
- A 1099 (Miscellaneous Income) form issued by the business;
- A narrated conversation with the employer.

Income, including money from self-employment, must be verified for all programs.

Acceptable proof of self-employment income includes:

- Income tax return;
- Check stubs or copies of contracts specifying payment schedule;
- Self-employment bookkeeping records;
- Copies of personal checking and savings account bank statements;
- Copies of business account bank statements;
- Proof of salary, stipend, allowance, donations or gifts received;
- Copy of any contract or work agreement;
- Statement from organization or business explaining access rights to an organization's or business' bank accounts.

For SNAP, self-employed individuals with no records can be certified once without acceptable income verification. At the certification interview, explain to the individual – in writing – that they must begin keeping income records and provide the verification at renewal. ONE will send the ONE-108 notice (proof of self-employment verification) when 'No Verification - Hardship' is selected as the verification type.

At renewal, if they fail to supply acceptable verification of the elf employment income, they will be denied. Do not use "No Verification – Hardship" if they have received the ONE – 108 and failed to keep records. Narrate the conversation and notice given.

Individuals with marginal employment – such as those experiencing homelessness – sometimes report very limited earnings from collecting and redeeming beverage containers, selling plasma, returning airport luggage carts for the deposit money, etc. In many cases, requiring them to provide written verification of self-employment earnings would be an unreasonable barrier to eligibility. To get an acceptable estimate of their income, ask the individual about their typical monthly earnings and accept their self-attestation. If the person is not sure about how much money they earn, ask:

- What the money is spent on. For example, if the individual says they make enough to buy cigarettes for the month, how much do they smoke? If they pick up cans to pay their OHP premium, do they have any money left over after paying?
- How many days a week they typically pick up cans (or how many times a month they sell their plasma). If the person says they pick up three or four bags of cans a week, about how many cans fit in one bag?
- How much walking around money they get? Most of the time, how much money do you have in your pocket?

Note: If the individual is claiming marginal income, but substantial living expenses, income verification must be provided as this is questionable information.

Identifying countable business income

Most applicants accurately report their stake in a business. Others will report only the portion they draw each month in earnings. Some red flags that may lead you to ask about other business income include:

- Paychecks are always in exact hundreds (e.g., $800, $1100);
- Paychecks are personal checks or handwritten business checks;
- Wages are too low to cover the individual's claimed expenses;
- When you check the employer's business on the computer:
  - The owner has the same last name as the individual;
  - The individual is listed as an officer or agent of the company
- Service employees (nail technicians, hairstylists, etc.) report no tips.

Personal and business bank statements often reveal diverted income. Be sure to check the business name on the account. If you see any DBA (doing business as), check the ownership and agents listed for other businesses. Also review the types of payments going into and coming out of the business account. A small business owner may be depositing all earnings into the business, then paying personal bills such as credit cards directly from the business account.

Ask questions to determine how much income to count. Ask what costs the business pays. If tax forms show costs for rent, mortgage, etc., get the address of the property and compare it to the home address. If you determine that the corporation is paying the home mortgage, etc., add those amounts to the individual's income and allow the appropriate shelter and utility deductions.

If a cost paid by the company can reasonably be explained as a business vs a personal cost, simply narrate; do not pursue further verification on the cost (e.g., a vehicle registered on WVIR under the business name). For SNAP, count personal bills paid by the business (such as life insurance for the owner/employee) as earned income.

If the individual refuses to answer questions and is reporting income below the level needed to meet their reported expenses, deny the application for failure to supply requested information/verification.

Note: Always review the case notes – at least back to the last eligibility determination – to help get a clear picture of the situation. This is critical when the amount and source of income is in question. In the rare case that you suspect fraud, follow local procedures for referring the case to Investigations.

Reading tax forms

If a business has been in existence at least one full calendar year, tax forms can be a great help with calculating self-employment income. If not representative, tax forms can still be used as a base to anticipate income for prospective budgeting.

Always request the entire federal tax filing and start with page 1 of the 1040 (U.S. Individual Income Tax Return). Not every form will be needed, but it is much better to make just one, comprehensive pending request. Use the following table as your guide to which forms, sections and lines to reference when calculating business income.

Note: Local areas should consider whether they want to specialize work with tax forms. Tax forms, including instructions that help identify entries, are available online at www.irs.gov. Policy analysts in Central Office are also available to help staff cases.

Verifying self-employment costs

The Self-Employment Income (DHS 859B) form may be used to help collect information about costs related to producing self-employment income. For SNAP and medical, the form cannot be accepted as verification of either income or costs for self-employed individuals.

Verify self-employment costs as follows:

SNAP Ask the individual what costs they have related to their self-employment. Narrate the individual's statement about allowable costs to support use of the SEC 50 percent income exclusion. Do not verify unless questionable.

TANF Verify costs only for JOBS Microenterprise. Costs must be verified along with income as specified above, by providing an income statement quarterly to ODHS|OHA.

ERDC Verify costs only if questionable.

MSP Verify all costs.

OSIPM Verify all costs.

Treatment of self-employment income

For all programs:

- Self-employment is defined the same, except that corporations cannot be considered self-employment for SNAP, OSIPM, or MSPs.
- Gross self-employment income (including microenterprise) is the gross sales or receipts (before costs).

Self-employment income is counted as earned income: the differences are in how allowable costs are treated.

SNAP Self-employed individuals who have no costs have their gross self-employment income coded as SEN. That income is given the same 20 percent deduction as all other earned income. Most self-employed individuals do have allowable costs. Their income is coded as SEC and is given a 50 percent deduction before the 20 percent earned income deduction is applied.

TANF Self-employment is treated the same as other earned income and given a 50 percent disregard by ONE. The only exception is for JOBS Microenterprises. The earned income deduction for income earned in the Microenterprise is 50 percent of the individual's countable income calculated per OARs 461-145-0920 and 461-145-0930.

ERDC Self-employment income is counted as earned income.

MSP Self-employment income is counted as earned income. Gross self-employment income (including microenterprise) is the gross sales or receipts (before costs). All allowable costs are excluded from gross self-employment receipts or income (after general exclusions) to determine countable income, earned income deductions are taken to determine adjusted income, and then the adjusted income is compared to the adjusted income limit.

OSIPM All the costs currently allowed by the IRS are allowed as exclusions for OSIPM and MSPs, which means all the expenses listed on the IRS Schedule C (this includes the "Other expenses" category). If the individual has filed a schedule C, then it's easy to determine the allowable costs. But if the individual doesn't or hasn't filed taxes, he/she can claim similar expenses for anything related to the business. If the expenses are for both personal and business, for example a personal car or truck that's also used for delivering a product, then the individual has to break out what portion is attributed to business use. The expenses listed below are examples of what can be allowed. Remember, because the IRS has an "Other expenses" category (which includes expenses not captured in the list below), this is not an exhaustive list. You may have to use your judgement when self-employed individuals who don't file a Schedule C claim expenses that don't appear on this list:

- Car and truck expenses.
- Commissions and fees.
- Contract labor.
- Depletion.
- Depreciation.
- Employee benefit programs.
- Insurance, other than health.
- Mortgage interest.
- Legal and professional services.
- Office expenses.
- Pension and profit-sharing plans.
- Rent or lease of vehicles, machinery, equipment, and other business property.

- Repairs and maintenance.
- Supplies.
- Taxes and licenses.
- Travel, meals, and entertainment.
- Utilities.
- Wages, less employment credits.
- Meals and snacks provided by family day care providers for children in their care except the provider's own children. The actual cost of the meals is used if the provider is able to document the cost. If the provider is unable to document the actual cost, the USDA meal reimbursement rates are used.
- Materials purchased for resale, such as cosmetic products.
- For newspaper carriers, the cost of newspapers, bags, and rubber bands.

Applying self-employment losses to other earned income; OSIPM, MSP

If you are using income and cost records from the previous or current year, and you have verified that the individual operated or is operating at a net loss, the loss is calculated the same way as the net profit or income to determine the monthly amount. If there is no other source of earned income in the financial group, you would use $0 as the total earned income (you do not get to reduce the unearned income). But if there is another source of earned income (including other self-employment income), the loss can be excluded from the gross income. If it's self-employment, then it would be excluded before costs; for wages, it's excluded from the gross pay. Losses have to be documented and verified; they cannot be anticipated!

Other resources

Self-Employment Income: How to identify self-employment and use the Self-Employment Screening Tool and the types of verification used for self-employment, reading tax forms, and review of Self-employment screens in ONE.

OTAP and Lifeline

The Oregon Lifeline (formerly OTAP) program is a federal and state government program that reduces the monthly cost of phone or broadband service for qualifying low-income individuals. The program provides one of the following benefits to eligible applicants:

- A monthly bill discount on residential landline service with participating companies;
- A monthly bill discount on residential wireless service with participating companies; or
- Free monthly wireless/text minutes and a free handset offered by participating companies.
- Visit www.rspf.org for the current discount amount and list of participating companies.

About Oregon Lifeline programs

Lifeline can provide reduced rates on currently existing phone bills or provide new phones to those without one. To

qualify, the individual's phone bill must be under their name, and the total household income must be at or below 135% of federal poverty guidelines, OR receiving any of the following programs:

- Supplemental Nutrition Assistance Program (SNAP);
- Medicaid;
- Supplemental Security Income (SSI);
- Veterans Assistance;
- Survivors Pension Benefits (SSB);
- Federal Public Housing Assistance.

How individuals may apply

At application and renewal for any of the above programs, ODHS staff should inform applicants that Lifeline services may be available to them. Information is available at: https://www.oregon.gov/puc/Pages/Oregon-Lifeline.aspx.

Interested individuals may also contact Oregon Lifeline via phone by calling 1-800-848-4442 Monday through Friday 9am – 4pm or emailing puc.rspf@state.or.us.

Note: Eligibility for Lifeline services is re-determined on an annual basis. If individuals do not use their phone (making a call, sending a text message, using data, or buying additional minutes or data) for a 30-day period, they will receive notice(s) from their service provider; if no action is taken, their Lifeline service will be canceled, and they will need to re-apply. Individuals must report if they move or disconnect their service to keep their file updated. More information can be found at: https://www.puc.state.or.us/Pages/rspf/otap.aspx.

Out of state contact chart

The following contact information can be used when verifying benefits received in another state.

For verification of duplicate participation or receipt of out-of-state SNAP benefits, click here for the National Directory of Contacts.

State	Phone number(s)	Fax number(s)	Additional information
Alabama	Medical: 334-242-5010 TANF: 334-242-1773	TANF: 334-242-0513	MEDICAL: Phone request only. TANF: Fax request only.
Alaska		General: 907-465-5254	Fax request only.
American Samoa	General: 011-684-633-2609		
Arizona	General: 855-432-7587, #1, #6	General: 602-353-5746	Verifications should now be e-mailed to: AZStateInquiries@azdes.gov

State	Phone number(s)	Fax number(s)	Additional information
Arkansas	General: 501-682-8993 General: 800-482-8988	General: 501-682-8978	The receptionist at the general number will forward the caseworker to the appropriate local department.
California	TANF (Time limits only): 877-365-7378		http://www.wdtip.ca.gov/county.shtml and http://www.cdss.ca.gov/cdssweb/entres/pdf/CountyCentralIndexListing.pdf TANF (Time limits only): wdtip2@osi.ca.gov
Colorado	Medical: 800-221-3943		Phone request only.
Connecticut		General: 860-566-2022	Fax request on agency letterhead only.
Delaware	General: 800-372-2022 Option 5	General: 302-571-4901	Fax request on agency letterhead preferred.
District of Columbia (DC)	General: 866-419-1720	General: 202-535-1514	Fax request only. (Call General numbers only to update info.)
Florida	General: 850-717-4091		Phone request. Joyce Crawford is the verification contact person.
Georgia	General: 404-719-9204	General: 770-344-5544	Email, Phone or Fax request. Email preferred: GA.Paris@DHS.ga.gov
Guam	General: 671-735-7279	General: 671-734-5910	Phone or email request. Email: linda.susuico@dphss.guam.gov or elsa.perez@dphss.guam.gov if additional information is required.
Hawaii	TANF: 808-586-5725 or 808-586-5732 SNAP: 808-586-5720 Medical: E. Hawaii: 808-933-0339 W. Hawaii: 808-327-4970 Maui: 808-243-5780	Medical: 808-933-0344 808-327-4975 Kauai: 808-241-2583 808-243-5788 Oahu: 808-586-5718	Phone request only.
Idaho	General: 877-456-1233	General: 208-334-5817	

State	Phone number(s)	Fax number(s)	Additional information
Illinois	General: 217-524-4174	General: 217-557-1370	Email: DHS.OUTOFSTATE@illinois.gov to request an electronic Verification for Public Assistance form (Word or PDF). Instructions can be found by clicking here. All out-of-state verifications are processed through the email address above, and must include individual's name, DOB, the last four digits of the individual's SSN and his/her out-of-state address. Please note "Out of State Inquiry" in the subject line of all emails.
Indiana	General: 317-233-0826	General: 317-233-0828	Email: Inoutofstate.inquiries@fssa.IN.gov
Iowa	General: 877-855-0021 Option #2	General: 515-564-4095	Phone or Email request. Email: ICRU@DHS.state.ia.us
Kansas		General: 785-296-6960	E-mail: ebtmail@srs.ks.gov
Kentucky	General: 502-564-7514	General: 502-564-4021	For Medicaid: DFS.Medicaid@ky.gov For TANF: FSSBK-TAF@ky.gov
Louisiana	General: 225-342-2342 Medical: 888-342-6207 or 225-342-5774	General: 225-342-6996	
Maine	General: 207-287-1899, 207-287-1838, or 207-287-1839	General: 207-287-3455	Fax request. A signed release is required to obtain verification.
Maryland	General: 800-332-6347 Option 1, 3 & then option # of benefits department you need to verify		Phone request only.

State	Phone number(s)	Fax number(s)	Additional information
Massachusetts	General: 617-348-8500 General: 800-445-6604 MEDICAL: 800-242-1340, Option 1, 5, 1 or 2 (depending on individual's age)	General: 617-889-7874	Mail or fax request on agency letterhead.
Michigan	General: 517-335-3900	General: 517-335-6054	
Minnesota			Requests must be made by email: https://mn.gov/snap-tanf-benefit-verification/ Please supply agency information and enter "guest" in the code box. All responses will be via email.
Mississippi	General: 800-948-3050 Medical: 601-961-4361	General: 601-359-4550	Fax or email request. Email: ea.CustomerService@mDHS.ms.gov
Missouri	General: 855-373-4636 Option 3	General: 573-522-2886	Phone or Fax request. Email: cole.coxix@dss.mo.gov Missouri's new policy prefers email communication for verifications at the above address. You will need to set up a log-in account with a password and security question to access their online system via email. Phone requests will take much longer.
Montana	General: 406-444-4987 TANF: 406-454-5685		Email: tanf@mt.gov
Nebraska	General: 800-383-4278 TANF Time Limits: 402-471-9325	General: 402-471-9597 TANF Time Limits: 470-959-9597	SNAP/TANF e-mail: DHHS.EconomicAssistancePolicyQuestions@nebraska.gov Medical e-mail: DHHS.MedicaidPolicyQuestions@nebraska.gov
Nevada	General: 702-486-1646	General: 775-684-0680	E-mail (preferred): WELFOOSinquiries@dwss.nv.gov

State	Phone number(s)	Fax number(s)	Additional information
New Hampshire	General: 603-271-9700 Option 5	General: 603-271-4230	Phone (preferred) or fax request. Written authorization from individual required for fax.
New Jersey	General: 609-588-2283	Questions to Robert Clayborne: 609-631-4552	Select here for the County Directory. Need to fax copy of pages 11-13 showing signature and locations of release authorization.
New Mexico	General: 505-827-7250	General: 505-727-7203	Phone or fax request.
New York		General: 518-474-8090 or 518-474-5281	Fax request only, on department letterhead, plus reason for information
North Carolina	General: 866-719-0141 Medical: 919-855-4000	General: 252-789-5395 Medical: 919-715-0801	SNAP and TANF requests must be by e-mail or fax. Call center e-mail: ebt.csc.leads@dhhs.nc.gov
North Dakota	General: 701-328-2332	General: 701-328-1060	Phone or fax request. E-mail: DHSeap@nd.gov
Ohio		General: 614-466-1767	To access direct information for each county agency, select here for the Ohio Counties List. Send from state/county agency e-mail address or send with agency letterhead.
Oklahoma	General: 405-521-2779		E-mail: SNAP@okDHS.org
Oregon	General: 503-945-5600	General: 503-373-7032	Email: Benefits.Verification@dhsoha.state.or.us
Pennsylvania		General: 717-705-0040	Fax or e-mail requests only. Fax request preferred. E-mail: ra-dpwoimnet@pa.gov
Puerto Rico	General: 787-289-7600 x 2613 or x 2609 Medical: 787-765-1230 x 5811	General: 787-289-7614 Medical: 787-250-0900	
Rhode Island	General: 401-462-1589		Phone request only.

State	Phone number(s)	Fax number(s)	Additional information
South Carolina	General: 803-898-1764, Option 6 Medical: 888-549-0820 #1 for English #1 for caseworker feedback #2 to speak to a representative	General: 803-898-7313	Email (preferred): IndividualServices@dss.sc.gov General: Phone or Fax request. Medical: Phone request only. Fraud and PARIS matches: Mrs Angela Clark: angela.clark@dss.sc.gov
South Dakota	General: 605-773-3493 Medical: 605-773-4678	General: 605-773-7183	
Tennessee	General: 615-313-4700	General: 615-687-5535	Fax request only.
Texas	General: 877-541-7905 then select the following options from the Interactive Voice Response System: • Option 1 for English; • Option 2 for benefit information; • Option 1 for Medicaid and TANF information, and Option 1 to hear benefit status information (stay on the line to talk to a representative)	General: 877-447-2839 General: 877-447-2839	Please submit one inquiry per page and fax each inquiry separately.
Utah	General: 866-435-7414 Option 5, then Option 3	General: 801-526-9500	
Vermont	General: 800-287-0589 Medical: 800-250-8427		Phone request only.
Virgin Islands	General: 340-773-2323 General: 340-773-5060	General: 340-773-6121	
Virginia	General: 855-927-2747		
Washington	General: 855-927-2747	Fax: 1-888-212-2319	Fax requests only include description of request, individual's full name, SSN, and DOB on agency letterhead. Website: http://www.dshs.wa.gov
West Virginia	General: 877-716-1212	General: 304-558-1869	Phone request only.

State	Phone number(s)	Fax number(s)	Additional information
Wisconsin	General: 608-261-6378, Option 3 TANF: 608-264-1656		Phone: Leave a message; or E-mail: http://dcf.wisconsin/gov/w2/callcenter/default.htm
Wyoming	General: 307-777-5846		Phone request only.

Narration guidelines

It is important to provide, clear and complete narration on cases. Good narration can make a difference when your coworker needs to respond in your absence, to support continuity of service when the case is transferred to a new office and can be a major factor in the outcome of quality assurance reviews and audits.

This worker guide is not intended to be a template, but a guideline for elements to be addressed in eligibility narratives. They are listed below with specific categories that should be considered under each.

ELIGIBILITY DECISION: Decision for each program and person, approved, pending, denial, notices sent, length of certification, reporting system, referrals.

NARRATIVE HEADING: The type of narrative (SNAP recertification, TANF re-determination, etc.), clearly labeled to be easy to find in TRACS.

SITUATION: The circumstances that brought the applicant(s) in: include items such as date of request, filing date, interview date, program(s) applying for, alternate formats, expedited criteria.

HH COMP (EXPLAIN ELIGIBILITY DETERMINATION GROUP): Who is in the household, who is in the filing group and why (i.e., who must apply together, who can apply separately, who cannot apply together.) Should also include authorized representative/alternate payee, anyone pregnant and due date.

NONFINANCIAL ELIGIBILITY: Nonfinancial eligibility for the program(s) applying for; pursuing assets; include items such as I.D., Social Security number (SSN), residency, citizenship, non-citizen status, immigration documents, Date of Entry, student status, OFSET status, JOBS status, job quit/reduction, disqualifications, fleeing felon, disability, child care situation, tribal members, caretaker relatives that completed the Employability Screening Tool (DHS 7823A), and which caretaker relative received a JOBS overview.

Note: At time of eligibility, after one has checked all appropriate screens, narrate your finding along with all IEVS screens checked. One can also click the box in the New Narrative window that says, "IEVS checked."

Note: SNAP requires information on meeting basic needs only when the applicant is claiming shelter cost, but has no income.

Note: Applicants for medical programs do not need to explain how they are meeting basic needs with no income.

SNAP DEDUCTIONS: Shelter, utilities, medical deductions, child care costs, court-ordered support.

For all narratives and case notes:

- Use clear, simple, concise language that is objective and unbiased;

- Be respectful (your narrative could be reviewed by the applicant, co-workers, management, quality control, central office or an administrative law judge);
- Record facts accurately and completely.

Narratives and case notes should NOT include:

- Sensitive information that is not needed for the program or services applied for;
- Personal opinions or assumptions;
- Judgmental statements, stereotypical comments or any offensive statement;
- Comments you could not defend to a manager or in a hearing;
- Speculations or criticisms;
- Details of applicants' lives that do not have an impact on the program they are applying for. REMEMBER Applicants have a right to see their records, including narratives.

Resources:

For narration of Domestic Violence information, click here for the Temporary Assistance for Domestic Violence Survivors eligibility chapter.

Transmittals related to narration, see:

- SS-IM-08-037 – Narrating Information from SSA Screens
- SS-IM-09-023 – Narrative Guide Training Q & A
- SS-PT-10-025 – FSM, Pre-TANF, B, Application, Verification, Eligibility and Participation
- SS-AR-15-008 –TRACS: Documenting the Income Eligibility and Verification System (IEVS)

Non-citizen class of admissions codes chart

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
A–1	Non-Immigrant	Ambassador, public minister, career diplomatic or consular officer, and members of immediate family.	Sec. 101(a)(15)(A)(i) of the INA
A–2	Non-Immigrant	Other foreign government official or employee and members of immediate family.	Sec. 101(a)(15)(A)(ii) of the INA
A–3	Non-Immigrant	Attendant, servant, or personal employee of A–1 or A–2 and members of immediate family.	Sec. 101(a)(15)(A)(iii) of the INA
A36	Immigrant	Married Amerasian son or daughter of a U.S. citizen born in Cambodia, Korea, Laos, Thailand, or Vietnam.	Sec. 203(a)(3) of the INA and 204(g) as added by PL 97– 359 (Oct. 22, 1982)

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
A37	Immigrant	Spouse of an noncitizen classified as A31 or A36.	Sec. 203(d) of the INA and 204(g) as added by PL 97– 359 (Oct. 22, 1982)
A38	Immigrant	Child of an noncitizen classified as A31 or A36.	Sec. 203(d) of the INA and 204(g) as added by PL 97– 359 (Oct. 22, 1982)
AM1	Immigrant	Amerasian born in Vietnam after Jan. 1, 1962 and before Jan. 1, 1976, who was fathered by a U.S. citizen.	Sec. 584(b)(1)(A) of PL 100–202 (Dec. 22, 1987)
AM2	Immigrant	Spouse or child of an noncitizen classified as AM1 or AM6.	Sec. 584(b)(1)(B) of PL 100–202 (Dec. 22, 1987)
AM3	Immigrant	Mother, guardian, or next-of-kin of an noncitizen classified as AM1 or AM6, and spouse or child of the mother, guardian, or next-of-kin.	Sec. 584(b)(1)(C) of PL 100–202 (Dec. 22, 1987)
AM6	Immigrant	Amerasian born in Vietnam after Jan. 1, 1962 and before Jan. 1, 1976, who was fathered by a U.S. citizen.	Sec. 584(b)(1)(A) of PL 100–202 (Dec. 22, 1987)
AM7	Immigrant	Spouse or child of an noncitizen classified as AM1 or AM6.	Sec. 584(b)(1)(B) of PL 100–202 (Dec. 22, 1987)
AM8	Immigrant	Mother, guardian, or next-of-kin of an noncitizen classified as AM1 or AM6, and spouse or child of the mother, guardian, or next-of-kin.	Sec. 584(b)(1)(C) of PL 100–202 (Dec. 22, 1987)
AS	Immigrant	Asylee Applicant with work authorization.	Sec. 208 of the INA
AS1	Immigrant	Approved Asylee Principal.	Sec. 208 of the INA
AS2	Immigrant	Approved Spouse of Asylee.	Sec. 208 of the INA
AS3	Immigrant	Approved Child of Asylee.	Sec. 208 of the INA
AS6	Immigrant	Asylee principal.	Sec. 209(b) of the INA as added by PL 96–212 (Mar. 17, 1980)
AS7	Immigrant	Spouse of an noncitizen classified as AS6.	Sec. 209(b) of the INA as added by PL 96–212 (Mar. 17, 1980)
AS8	Immigrant	Child of an noncitizen classified as AS6.	Sec. 209(b) of the INA as added by PL 96–212 (Mar. 17,1980)
AY	Immigrant	Asylee admission.	Sec. 208 of the INA
B–1	Non-Immigrant	Temporary visitor for business (including Peace Corps).	Sec. 101(a)(15)(B) of the INA

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
B11	Immigrant	Self-petition unmarried son/daughter of U.S. citizen.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
B12	Immigrant	Child of an noncitizen classified as B11 or B16.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
B16	Immigrant	Self-petition unmarried son/daughter of U.S. citizen.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
B17	Immigrant	Child of an noncitizen classified as B11 or B16.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
B–2	Non-Immigrant	Temporary visitor for pleasure.	Sec. 101(a)(15)(B) of the INA
B20	Immigrant	Child of an noncitizen classified as B24 or B29.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
B21	Immigrant	Self-petition spouse of legal permanent resident.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
B22	Immigrant	Self-petition child of legal permanent resident.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
B23	Immigrant	Child of an noncitizen classified as B21, B22, B26, or B27.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
B24	Immigrant	Self-petition unmarried son/daughter of legal permanent resident.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
B25	Immigrant	Child of an noncitizen classified as B24 or B29.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
B26	Immigrant	Self-petition spouse of legal permanent resident.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
B27	Immigrant	Self-petition child of legal permanent resident.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
B28	Immigrant	Child of an noncitizen classified as B21, B22, B26, or B27.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
B29	Immigrant	Self-petition unmarried son/daughter of legal permanent resident.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
B31	Immigrant	Self-petition married son/daughter of U.S. citizen.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
B32	Immigrant	Spouse of an noncitizen classified as B31 or B36.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
B33	Immigrant	Child of an noncitizen classified as B31 or B36.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
B36	Immigrant	Self-petition married son/daughter of U.S. citizen.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
B37	Immigrant	Spouse of an noncitizen classified as B31 or B36.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
B38	Immigrant	Child of an noncitizen classified as B31 or B36.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
BC1	Immigrant	Noncitizen entering the United States to work as broadcaster or for a grantee for the IBCB of BBG.	Sec. 101(a)(27) of the INA as added by PL 106–536 (Nov. 22, 2000) International Broadcasting Bureau of the Broadcasting Board of Governors (IBCB of BBG)
BC2	Immigrant	(IBCB of BBG) Spouse of BC1.	Sec. 101(a)(27) of the INA as added by PL 106–536 Nov. 22, 2000) International Broadcasting Bureau of the Broadcasting Board of Governors (IBCB of BBG)
BC3	Immigrant	(IBCB of BBG) Child of BC1.	Sec. 101(a)(27) of the INA as added by PL 106–536 Nov. 22, 2000) International Broadcasting Bureau of the Broadcasting Board of Governors (IBCB of BBG)
BC6	Immigrant	Noncitizen entering the United States to work as broadcaster or for a grantee for the IBCB of BBG.	Sec. 101(a)(27) of the INA as added by PL 106–536 (Nov. 22, 2000) International Broadcasting Bureau of the Broadcasting Board of Governors (IBCB of BBG)
BC7	Immigrant	(IBCB of BBG) Child of BC6.	Sec. 101(a)(27) of the INA as added by PL 106–536 Nov. 22, 2000) International Broadcasting Bureau of the Broadcasting Board of Governors (IBCB of BBG)
BC8	Immigrant	(IBCB of BBG) Child of BC6.	Sec. 101(a)(27) of the INA as added by PL 106–536 Nov. 22, 2000) International Broadcasting Bureau of the Broadcasting Board of Governors (IBCB of BBG)
BE	Non-Immigrant	Bering Strait Agreement: visa-free travel for Russian citizens to designated areas of Alaska, restricted to indigenous tribes of specified areas of Siberia.	Sec. 212(d)(4) of the INA as added by the Bering Strait Agreement (Sept. 23, 1989)
BX1	Immigrant	Self-petition spouse of legal permanent resident - exempt.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
BX2	Immigrant	Self-petition child of legal permanent resident - exempt.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
BX3	Immigrant	Child of an noncitizen classified as BX1, BX2, BX6, or BX7.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
BX6	Immigrant	Self-petition spouse of legal permanent resident - exempt.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
BX7	Immigrant	Self-petition child of legal permanent resident - exempt.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
BX8	Immigrant	Child of an noncitizen classified as BX1, BX2, BX6, or BX7.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
C-1	Non-Immigrant	Noncitizen in continuous and immediate transit through the United States	Sec. 101(a)(15)(C) of the INA
C-2	Non-Immigrant	Noncitizen in Transit to United Nations Headquarters District under Sec. 11 (3), (4), or (5) of the Headquarters Agreement with the United Nations.	Sec. 101(a)(15)(C) of the INA
C20	Immigrant	Child of an noncitizen classified as C24 or C29.	Sec. 203(d) of the INA and 216 as added by PL 99–639 (Nov. 10, 1986)
C21	Immigrant	Spouse of a lawful permanent resident noncitizen (subject to country limitations).	Sec. 203(a)(2)(A) of the INA and 216 as added by PL 99–639 (Nov. 10, 1986)
C22	Immigrant	Step-child (under 21 years of age) of a lawful permanent resident noncitizen (subject to country limitations).	Sec. 203(a)(2)(A) of the INA and 216 as added by PL 99–639 (Nov. 10, 1986)
C23	Immigrant	Child of an noncitizen classified as C21, C22, C26, or C27 (subject to country limitations).	Sec. 203(d) of the INA and 216 as added by PL 99–639 (Nov. 10, 1986)
C24	Immigrant	Unmarried son or daughter (21 years of age or older) who is a step-child of a lawful permanent resident noncitizen (subject to country limitations).	Sec. 203(a)(2)(B) of the INA and 216 as added by PL 99–639 (Nov. 10, 1986)
C25	Immigrant	Child of an noncitizen classified as C24 or C29.	Sec. 203(d) of the INA and 216 as added by PL 99–639 (Nov. 10, 1986)

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
C26	Immigrant	Spouse of a lawful permanent resident noncitizen (subject to country limitations).	Sec. 203(a)(2)(A) of the INA and 216 as added by PL 99–639 (Nov. 10, 1986)
C27	Immigrant	Step-child (under 21 years of age) of a lawful permanent resident noncitizen (subject to country limitations).	Sec. 203(a)(2)(A) of the INA and 216 as added by PL 99–639 (Nov. 10, 1986)
C28	Immigrant	Child of an noncitizen classified as C21, C22, C26, or C27 (subject to country limitations).	Sec. 203(d) of the INA and 216 as added by PL 99–639 (Nov. 10, 1986)
C29	Immigrant	Unmarried son or daughter (21 years of age or older) who is a step-child of a lawful permanent resident noncitizen (subject to country limitations).	Sec. 203(a)(2)(B) of the INA and 216 as added by PL 99–639 (Nov. 10, 1986)
C-3	Non-Immigrant	Foreign government official, members of immediate family, attendant, servant, or personal employee, in transit.	Sec. 212(d)(8) of the INA
C31	Immigrant	Married son or daughter who is a step-child of a U.S. citizen.	Sec. 203(a)(3) of the INA and 216 as added by PL 99–639 (Nov. 10, 1986)
C32	Immigrant	Spouse of an noncitizen classified as C31 or C36.	Sec. 203(d) of the INA and 216 as added by PL 99–639 (Nov. 10, 1986)
C33	Immigrant	Child of an noncitizen classified as C31 or C36.	Sec. 203(d) of the INA and 216 as added by PL 99–639 (Nov. 10, 1986)
C36	Immigrant	Married son or daughter who is a step-child of a U.S. citizen.	Sec. 203(a)(3) of the INA and 216 as added by PL 99–639 (Nov. 10, 1986)
C37	Immigrant	Spouse of an noncitizen classified as C31 or C36.	Sec. 203(d) of the INA and 216 as added by PL 99–639 (Nov. 10, 1986)
C38	Immigrant	Child of an noncitizen classified as C31 or C36.	Sec. 203(d) of the INA and 216 as added by PL 99–639 (Nov. 10, 1986)
C51	Immigrant	Employment creation immigrant (not in targeted area).	Sec. 203(b)(5)(A) of the INA

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
C52	Immigrant	Spouse of an noncitizen classified as C51 or C56 (not in targeted area).	Sec. 203(d) of the INA
C53	Immigrant	Child of an noncitizen classified as C51 or C56 (not in targeted area).	Sec. 203(d) of the INA
C56	Immigrant	Employment creation immigrant (not in targeted area).	Sec. 203(b)(5)(A) of the INA
C57	Immigrant	Spouse of an noncitizen classified as C51 or C56 (not in targeted area).	Sec. 203(d) of the INA
C58	Immigrant	Child of an noncitizen classified as C51 or C56 (not in targeted area).	Sec. 203(d) of the INA
CC	Non-Immigrant	Mass Migration Cuban Parolee.	Sec. 212 of the INA
CF1	Immigrant	Noncitizen whose record of admission is created upon the conclusion of a valid marriage contract after entering as a fiance or fiancee of a U.S. citizen.	Sec. 214(d) of the INA and 216 as added by PL 99–639 (Nov. 10, 1986)
CF2	Immigrant	Minor step-child of an noncitizen classified as CF1.	Sec. 214(d) of the INA and 216 as added by PL 99–639 (Nov. 10, 1986)
CH	Non-Immigrant	Parole (Humanitarian).	Sec. 212 of the INA
CH6	Immigrant	Cuban-Haitian entrant.	Sec. 202 of PL 99–603 (Nov. 6, 1986)
CP	Non-Immigrant	Parole (Public Interest).	Sec. 212 of the INA
CR1	Immigrant	Spouse of a U.S. citizen.	Sec. 201(b)(2)(A)(i) of the INA and 216 as added by PL 99–639 (Nov. 10, 1986)
CR2	Immigrant	Step-child of a U.S. citizen.	Sec. 201(b)(2)(A)(i) of the INA and 216 as added by PL 99–639 (Nov. 10, 1986)
CR6	Immigrant	Spouse of a U.S. citizen.	Sec. 201(b)(2)(A)(i) of the INA and 216 as added by PL 99–639 (Nov. 10, 1986)
CR7	Immigrant	Step-child of a U.S. citizen.	Sec. 201(b)(2)(A)(i) of the INA and 216 as added by PL 99–639 (Nov. 10, 1986)
CU6	Immigrant	Cuban refugee.	Sec. 1 of PL 89–732 (Nov. 2, 1966) as amended by PL 94–571 (Oct. 20, 1976)

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
CU7	Immigrant	Non-Cuban spouse or child of an noncitizen classified as a CU6.	Sec. 1 of PL 89–732 (Nov. 2, 1966) as amended by PL 94–571 (Oct. 20, 1976)
CW-1	Non-Immigrant	Commonwealth of the Northern Mariana Islands (CNMI) - Only Transitional Worker.	Consolidated Natural Resources Act of 2008, PL 110–229 (May 8, 2008). See also, 8 CFR 214.2(w)
CW-2	Non-Immigrant	Spouse and children of CW-1.	Consolidated Natural Resources Act of 2008, PL 110–229 (May 8, 2008). See also, 8 CFR 214.2(w)
CX1	Immigrant	Spouse of a lawful permanent resident noncitizen (exempt from country limitations).	Sec. 203(a)(2)(A) of the INA and 216 as added by PL 99–639 (Nov. 10, 1986)
CX2	Immigrant	Step-child (under 21 years of age) of a lawful permanent resident noncitizen (exempt from country limitations)	Sec. 203(a)(2)(A) of the INA and 216 as added by PL 99–639 (Nov. 10, 1986)
CX3	Immigrant	Child of an noncitizen classified as CX2 or CX7 (exempt from country limitations).	Sec. 203(d) of the INA and 216 as added by PL 99–639 (Nov. 10, 1986)
CX6	Immigrant	Spouse of a lawful permanent resident noncitizen (exempt from country limitations).	Sec. 203(a)(2)(A) of the INA and 216 as added by PL 99–639 (Nov. 10, 1986)
CX7	Immigrant	Step-child (under 21 years of age) of a lawful permanent resident noncitizen (exempt from country limitations).	Sec. 203(a)(2)(A) of the INA and 216 as added by PL 99–639 (Nov. 10, 1986)
CX8	Immigrant	Child of an noncitizen classified as CX2 or CX7 (exempt from country limitations).	Sec. 203(d) of the INA and 216 as added by PL 99–639 (Nov. 10, 1986)
D-1	Non-Immigrant	Noncitizen crewman on a vessel or aircraft temporarily in the United States, departing on same vessel or airline of arrival.	Sec. 101(a)(15) (D)(i) and Sec. 252 (a)(1) of the INA as interpreted by 8 CFR Sec. 252.1(d)
D-2	Non-Immigrant	Noncitizen crewman departing on vessel other than one of arrival.	Sec. 101(a)(15) (D)(ii) and Sec. 252 (a)(2) of the INA as interpreted by 8 CFR Sec. 252.1(d)
DA	Non-Immigrant	Advance Parole (District).	Sec. 212 of the INA

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
DS1	Immigrant	Creation of a record of lawful permanent resident status for individuals born under diplomatic status in the United States.	8 CFR 101.3 as revised effective Feb. 10, 1982 (Federal Register, Vol. 47, p. 940: Jan. 8, 1982)
DT	Non-Immigrant	Parolee (District / Port of Entry).	Sec. 212 of the INA
DV1	Immigrant	Diversity immigrant.	Sec. 201 and 203(c) of the INA as amended by PL 101–649 (Nov. 29, 1990)
DV2	Immigrant	Spouse of an noncitizen classified as DV1 or DV6.	Sec. 201 and 203(c) of the INA as amended by PL 101–649 (Nov. 29, 1990)
DV3	Immigrant	Child of an noncitizen classified as DV1 or DV6.	Sec. 201 and 203(c) of the INA as amended by PL 101–649 (Nov. 29, 1990)
DV6	Immigrant	Diversity immigrant.	Sec. 201 and 203(c) of the INA as amended by PL 101–649 (Nov. 29, 1990)
DV7	Immigrant	Spouse of an noncitizen classified as DV1 or DV6.	Sec. 201 and 203(c) of the INA as amended by PL 101–649 (Nov. 29, 1990)
DV8	Immigrant	Child of an noncitizen classified as DV1 or DV6.	Sec. 201 and 203(c) of the INA as amended by PL 101–649 (Nov. 29, 1990)
E-1	Non-Immigrant	Treaty trader, spouse and children.	Sec. 101(a)(15)(E)(i) of the INA
E10	Immigrant	Child of a priority worker classified as E11, E16, E12, E17, E13, or E18.	Sec. 203(d) of the INA
E11	Immigrant	Priority worker - noncitizen with extraordinary ability.	Sec. 203(b)(1)(A) of the INA
E12	Immigrant	Priority worker - outstanding professor or researcher.	Sec. 203(b)(1)(B) of the INA
E13	Immigrant	Priority worker - certain multinational executive or manager.	Sec. 203(b)(1)(C) of the INA
E14	Immigrant	Spouse of a priority worker classified as E11, E16, E12, E17, E13, or E18.	Sec. 203(d) of the INA
E15	Immigrant	Child of a priority worker classified as E11, E16, E12, E17, E13, or E18.	Sec. 203(d) of the INA
E16	Immigrant	Priority worker - noncitizen with extraordinary ability.	Sec. 203(b)(1)(A) of the INA
E17	Immigrant	Priority worker - outstanding professor or researcher.	Sec. 203(b)(1)(B) of the INA

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
E18	Immigrant	Priority worker - certain multinational executive or manager.	Sec. 203(b)(1)(C) of the INA
E19	Immigrant	Spouse of a priority worker classified as E11, E16, E12, E17, E13, or E18.	Sec. 203(d) of the INA
E-2	Non-Immigrant	Treaty investor, spouse and children.	Sec. 101(a)(15)(E)(ii) of the INA
E21	Immigrant	Professional holding an advanced degree or of exceptional ability.	Sec. 203(b)(2) of the INA
E22	Immigrant	Spouse of an noncitizen classified as E21 or E26.	Sec. 203(d) of the INA
E23	Immigrant	Child of an noncitizen classified as E21 or E26.	Sec. 203(d) of the INA
E26	Immigrant	Professional holding an advanced degree or of exceptional ability.	Sec. 203(b)(2) of the INA
E27	Immigrant	Spouse of an noncitizen classified as E21 or E26.	Sec. 203(d) of the INA
E28	Immigrant	Child of an noncitizen classified as E21 or E26.	Sec. 203(d) of the INA
E2C	Non-Immigrant	Commonwealth of the Northern Mariana Islands (CNMI) - only E2 investors, spouse and children.	Consolidated Natural Resources Act of 2008, PL 110–229 (May 8, 2008). See also, 8 CFR 214.2(e)
E-3	Non-Immigrant	Australian Free Trade Agreement (Principal noncitizen, spouse and child): issued to Australian nationals coming to work in “specialty occupations”.	Sec. 101(a)(15) (E)(iii) as added by the REAL ID Act of 2005, PL 109–13 (May 11, 2005)
E30	Immigrant	Child of a skilled worker or professional classified as E31, E36, E32, or E37.	Sec. 203(d) of the INA
E31	Immigrant	Noncitizen who is a skilled worker.	Sec. 203(b)(3)(A)(i) of the INA
E32	Immigrant	Professional who holds a baccalaureate degree or who is a member of a profession.	Sec. 203(b)(3)(A)(ii) of the INA
E34	Immigrant	Spouse of a skilled worker or professional classified as E31, E36, E32, or E37.	Sec. 203(d) of the INA
E35	Immigrant	Child of a skilled worker or professional classified as E31, E36, E32, or E37.	Sec. 203(d) of the INA
E36	Immigrant	Noncitizen who is a skilled worker.	Sec. 203(b)(3)(A)(i) of the INA

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
E37	Immigrant	Professional who holds a baccalaureate degree or who is a member of a profession.	Sec. 203(b)(3)(A)(ii) of the INA
E39	Immigrant	Spouse of a skilled worker or professional classified as E31, E36, E32, or E37.	Sec. 203(d) of the INA
E56	Immigrant	Employment creation immigrant.	Sec. 203(b)(5)(A) of the INA
E57	Immigrant	Spouse of an noncitizen classified as E51 or E56.	Sec. 203(d) of the INA
E58	Immigrant	Child of an noncitizen classified as E51 or E56.	Sec. 203(d) of the INA
EC6	Immigrant	Noncitizen covered by Chinese Student Protection Act.	Sec. 245 as amended by PL 101–649 (Nov. 29, 1990) and PL 102–404 (Oct. 9, 1992)
EC7	Immigrant	Spouse of noncitizen covered by Chinese Student Protection Act.	Sec. 245 as amended by PL 101–649 (Nov. 29, 1990) and PL 102–404 (Oct. 9, 1992)
EC8	Immigrant	Child of noncitizen covered by Chinese Student Protection Act.	Sec. 245 as amended by PL 101–649 (Nov. 29, 1990) and PL 102–404 (Oct. 9, 1992)
EW0	Immigrant	Child of an noncitizen classified as EW3 or EW8.	Sec. 203(d) of the INA
EW3	Immigrant	Other worker performing unskilled labor, not of a temporary or seasonal nature, for which qualified workers are not available in the United States.	Sec. 203(b)(3)(A)(iii) of the INA
EW4	Immigrant	Spouse of an noncitizen classified as EW3 or EW8.	Sec. 203(d) of the INA
EW5	Immigrant	Child of an noncitizen classified as EW3 or EW8.	Sec. 203(d) of the INA
EW8	Immigrant	Other worker performing unskilled labor, not of a temporary or seasonal nature, for which qualified workers are not available in the United States.	Sec. 203(b)(3)(A)(iii) of the INA
EW9	Immigrant	Spouse of an noncitizen classified as EW3 or EW8.	Sec. 203(d) of the INA

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
EX1	Immigrant	Schedule-A worker (RN/PT, professional & science/arts, exceptional ability).	Sec. 502 of the Real ID Act of 2005
EX2	Immigrant	Spouse of EX1 or EX6.	Sec. 502 of the REAL ID Act of 2005, PL 109–13 (May 11, 2005).
EX3	Immigrant	Child of EX1 or EX6.	Sec. 502 of the REAL ID Act of 2005, PL 109–13 (May 11, 2005).
EX6	Immigrant	Schedule - A worker.	Sec. 502 of the REAL ID Act of 2005, PL 109–13 (May 11, 2005).
EX7	Immigrant	Spouse of EX1 or EX6.	Sec. 502 of the REAL ID Act of 2005, PL 109–13 (May 11, 2005).
EX8	Immigrant	Child of EX1 or EX6	Sec. 502 of the REAL ID Act of 2005, PL 109–13 (May 11, 2005).
F-1	Non-Immigrant	Student, academic or language program.	Sec. 101(a)(15)(F)(i) of the INA
F11	Immigrant	Unmarried son or daughter of a U.S. citizen.	Sec. 203(a)(1) of the INA
F12	Immigrant	Child of an noncitizen classified as F11 or F16.	Sec. 203(d) of the INA
F16	Immigrant	Unmarried son or daughter of a U.S. citizen.	Sec. 203(a)(1) of the INA
F17	Immigrant	Child of an noncitizen classified as F11 or F16.	Sec. 203(d) of the INA
F-2	Non-Immigrant	Spouse or child of F-1.	Sec. 101(a)(15)(F)(ii) of the INA
F20	Immigrant	Child of an noncitizen classified as F24 or F29.	Sec. 203(d) of the INA
F21	Immigrant	Spouse of a lawful permanent resident noncitizen (subject to country limitations).	Sec. 203(a)(2)(A) of the INA
F22	Immigrant	Child (under 21 years of age) of a lawful permanent resident noncitizen (subject to country limitations).	Sec. 203(a)(2)(A) of the INA
F23	Immigrant	Child of an noncitizen classified as F21, F22, F26, or F27 (subject to country limitations).	Sec. 203(d) of the INA
F24	Immigrant	Unmarried son or daughter (21 years of age or older) of a lawful permanent resident noncitizen.	Sec. 203(a)(2)(B) of the INA
F25	Immigrant	Child of an noncitizen classified as F24 or F29.	Sec. 203(d) of the INA

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
F26	Immigrant	Spouse of a lawful permanent resident noncitizen (subject to country limitations).	Sec. 203(a)(2)(A) of the INA
F27	Immigrant	Child (under 21 years of age) of a lawful permanent resident noncitizen (subject to country limitations).	Sec. 203(a)(2)(A) of the INA
F28	Immigrant	Child of an noncitizen classified as F21, F22, F26, or F27 (subject to country limitations).	Sec. 203(d) of the INA
F29	Immigrant	Unmarried son or daughter (21 years of age or older) of a lawful permanent resident noncitizen.	Sec. 203(a)(2)(B) of the INA
F-3	Non-Immigrant	Canadian or Mexican national commuter student.	Sec. 101(a)(15)(F)(iii) of the INA as added by PL 107–274, Sec. 2(a) (Nov. 2, 2002)
F31	Immigrant	Married son or daughter of a U.S. citizen.	Sec. 203(a)(3) of the INA
F32	Immigrant	Spouse of an noncitizen classified as F31 or F36.	Sec. 203(d) of the INA
F33	Immigrant	Child of an noncitizen classified as F31 or F36.	Sec. 203(d) of the INA
F36	Immigrant	Married son or daughter of a U.S. citizen.	Sec. 203(a)(3) of the INA
F37	Immigrant	Spouse of an noncitizen classified as F31 or F36.	Sec. 203(d) of the INA
F38	Immigrant	Child of an noncitizen classified as F31 or F36.	Sec. 203(d) of the INA
F41	Immigrant	Brother or sister of a U.S. citizen.	Sec. 203(a)(4) of the INA
F42	Immigrant	Spouse of an noncitizen classified as F41 or F46.	Sec. 203(d) of the INA
F43	Immigrant	Child of an noncitizen classified as F41 or F46.	Sec. 203(d) of the INA
F46	Immigrant	Brother or sister of a U.S. citizen.	Sec. 203(a)(4) of the INA
F47	Immigrant	Spouse of an noncitizen classified as F41 or F46.	Sec. 203(d) of the INA
F48	Immigrant	Child of an noncitizen classified as F41 or F46.	Sec. 203(d) of the INA
FSM	Non-Immigrant	Citizen of the Federated States of Micronesia.	Compact of Free Association Act of 1985, PL 99–239 and PL 99–259

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
FX1	Immigrant	Spouse of a lawful permanent resident noncitizen (exempt from country limitations).	Sec. 203(a)(2)(A) and 202(a)(4)(A) of the INA
FX2	Immigrant	Child (under 21 years of age) of a lawful permanent resident noncitizen (exempt from country limitations).	Sec. 203(a)(2)(A) and 202(a)(4)(A) of the INA
FX3	Immigrant	Child of an noncitizen classified as FX1, FX2, FX6, or FX7 (exempt from country limitations).	Sec. 203(d) and 202(a)(4)(A) of the INA
FX6	Immigrant	Spouse of a lawful permanent resident noncitizen (exempt from country limitations).	Sec. 203(a)(2)(A) and 202(a)(4)(A) of the INA
FX7	Immigrant	Child (under 21 years of age) of a lawful permanent resident noncitizen (exempt from country limitations).	Sec. 203(a)(2)(A) and 202(a)(4)(A) of the INA
FX8	Immigrant	Child of an noncitizen classified as FX1, FX2, FX6, or FX7 (exempt from country limitations).	Sec. 203(d) and 202(a)(4)(A) of the INA
G-1	Non-Immigrant	Principal resident representative of recognized foreign member government to international organization, staff, and members of immediate family.	Sec. 101(a)(15)(G)(i) of the INA
G-2	Non-Immigrant	Temporary representative of recognized foreign member government to an international organization, and members of immediate family.	Sec. 101(a)(15)(G)(ii) of the INA
G-3	Non-Immigrant	Representative of nonrecognized or nonmember foreign government to international organization, and members of immediate family.	Sec. 101(a)(15)(G)(iii) of the INA
G-4	Non-Immigrant	Officer or employee of international organization and members of immediate family.	Sec. 101(a)(15)(G)(iv) of the INA
G-5	Non-Immigrant	Attendant, servant, or personal employee of G-1, G-2, G-3, or G-4, and members of immediate family.	Sec. 101(a)(15)(G)(v) of the INA
GA6	Immigrant		Sec. 128 of PL 105–277 (Oct. 20, 1998)

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
GA7	Immigrant	Spouse of GA6.	Sec. 128 of PL 105–277 (Oct. 20, 1998)
GA8	Immigrant	Child of GA6.	Sec. 128 of PL 105–277 (Oct. 20, 1998)
GB	Non-Immigrant	Temporary visitor for business admitted without visa to Guam under the Guam Visa Waiver Program.	Sec. 217 of the INA as added by IRCA, PL 99–603, Sec. 313 (Nov. 6, 1986); revised by the Immigration Act of 1990, PL 101–649, Sec. 201 (Nov. 29, 1990)
GT	Non-Immigrant	Temporary visitor for pleasure admitted without visa to Guam under the Guam Visa Waiver Program.	Sec. 217 of the INA as added by IRCA, PL 99–603, Sec. 313 (Nov. 6, 1986); revised by the Immigration Act of 1990, PL 101–649, Sec. 201 (Nov. 29, 1990)
H-1B	Non-Immigrant	Temporary worker (other than registered nurse) with "specialty occupation" admitted on the basis of professional education, skills, and/or equivalent experience	Sec. 101(a)(15)(H)(i)(b) of the INA as added by the Immigration Nursing Relief act of 1989, PL 101–238, Sec. 3(a) (Dec. 18, 1989); revised by the Immigration Act of 1990, PL 101–649, Sec. 205(c) (Nov. 29, 1990)
H-1B1	Non-Immigrant	Free Trade, Singapore / Chile nationals to work in specialty occupations.	Sec. 101(a)(15)(H)(i)(b)(1) of the INA as added by the U.S.-Chile Free Trade Agreement Implementation Act, PL 108–77, Sec. 402 (Sept. 3, 2003), and amended by the U.S.-Singapore Free Trade Agreement Implementation Act, PL 108–78, Sec. 402 (Sept. 3, 2003)
H-1C	Non-Immigrant	Registered nurse who will work in facilities that serve health professional shortage areas under provisions of the Nursing Relief for Disadvantage Areas Act of 1999	Sec. 101(a)(15)(H)(i)(c) of the INA as added by the Nursing Relief for Disadvantaged Areas Act of 1999, PL 106–95, Sec. 2 (Nov. 12, 1999) and extended by PL 109–423 (Dec. 20, 2006)
H-2A	Non-Immigrant	Worker to perform agricultural services or labor of a temporary or seasonal nature when services are unavailable in the U.S. and will not adversely affect wages and working conditions of U.S. workers.	Sec. 101(a)(15)(H)(ii)(a) of the INA as added by IRCA, PL 99–603, Sec. 301(a)(a) and Sec. 216(a)(1)(A) and (B) (Nov. 6, 1986)

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
H-2B	Non-Immigrant	Nonagricultural worker performing services of a temporary nature or labor unavailable in the United States.	Sec. 101(a)(15)(H)(ii)(b) of the INA as added by IRCA, PL 99–603, Sec. 301(a)(b) (Nov. 6, 1986); revised by the Immigration Act of 1990, PL 101–649, Sec. 205 (Nov. 29, 1990)
H-2R	Non-Immigrant	Returning H-2B worker not subject to the numerical cap (exempts returning workers from the H-2B numerical cap for FY05, FY06, FY07), expires at the conclusion of FY 2007.	Title IV (section 401–07) REAL ID Act of 2005, division B of PL 109–13 (May 11, 2005), extended by PL 109–364 Sec. 1074 (Oct. 17, 2006)
H-3	Non-Immigrant	Temporary trainee to receive instruction in any field except medical education.	Sec. 101(a)(15)(H)(iii) of the INA
H-3B	Non-Immigrant	Special education training.	Sec. 101(a)(15)(H)(iii) of the INA
H-4	Non-Immigrant	Spouse or child of H-1B, H-1B1, H-1C, H-2A, H-2B, H-2R, or H-3.	Sec. 101(a)(15)(H) of the INA
HA6	Immigrant	Haitian National adjusting status under the Haitian Refugee Fairness Act of 1998.	Sec. 902(b)(1)(A) of PL 105–277. Haitian Refugee Immigration Fairness Act (HRIFA Oct. 21, 1998)
HA7	Immigrant	Spouse of HA6.	Sec. 902(b)(1)(A) of PL 105–277. Haitian Refugee Immigration Fairness Act (HRIFA Oct. 21, 1998)
HA8	Immigrant	Child of HA6.	Sec. 902(b)(1)(A) of PL 105–277. Haitian Refugee Immigration Fairness Act (HRIFA Oct. 21, 1998)
HA9	Immigrant	Unmarried son or daughter of HA6.	Sec. 902(b)(1)(A) of PL 105–277. Haitian Refugee Immigration Fairness Act (HRIFA Oct. 21, 1998)
HB6	Immigrant	Haitian National who was paroled into the U.S. prior to December 31, 1995, after having been identified as having a credible fear of persecution, or paroled for emergent reasons or reasons deemed strictly in the public interest.	Sec. 902(b)(1)(A) of PL 105–277. Haitian Refugee Immigration Fairness Act (HRIFA Oct. 21, 1998)
HB7	Immigrant	Spouse of HB6.	Sec. 902(b)(1)(A) of PL 105–277. Haitian Refugee Immigration Fairness Act (HRIFA Oct. 21, 1998)

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
HB8	Immigrant	Child of HB6.	Sec. 902(b)(1)(A) of PL 105–277. Haitian Refugee Immigration Fairness Act (HRIFA Oct. 21, 1998)
HB9	Immigrant	Unmarried son or daughter of HB6.	Sec. 902(b)(1)(A) of PL 105–277. Haitian Refugee Immigration Fairness Act (HRIFA Oct. 21, 1998)
HC6	Immigrant	A Haitian National who entered the U.S. as a child prior to December 31, 1995, was orphaned before arrival in the U.S., and has remained parentless.	Sec. 902(b)(1)(C)(i) of PL 105–277. Haitian Refugee Immigration Fairness Act (HRIFA Oct. 21, 1998)
HC7	Immigrant	Spouse of HC6.	Sec. 902(b)(1)(A) of PL 105–277. Haitian Refugee Immigration Fairness Act (HRIFA Oct. 21, 1998)
HC8	Immigrant	Child of HC6.	Sec. 902(b)(1)(A) of PL 105–277. Haitian Refugee Immigration Fairness Act (HRIFA Oct. 21, 1998)
HC9	Immigrant	Unmarried son or daughter of HC6.	Sec. 902(b)(1)(A) of PL 105–277. Haitian Refugee Immigration Fairness Act (HRIFA Oct. 21, 1998)
HD6	Immigrant	A Haitian National who entered the U.S. as a child prior to December 31, 1995 and became orphaned after arrival.	Sec. 902(b)(1)(C)(ii) of PL 105–277. Haitian Refugee Immigration Fairness Act (HRIFA Oct. 21, 1998)
HD7	Immigrant	Spouse of HD6.	Sec. 902(b)(1)(A) of PL 105–277. Haitian Refugee Immigration Fairness Act (HRIFA Oct. 21, 1998)
HD8	Immigrant	Child of HD6.	Sec. 902(b)(1)(A) of PL 105–277. Haitian Refugee Immigration Fairness Act (HRIFA Oct. 21, 1998)
HD9	Immigrant	Unmarried son or daughter of HD6.	Sec. 902(b)(1)(A) of PL 105–277. Haitian Refugee Immigration Fairness Act (HRIFA Oct. 21, 1998)
HE6	Immigrant	A Haitian National who entered the U.S. as a child prior to December 31, 1995 was abandoned by parents or guardians prior to April 1, 1998 and has remained abandoned.	Sec. 902(b)(1)(C)(iii) of PL 105–277. Haitian Refugee Immigration Fairness Act (HRIFA Oct. 21, 1998)

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
HE7	Immigrant	Spouse of HE6.	Sec. 902(b)(1)(A) of PL 105–277. Haitian Refugee Immigration Fairness Act (HRIFA Oct. 21, 1998)
HE8	Immigrant	Child of HE6.	Sec. 902(b)(1)(A) of PL 105–277. Haitian Refugee Immigration Fairness Act (HRIFA Oct. 21, 1998)
HE9	Immigrant	Unmarried son or daughter of HE6.	Sec. 902(b)(1)(A) of PL 105–277. Haitian Refugee Immigration Fairness Act (HRIFA Oct. 21, 1998)
HSC	Non-Immigrant	See H-1B1.	
I	Non-Immigrant	Representative of foreign information media, spouse and children.	Sec. 101(a)(15)(I) of the INA
I51	Immigrant	Investor Pilot Program, principal (targeted area).	Sec. 203(b)(5) of the INA and Sec. 610 of PL 102–395 (Oct. 6, 1992)
I52	Immigrant	Spouse of an noncitizen classified as I51 or I56.	Sec. 203(b)(5) of the INA and Sec. 610 of PL 102–395 (Oct. 6, 1992)
I53	Immigrant	Child of an noncitizen classified as I51 or I56.	Sec. 203(b)(5) of the INA and Sec. 610 of PL 102–395 (Oct. 6, 1992)
I56	Immigrant	Investor Pilot Program, principal (targeted area).	Sec. 203(b)(5) of the INA and Sec. 610 of PL 102–395 (Oct. 6, 1992)
I57	Immigrant	Spouse of an noncitizen classified as I51 or I56.	Sec. 203(b)(5) of the INA and Sec. 610 of PL 102–395 (Oct. 6, 1992)
I58	Immigrant	Child of an noncitizen classified as I51 or I56.	Sec. 203(b)(5) of the INA and Sec. 610 of PL 102–395 (Oct. 6, 1992)
IB0	Immigrant	Self-petition battered or abused parent of U.S. citizen, residing with citizen and being battered by citizen.	Sec. 204(a)(1)(A) of the INA as amended by sec. 816 of PL 109–162 (Jan. 5, 2006)
IB1	Immigrant	Self-petition spouse of U.S. citizen.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
IB2	Immigrant	Self-petition child of U.S. citizen.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
IB3	Immigrant	Child of an noncitizen classified as IB1 or IB6.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
IB5	Immigrant	Self-petition battered or abused parent of U.S. citizen, residing with citizen and being battered by citizen.	Sec. 204(a)(1)(A) of the INA as amended by sec. 816 of PL 109–162 (Jan. 5, 2006)
IB6	Immigrant	Self-petition spouse of U.S. citizen.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
IB7	Immigrant	Self-petition child of U.S. citizen.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
IB8	Immigrant	Child of an noncitizen classified as IB1 or IB6.	Sec. 40701 of PL 103–322 (Sept. 13, 1994)
IC6	Immigrant	Indochinese refugee.	Sec. 101 of PL 95–145 (Oct. 28, 1977)
IC7	Immigrant	Spouse or child of an Indochinese refugee not qualified as a refugee on their own.	Sec. 101 of PL 95–145 (Oct. 28, 1977)
ID6	Immigrant	Indochinese Parolee.	Sec. 586 of PL 106–429
IF1	Immigrant	Noncitizen whose record of admission is created upon the conclusion of a valid marriage contract after entering as a fiance or fiancee of a U.S. citizen.	Sec. 214(d) of the INA as amended by PL 91–225 (Apr. 7, 1970)
IF2	Immigrant	Minor child of an noncitizen classified as IF1.	Sec. 214(d) of the INA as amended by PL 91–225 (Apr. 7, 1970)
IN	Non-Immigrant	Parolee (Indefinite).	Sec. 212 of the INA
IR0	Immigrant	Parent of a U.S. citizen.	Sec. 201(b)(2)(A)(i) of the INA
IR1	Immigrant	Spouse of a U.S. citizen.	Sec. 201(b)(2)(A)(i) of the INA
IR2	Immigrant	Child of a U.S. citizen.	Sec. 201(b)(2)(A)(i) of the INA
IR3	Immigrant	Orphan adopted abroad by a U.S. citizen.	Sec. 201(b)(2)(A)(i) of the INA
IR4	Immigrant	Orphan to be adopted by a U.S. citizen.	Sec. 201(b)(2)(A)(i) of the INA
IR5	Immigrant	Parent of a U.S. citizen.	Sec. 201(b)(2)(A)(i) of the INA
IR6	Immigrant	Spouse of a U.S. citizen.	Sec. 201(b)(2)(A)(i) of the INA
IR7	Immigrant	Child of a U.S. citizen.	Sec. 201(b)(2)(A)(i) of the INA
IR8	Immigrant	Orphan adopted abroad by a U.S. citizen.	Sec. 201(b)(2)(A)(i) of the INA
IR9	Immigrant	Orphan to be adopted by a U.S. citizen.	Sec. 201(b)(2)(A)(i) of the INA
IW1	Immigrant	Widow or widower of a U.S. citizen.	Sec. 201(b)(2)(A)(i) of the INA as amended by PL 103–416 (Oct. 7, 1994)
IW2	Immigrant	Child of an noncitizen classified as IW1 or IW6.	Sec. 201(b)(2)(A)(i) of the INA as amended by PL 103–416 (Oct. 7, 1994)
IW6	Immigrant	Widow or widower of a U.S. citizen.	Sec. 201(b)(2)(A)(i) of the INA as amended by PL 103–416 (Oct. 7, 1994)

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
IW7	Immigrant	Child of an noncitizen classified as IW1 or IW6.	Sec. 201(b)(2)(A)(i) of the INA as amended by PL 103–416 (Oct. 7, 1994)
J-1	Non-Immigrant	Exchange visitor.	Sec. 101(a)(15)(J) of the INA
J-2	Non-Immigrant	Spouse or child of J-1.	Sec. 101(a)(15)(J) of the INA
K-1	Non-Immigrant	Fiancé or fiancée of a U.S. citizen entering solely to conclude a valid marriage contract.	Sec. 101(a)(15)(K) of the INA
K-2	Non-Immigrant	Child of K-1.	Sec. 101(a)(15)(K) of the INA
K-3	Non-Immigrant	Spouse of a U.S. citizen who is a beneficary of a petition for status as the immediate relative of a U.S. citizen (I-130).	Sec. 101(a)(15)(K) of the INA as added by the Legal Immigration Family Equity (LIFE) Act as part of the Departments of Commerce, Justice, and State, the Judiciary, and Related Agencies Appropriations Act of 2001, PL 106–553, Sec. 1103(a) (Dec. 21, 2000)
K-4	Non-Immigrant	Child accompanying or following to join a K-3 noncitizen.	Sec. 101(a)(15)(K) of the INA as added by the Legal Immigration Family Equity (LIFE) Act as part of the Departments of Commerce, Justice, and State, the Judiciary, and Related Agencies Appropriations Act of 2001, PL 106–553, Sec. 1103(a) (Dec. 21, 2000)
L-1	Non-Immigrant	Intracompany transferee (executive, managerial, and specialized personnel entering to render services to a branch, parent, subsidiary, or affiliate of the company of previous employment outside the United States).	Sec. 101(a)(15)(L) of the INA
L-1A	Non-Immigrant	Intracompany transferee (managers and executives).	Sec. 101(a)(15)(L) of the INA
L-1B	Non-Immigrant	Intracompany transferee (specialized knowledge).	Sec. 101(a)(15)(L) of the INA
L-2	Non-Immigrant	Spouse or child of L-1.	Sec. 101(a)(15)(L) of the INA

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
LA6	Immigrant	Certain parolees from the Soviet Union, Cambodia, Laos, or Vietnam who were denied refugee status and paroled between Aug. 15, 1988 and Sep. 30, 1999.	Sec. 599(E) of PL 101–167 (Nov. 22, 1989, extended through September 30, 1999)
LB2	Immigrant	Child of legalized noncitizen.	Immigration Act of 1990, PL 101–649 (Nov. 29, 1990).
M-1	Non-Immigrant	Student pursuing a full course of study at an established vocational or other recognized nonacademic institution (other than in a language training program).	Sec. 101(a)(15)(M)(i) of the INA as added by PL 97–116, Sec. 2(a)(2) (Dec. 29, 1981)
M-2	Non-Immigrant	Spouse or child of M-1.	Sec. 101(a)(15)(M)(ii) of the INA as added by PL 97–116, Sec. 2(a)(2) (Dec. 29, 1981)
M-3	Non-Immigrant	Canadian or Mexican national commuter student (vocational student or other nonacademic student).	Sec. 101(a)(15)(M)(iii) of the INA as added by PL 107–274, Sec. 2(b) (Nov. 2, 2002)
M83	Immigrant	Refugee-escapee previously admitted for lawful permanent resident status.	Fair Share Refugee Act, PL 86–648 (Jul. 14, 1960)
M93	Immigrant	Hungarian parolee previously admitted for lawful permanent resident status.	Hungarian Refugee Act, PL 85–559 (Jul. 25, 1958)
MIS	Non-Immigrant	Citizen of the Republic of Marshall Islands.	Compact of Free Association Act of 1985, PL 99–239 and PL 99–258
ML	Non-Immigrant	Parolee (Medical, Legal, Humanitarian).	Sec. 212 of the INA
MR0	Immigrant	Parent of a U.S. citizen presumed to be a lawful permanent resident noncitizen - Northern Mariana Islands	Sec. 201(b)(2)(A)(i) of the INA and PL 94–241 (Mar. 24, 1976)
MR6	Immigrant	Spouse of a U.S. citizen presumed to be lawful permanent resident noncitizen - Northern Mariana Islands.	Sec. 201(b)(2)(A)(i) of the INA and PL 94–241 (Mar. 24, 1976)

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
MR7	Immigrant	Child of a U.S. citizen presumed to be a lawful permanent resident noncitizen - Northern Mariana Islands.	Sec. 201(b)(2)(A)(i) of the INA and PL 94–241 (Mar. 24, 1976)
N-8	Non-Immigrant	Parent of an noncitizen classified SK3 or SN3.	Sec. 101(a)(15)(N)(i) of the INA as added by IRCA, PL 99–603, Sec. 312(b) (Nov. 6, 1986) and as amended by PL 105–277, Div. C, Title IV, Sec. 421(b)(1) (Oct. 21, 1998)
N-9	Non-Immigrant	Child of N-8 or of an noncitizen classified SK1, SK2, SK4, SN1, SN2, or SN4.	Sec. 101(a)(15)(N)(ii) of the INA as added by IRCA, PL 99–603, Sec. 312(b) (Nov. 6, 1986) and as amended by PL 105–277, Div. C, Title IV, Sec. 421(b)(2) (Oct. 21, 1998)
NA3	Immigrant	Child born during the temporary visit abroad of a mother who is a lawful permanent resident noncitizen or national of the United States.	8 CFR, Sec. 211.1 and OI, Sec. 211
NATO-1	Non-Immigrant	Principal permanent representative of Member State to NATO (including any of its subsidiary bodies) resident in the United States and resident members of permanent representative's official staff; Secretary General, Deputy Secretary General, Assistant Secretaries General, and Executive Secretary of NATO; other permanent NATO officials of similar rank; and members of immediate family.	Art.12, 5 UST 1094; Art. 20, 5 UST 1098

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
NATO-2	Non-Immigrant	Other representatives of Member States to NATO (including any of its subsidiary bodies) including representatives, advisors and technical experts of delegations, and members of the immediate family; dependents of member of a force entering in accordance with the provisions on the NATO Status-of-Forces Agreement or in accordance with the provisions of the Protocol on the Status of International Military Headquarters; members of such a force if issued visas.	Art. 13, 5 UST 1094; Art. 1, 4 UST 1794; Art. 3, 4 UST 1796
NATO-3	Non-Immigrant	Official clerical staff accompanying a representative of Member State to NATO (including any of its subsidiary bodies) and members of immediate family.	Art. 14, 5 UST 1096
NATO-4	Non-Immigrant	Officials of NATO (other than those classifiable under NATO-1) and members of immediate family.	Art. 18, 5 UST 1098
NATO-5	Non-Immigrant	Experts, other than NATO officials classifiable under the symbol NATO-4, employed on missions on behalf of NATO and their dependents.	Art. 21, 5 UST 1100
NATO-6	Non-Immigrant	Members of a civilian component accompanying a force entering in accordance with the provisions of the NATO Status-of-Forces Agreement; members of a civilian component attached to or employed by an Allied Headquarters under the Protocol on the Status of International Military Headquarters Set Up Pursuant to the North Atlantic Treaty; and their dependents.	Art. 1, 4 UST 1794; Art. 3, 5 UST 877

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
NATO-7	Non-Immigrant	Attendant, servant, or personal employee of NATO-1, NATO-2, NATO-3, NATO-4, NATO-5, and NATO-6 classes, and members of immediate family.	Arts. 12–20,5 UST 1094–1098
NC6	Immigrant	(NACARA) Nicaraguan or Cuban national granted adjustment of status to lawful permanent residence.	Sec. 202 of PL 105–100(Nov. 19, 1997) Nicaraguan Adjustment and Central American Relief Act (NACARA)
NC7	Immigrant	(NACARA) Nicaraguan or Cuban national granted adjustment of status to lawful permanent residence as spouse of NC6.	Sec. 202 of PL 105–100(Nov. 19, 1997) Nicaraguan Adjustment and Central American Relief Act (NACARA)
NC8	Immigrant	(NACARA) Nicaraguan or Cuban national granted adjustment of status to lawful permanent residence as child of NC6.	Sec. 202 of PL 105–100(Nov. 19, 1997) Nicaraguan Adjustment and Central American Relief Act (NACARA)
NC9	Immigrant	(NACARA) Nicaraguan or Cuban national granted adjustment of status to lawful permanent residence as unmarried son/daughter of NC6.	Sec. 202 of PL 105–100(Nov. 19, 1997) Nicaraguan Adjustment and Central American Relief Act (NACARA)
NP8	Immigrant	Noncitizen who filed and was qualified with investor status prior to June 1, 1978.	Sec. 19 of PL 97–116 (Dec. 29, 1981)
NP9	Immigrant	Spouse or child of an noncitizen classified as NP8.	Sec. 19 of PL 97–116 (Dec. 29, 1981)
O-1	Non-Immigrant	Temporary worker with extraordinary ability/achievement in the sciences, arts, education, business, or athletics.	Sec. 101(a)(15)(O)(i) of the INA as added by the Immigration Act of 1990, PL 101–649, Sec. 207 (Nov. 29, 1990)
O-1A	Non-Immigrant	Extraordinary ability noncitizen non-arts.	Sec. 101(a)(15)(O) of the INA as added by the Immigration Act of 1990, PL 101–649, Sec. 207 (Nov. 29, 1990)
O-1B	Non-Immigrant	Extraordinary ability noncitizen in the arts.	Sec. 101(a)(15)(O) of the INA as added by the Immigration Act of 1990, PL 101–649, Sec. 207 (Nov. 29, 1990)
O1M	Immigrant	Native of Western Hemisphere Countries.	Sec. 101 (a)(27)(C) of the INA.

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
O-2	Non-Immigrant	Temporary worker accompanying or assisting O-1.	Sec. 101(a)(15)(O)(ii) of the INA as added by the Immigration Act of 1990, PL 101–649, Sec. 207 (Nov. 29, 1990)
O-3	Non-Immigrant	Spouse or child of O-1 or O-2.	Sec. 101(a)(15)(O)(iii) of the INA as added by the Immigration Act of 1990, PL 101–649, Sec. 207 (Nov. 29, 1990)
OP	Non-Immigrant	Overseas Parolee.	Sec. 212 of the INA
P-1	Non-Immigrant	Temporary Worker, internationally recognized athlete or entertainer for a specific competition or performance.	Sec. 101(a)(15)(P)(i) of the INA as added by the Immigration Act of 1990, PL 101–649, Sec. 207 (Nov. 29, 1990)
P-1A	Non-Immigrant	Noncitizen with athletic event	Sec. 101(a)(15)(P)(i) of the INA as added by PL 101–649, Sec. 207 (Nov. 29, 1990)
P-1B	Non-Immigrant	Noncitizen with entertainment group.	Sec. 101(a)(15)(P)(i) of the INA as added by PL 101–649, Sec. 207 (Nov. 29, 1990)
P-2	Non-Immigrant	Temporary worker, artist or entertainer under a reciprocal exchange program with a similar organization of a foreign state.	Sec. 101(a)(15)(P)(ii) of the INA as added by the Immigration Act of 1990, PL 101–649, Sec. 207 (Nov. 29, 1990)
P21	Immigrant	2nd Pref Spouse of Noncitizen Resident.	Sec. 203(a)(2) of the INA Act as amended by PL 94–571 (Oct. 20, 1976)
P22	Immigrant	Unmarried Child of Noncitizen Resident.	Sec. 203(a)(2) of the INA Act as amended by PL 94–571 (Oct. 20, 1976)
P23	Immigrant	Child Noncitizen of P21, P22, P26 OR P27.	Sec. 203(a)(8) of the INA Act as amended by PL 94–571 (Oct. 20, 1976)
P-3	Non-Immigrant	Temporary worker, artist or entertainer under a program that is “culturally unique”.	Sec. 101(a)(15)(P)(iii) of the INA as added by the Immigration Act of 1990, PL 101–649, Sec. 207 (Nov. 29, 1990)
P-3S	Non-Immigrant	Support person of P-3.	Sec. 101(a)(15)(P)(iii) of the INA as added by the Immigration Act of 1990, PL 101–649, Sec. 207 (Nov. 29, 1990)

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
P-4	Non-Immigrant	Spouse or child of P-1, P-2, or P-3.	Sec. 101(a)(15)(P)(iv) of the INA as added by the Immigration Act of 1990, PL 101–649, Sec. 207 (Nov. 29, 1990)
PAL	Non-Immigrant	Citizen of the Republic of Palau.	Compact of Free Association Act of 1985, PL 99–239 and PL 99–260
PEN	Immigrant	Application Pending for Adjustment to Permanent Resident.	Sec. 245 and 245A of the INA.
PH6	Immigrant	Noncitizen of Polish or Hungarian nationality who was paroled into the U.S. between Nov. 1, 1989 and Dec. 31, 1991	Sec. 646 of the INA Act as added by PL 104–208 (Sept. 30, 1996)
PI	Non-Immigrant	Pacific Trust Terrirory.	Act of July 18, 1947, ch. 271, 61 Stat. 397; Ex. Ord. No. 10265, eff. June 29, 1951, 16 F.R. 6419, superseded by Ex. Ord. No. 11021, eff. May 8, 1962, 27 F.R. 4409.
PR	Non-Immigrant	Parolee (Indefinite).	Sec. 212 of the INA
Q-1	Non-Immigrant	Temporary worker in an international cultural exchange program.	Sec. 101(a)(15)(Q)(i) of the INA as added by the Immigration Act of 1990, PL 101–649, Sec. 208 (Nov. 29, 1990)
Q-2	Non-Immigrant	Participants of the Irish Peace Process Cultural and Training (PPCT) Program, expires September 2008	Sec. 101(a)(15)(Q)(ii) of the INA as added by the Irish Peace Process Cultural and Training Program Act of 1998, PL 105–319 (Oct. 30, 1998) and amended by PL 108–449 (Dec. 10, 2004)
Q-3	Non-Immigrant	Spouse or child of Q-2, expires September 2008	Sec. 101(a)(15)(Q)(ii) of the INA as added by the Irish Peace Process Cultural and Training Program Act of 1998, PL 105–319 (Oct. 30, 1998) and amended by PL 108–449 (Dec. 10, 2004)
R1	Non-Immigrant	Temporary worker to perform work in religious occupations.	Sec. 101(a)(15)(R) of the INA as added by the Immigration Act of 1990, PL 101–649, Sec. 209 (Nov. 29, 1990)

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
R-1	Immigrant	Certain employees or former employees of the U.S. government abroad.	Sec. 101(a)(27)(G) of the I&N Act
R2	Non-Immigrant	Spouse and children of R1	Sec. 101(a)(15)(R) of the INA as added by the Immigration Act of 1990, PL 101–649, Sec. 209 (Nov. 29, 1990)
R-2	Immigrant	Accompanying Spouse / Child of R-1.	Sec. 101(a)(27)(G) of the I&N Act
R3	Non-Immigrant	Parolee.	Sec. 212 of the INA
R-3	Immigrant	Accompanying Child of Former Noncitizen Classified as R-1.	Sec. 101(a)(27)(G) of the I&N Act
R51	Immigrant	Investor pilot program not targeted, principal.	Sec. 203(b)(5) of the INA as amended by Sec. 610 of PL 102–395 (Oct. 6, 1992)
R52	Immigrant	Spouse of an noncitizen classified as R51 or R56.	Sec. 203(b)(5) of the INA as amended by Sec. 610 of PL 102–395 (Oct. 6, 1992)
R53	Immigrant	Child of an noncitizen classified as R51 or R56.	Sec. 203(b)(5) of the INA as amended by Sec. 610 of PL 102–395 (Oct. 6, 1992)
R56	Immigrant	Investor pilot program not targeted, principal.	Sec. 203(b)(5) of the INA as amended by Sec. 610 of PL 102–395 (Oct. 6, 1992)
R57	Immigrant	Spouse of an noncitizen classified as R51 or R56.	Sec. 203(b)(5) of the INA as amended by Sec. 610 of PL 102–395 (Oct. 6, 1992)
R58	Immigrant	Child of an noncitizen classified as R51 or R56.	Sec. 203(b)(5) of the INA as amended by Sec. 610 of PL 102–395 (Oct. 6, 1992)
R86	Immigrant	Refugee paroled into the United States prior to Apr. 1, 1980.	Sec. 5 of PL 95–412 (Oct. 5, 1978)
RE	Immigrant	Refugee	Sec. 207 of the INA
RE1	Immigrant	Refugee on or after 4/1/80	Sec. 207 of the INA
RE2	Immigrant	Spouse of Refugee RE1.	Sec. 207 of the INA
RE3	Immigrant	Child of Refugee Class RE1.	Sec. 207 of the INA
RE4	Immigrant	Derive Refuge status from RE1.	Sec. 207 of the INA
RE5	Immigrant	Haitian Refugee.	Sec. 207 of the INA
RE6	Immigrant	Refugee who entered the United States on or after Apr. 1, 1980.	Sec. 209(a) of the INA as added by PL 96–212 (Mar. 17, 1980)

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
RE7	Immigrant	Spouse of an noncitizen classified as RE6 (spouse entered on or after Apr. 1, 1980).	Sect 209(a) of the INA as amended by PL 96–212 (Mar. 17, 1980)
RE8	Immigrant	Child of an noncitizen classified as RE6 (child entered the United States on or after Apr. 1, 1980).	Sec. 209(a) of the INA as added by PL 96–212 (Mar. 17, 1980)
RE9	Immigrant	Other members of the case regarding an noncitizen classified as RE6 (entered the United States on or after Apr. 1, 1980).	Sec. 209(a) of the INA as added by PL 96–212 (Mar. 17, 1980)
REF	Immigrant	Refugee	Sec. 207 of the INA
RN6	Immigrant	Certain former H1 nonimmigrant registered nurses.	Sec. 2 of PL 101–238 (Dec. 18, 1989)
RN7	Immigrant	Accompanying spouse or child of an noncitizen classified as RN6.	Sec. 2 of PL 101–238 (Dec. 18, 1989)
S1	Non-Immigrant	Special Agricultural Worker - Group 1.	Sec. 101(a)(15) of the I&N Act as added by PL 99–603 (Nov. 6, 1986)
S13	Immigrant	American Indian born in Canada (nonquota).	Sec. 289 of the INA
S16	Immigrant	Seasonal Agricultural Worker (SAW) who worked at least 90 days during each year ending on May 1, 1984, 1985, and 1986 - Group 1.	Sec. 210(2)(A) of the INA as added by PL 99–603 (Nov. 6, 1986)
S2	Non-Immigrant	Special Agricultural Worker - Group 2.	Sec. 101(a)(15) of the I&N Act as added by PL 99–603 (Nov. 6, 1986)
S26	Immigrant	Seasonal Agricultural Worker (SAW) who worked at least 90 days during the year ending on May 1, 1986 - Group 2.	Sec. 210(2)(B) of the INA as added by PL 99–603 (Nov. 6, 1986)
S9	Non-Immigrant	H2A emergency farm worker.	Sec. 101(a)(15)(H)(ii)(a) of the INA as added by PL 99–603, Sec. 301(a)(a) and Sec. 216(a)(1)(A) and (B) (Nov. 6, 1986)
SA1	Immigrant	Noncitizen Born Indep Western Hemisphere Country.	Sec. 101(a)(27)(A) of the INA as amended by PL 94–571 (Oct. 26, 1976)
SC1	Immigrant	Person who lost U.S. citizenship through marriage.	Sec. 101(a)(27)(B) and 324(a) of the INA
SC2	Immigrant	Person who lost U.S. citizenship by serving in foreign armed forces.	Sec. 101(a)(27)(B) and 327 of the INA

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
SC6	Immigrant	Person who lost U.S. citizenship through marriage.	Sec. 101(a)(27)(B) and 324(a) of the INA
SC7	Immigrant	Person who lost U.S. citizenship by serving in foreign armed forces.	Sec. 101(a)(27)(B) and 327 of the INA
SD1	Immigrant	Minister of religion.	Sec. 101(a)(27)(C)(ii)(I) of the INA
SD2	Immigrant	Spouse of an noncitizen classified as SD1 or SD6.	Sec. 101(a)(27)(C) of the INA
SD3	Immigrant	Child of an noncitizen classified as SD1 or SD6.	Sec. 101(a)(27)(C) of the INA
SD6	Immigrant	Minister of religion.	Sec. 101(a)(27)(C)(ii)(I) of the INA
SD7	Immigrant	Spouse of an noncitizen classified as SD1 or SD6.	Sec. 101(a)(27)(C) of the INA
SD8	Immigrant	Child of an noncitizen classified as SD1 or SD6.	Sec. 101(a)(27)(C) of the INA
SE1	Immigrant	Certain employees or former employees of the U.S. government abroad	Sec. 101(a)(27)(D) of the INA
SE2	Immigrant	Spouse of an noncitizen classified as SE1 or SE6.	Sec. 101(a)(27)(D) of the INA
SE3	Immigrant	Child of an noncitizen classified as SE1 or SE6.	Sec. 101(a)(27)(D) of the INA
SE6	Immigrant	Certain employees or former employees of the U.S. government abroad.	Sec. 101(a)(27)(D) of the INA
SE7	Immigrant	Spouse of an noncitizen classified as SE1 or SE6.	Sec. 101(a)(27)(D) of the INA
SE8	Immigrant	Child of an noncitizen classified as SE1 or SE6.	Sec. 101(a)(27)(D) of the INA
SF1	Immigrant	Certain former employees of the Panama Canal Company or Canal Zone Government.	Sec. 101(a)(27)(E) of the INA as added by PL 96–70 (Sep. 27, 1979)
SF2	Immigrant	Spouse or child of an noncitizen classified as SF1 or SF6.	Sec. 101(a)(27)(E) of the INA as added by PL 96–70 (Sep. 27, 1979)
SF6	Immigrant	Certain former employees of the Panama Canal Company or Canal Zone Government.	Sec. 101(a)(27)(E) of the INA as added by PL 96–70 (Sep. 27, 1979)
SF7	Immigrant	Spouse or child of an noncitizen classified as SF1 or SF6.	Sec. 101(a)(27)(E) of the INA as added by PL 96–70 (Sep. 27, 1979)

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
SG1	Immigrant	Certain former employees of the U.S. Government in the Panama Canal Zone.	Sec. 101(a)(27)(F) of the INA as added by PL 96–70 (Sep. 27, 1979)
SG2	Immigrant	Spouse or child of an noncitizen classified as SG1 or SG6.	Sec. 101(a)(27)(F) of the INA as added by PL 96–70 (Sep. 27, 1979)
SG6	Immigrant	Certain former employees of the U.S. Government in the Panama Canal Zone.	Sec. 101(a)(27)(F) of the INA as added by PL 96–70 (Sep. 27, 1979)
SG7	Immigrant	Spouse or child of an noncitizen classified as SG1 or SG6.	Sec. 101(a)(27)(F) of the INA as added by PL 96–70 (Sep. 27, 1979)
SH1	Immigrant	Certain former employees of the Panama Canal Company or Canal Zone Government employed on Apr. 1, 1979.	Sec. 101(a)(27)(G) of the INA as added by PL 96–70 (Sep. 27, 1979)
SH2	Immigrant	Spouse or child of an noncitizen classified as SH1 or SH6.	Sec. 101(a)(27)(G) of the INA as added by PL 96–70 (Sep. 27, 1979)
SH6	Immigrant	Certain former employees of the Panama Canal Company or Canal Zone Government employed on Apr. 1, 1979.	Sec. 101(a)(27)(G) of the INA as added by PL 96–70 (Sep. 27, 1979)
SH7	Immigrant	Spouse or child of an noncitizen classified as SH1 or SH6.	Sec. 101(a)(27)(G) of the INA as added by PL 96–70 (Sep. 27, 1979)
SI1	Immigrant	Nationals of Iraq or Afghanistan serving as interpreters with the U.S. Armed Forces.	Sec. 1059 of H.R. 1815, National l Defense Authorization Act of FY 2006
SI2	Immigrant	Spouses of an SI1.	Sec. 1059 of H.R. 1815, National l Defense Authorization Act of FY 2006
SI3	Immigrant	Children of an SI1.	Sec. 1059 of H.R. 1815, National l Defense Authorization Act of FY 2006
SI6	Immigrant	Nationals of Iraq or Afghanistan serving as interpreters with the U.S. Armed Forces.	Sec. 1059 of H.R. 1815, National l Defense Authorization Act of FY 2006
SI7	Immigrant	Spouses of an SI6.	Sec. 1059 of H.R. 1815, National l Defense Authorization Act of FY 2006
SI8	Immigrant	Children of an SI6.	Sec. 1059 of H.R. 1815, National l Defense Authorization Act of FY 2006

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
SJ2	Immigrant	Spouse or child of an noncitizen classified as SJ6.	Sec. 101(a)(27)(H) of the INA as added by Sec. 5(d)(1) of PL 97–116 (Dec. 29, 1981)
SJ6	Immigrant	Foreign medical school graduate who was licensed to practice in the United States on Jan. 9, 1978.	Sec. 101(a)(27)(H) of the INA as added by Sec. 5(d)(1) of PL 97–116 (Dec. 29, 1981)
SJ7	Immigrant	Spouse or child of an noncitizen classified as SJ6.	Sec. 101(a)(27)(H) of the INA as added by Sec. 5(d)(1) of PL 97–116 (Dec. 29, 1981)
SK1	Immigrant	Certain retired international organization employees.	Sec. 101(a)(27)(I)(iii) of the INA as added by PL 99–603 (Nov. 6, 1986)
SK2	Immigrant	Spouse of an noncitizen classified as SK1 or SK6.	Sec. 101(a)(27)(I)(iv) of the INA as added by PL 99–603 (Nov. 6, 1986)
SK3	Immigrant	Certain unmarried sons or daughters of international organization employees.	Sec. 101(a)(27)(I)(i) of the INA as added by PL 99–603 (Nov. 6, 1986)
SK4	Immigrant	Certain surviving spouses of deceased international organization employees.	Sec. 101(a)(27)(I)(ii) of the INA as added by PL 99–603 (Nov. 6, 1986)
SK6	Immigrant	Certain retired international organization employees.	Sec. 101(a)(27)(I)(iii) of the INA as added by PL 99–603 (Nov. 6, 1986)
SK7	Immigrant	Spouse of an noncitizen classified as SK1 or SK6.	Sec. 101(a)(27)(I)(iv) of the INA as added by PL 99–603 (Nov. 6, 1986)
SK8	Immigrant	Certain unmarried sons or daughters of international organization employees.	Sec. 101(a)(27)(I)(i) of the INA as added by PL 99–603 (Nov. 6, 1986)
SK9	Immigrant	Certain surviving spouses of deceased international organization employees.	Sec. 101(a)(27)(I)(ii) of the INA as added by PL 99–603 (Nov. 6, 1986)
SL1	Immigrant	Juvenile court dependent.	Sec. 101(a)(27)(J) of the INA as added by PL 101–649 (Nov. 29, 1990)
SL6	Immigrant	Juvenile court dependent.	Sec. 101(a)(27)(J) of the INA as added by PL 101–649 (Nov. 29, 1990)
SM0	Immigrant	Spouse or child of an noncitizen classified as SM4 or SM9.	Sec. 101(a)(27)(K) of the INA as added by Sec. 1 of PL 102–110 (Oct. 1, 1991)

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
SM1	Immigrant	Noncitizen recruited outside the United States who has served, or is enlisted to serve, in the U.S. Armed Forces for 12 years (became eligible after Oct. 1, 1991).	Sec. 101(a)(27)(K) of the INA as added by Sec. 1 of PL 102–110 (Oct. 1, 1991)
SM2	Immigrant	Spouse of an noncitizen classified as SM1 or SM6.	Sec. 101(a)(27)(K) of the INA as added by Sec. 1 of PL 102–110 (Oct. 1, 1991)
SM3	Immigrant	Child of an noncitizen classified as SM1 or SM6.	Sec. 101(a)(27)(K) of the INA as added by Sec. 1 of PL 102–110 (Oct. 1, 1991)
SM4	Immigrant	Noncitizen recruited outside the United States who has served, or is enlisted to serve, in the U.S. Armed Forces for 12 years (eligible as of Oct. 1, 1991).	Sec. 101(a)(27)(K) of the INA as added by Sec. 1 of PL 102–110 (Oct. 1, 1991)
SM5	Immigrant	Spouse or child of an noncitizen classified as SM4 or SM9.	Sec. 101(a)(27)(K) of the INA as added by Sec. 1 of PL 102–110 (Oct. 1, 1991)
SM6	Immigrant	Noncitizen recruited outside the United States who has served, or is enlisted to serve, in the U.S. Armed Forces for 12 years (became eligible after Oct. 1, 1991).	Sec. 101(a)(27)(K) of the INA as added by Sec. 1 of PL 102–110 (Oct. 1, 1991)
SM7	Immigrant	Spouse of an noncitizen classified as SM1 or SM6.	Sec. 101(a)(27)(K) of the INA as added by Sec. 1 of PL 102–110 (Oct. 1, 1991)
SM8	Immigrant	Child of an noncitizen classified as SM1 or SM6.	Sec. 101(a)(27)(K) of the INA as added by Sec. 1 of PL 102–110 (Oct. 1, 1991)
SM9	Immigrant	Noncitizen recruited outside the United States who has served, or is enlisted to serve, in the U.S. Armed Forces for 12 years (eligible as of Oct. 1, 1991).	Sec. 101(a)(27)(K) of the INA as added by Sec. 1 of PL 102–110 (Oct. 1, 1991)

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
SN1	Immigrant	Certain retired NATO-6 civilian employees. The NATO-6 classification identifies members of a civilian component accompanying a force entering in accordance with the provisions of the NATO Status of Forces Agreement.	Sec 101(a)(27)(L) of the INA as added by section 421 of PL 105–277. NATO-6, provision of the NATO Status of Forces Agreement.
SN2	Immigrant	(NATO-6) Spouse of an immigrant classified as SN1 or SN6.	Sec 101(a)(27)(L) of the INA as added by section 421 of PL 105–277. NATO-6, provision of the NATO Status of Forces Agreement.
SN3	Immigrant	Certain unmarried sons or daughters of NATO-6 civilian employees.	Sec 101(a)(27)(L) of the INA as added by section 421 of PL 105–277. NATO-6, provision of the NATO Status of Forces Agreement.
SN4	Immigrant	Certain surviving spouses of deceased NATO-6 civilian employees.	Sec 101(a)(27)(L) of the INA as added by section 421 of PL 105–277. NATO-6, provision of the NATO Status of Forces Agreement
SN6	Immigrant	Certain retired NATO-6 civilian employees. The NATO-6 classification identifies members of a civilian component accompanying a force entering in accordance with the provisions of the NATO Status of Forces Agreement.	Sec 101(a)(27)(L) of the INA as added by section 421 of PL 105–277. NATO-6, provision of the NATO Status of Forces Agreement
SN7	Immigrant	(NATO-6) Spouse of an immigrant classified as SN1 or SN6.	Sec 101(a)(27)(L) of the INA as added by section 421 of PL 105–277. NATO-6, provision of the NATO Status of Forces Agreement
SN8	Immigrant	Certain unmarried sons or daughters of NATO-6 civilian employees.	Sec 101(a)(27)(L) of the INA as added by section 421 of PL 105–277. NATO-6, provision of the NATO Status of Forces Agreement
SN9	Immigrant	Certain surviving spouses of deceased NATO-6 civilian employees.	Sec 101(a)(27)(L) of the INA as added by section 421 of PL 105–277. NATO-6, provision of the NATO Status of Forces Agreement

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
SR1	Immigrant	Religious worker.	Sec. 101(a)(27)(C)(ii)(II) and (III) of the INA as added by PL 101–649 (Nov. 29, 1990)
SR2	Immigrant	Spouse of an noncitizen classified as SR1 or SR6.	Sec. 101(a)(27)(C) of the INA as added by PL 101–649 (Nov. 29, 1990)
SR3	Immigrant	Child of an noncitizen classified as SR1 or SR6.	Sec. 101(a)(27)(C) of the INA as added by PL 101–649 (Nov. 29, 1990)
SR6	Immigrant	Religious worker.	Sec. 101(a)(27)(C)(ii)(II) and (III) of the INA as added by PL 101–649 (Nov. 29, 1990)
SR7	Immigrant	Spouse of an noncitizen classified as SR1 or SR6.	Sec. 101(a)(27)(C) of the INA as added by PL 101–649 (Nov. 29, 1990)
SR8	Immigrant	Child of an ali noncitizen en classified as SR1 or SR6.	Sec. 101(a)(27)(C) of the INA as added by PL 101–649 (Nov. 29, 1990)
ST0	Immigrant	Parent of ST6. (NOTE: The code has been established but the regulations are still being written).	Sec. 101 (a)(15)(T)(ii) of the INA as added by Section 214(n), P.L.106–386, enacted into law on October 28, 2000. Victims of Trafficking and Violence Protection Act (VTVPA)
ST6	Immigrant	Victims of severe form of trafficking (T1 nonimmigrant). (NOTE: The code has been established but the regulations are still being written).	Sec. 101 (a)(15)(T)(i) of the INA as added by Section 214(n), P.L.106–386, enacted into law on October 28, 2000. Victims of Trafficking and Violence Protection Act (VTVPA)
ST7	Immigrant	Spouse of ST6. (NOTE: The code has been established but the regulations are still being written).	Sec. 101 (a)(15)(T)(ii) of the INA as added by Section 214(n), P.L.106–386, enacted into law on October 28, 2000. Victims of Trafficking and Violence Protection Act (VTVPA)
ST8	Immigrant	Child of ST6. (NOTE: The code has been established but the regulations are still being written).	Sec. 101 (a)(15)(T)(ii) of the INA as added by Section 214(n), P.L.106–386, enacted into law on October 28, 2000. Victims of Trafficking and Violence Protection Act (VTVPA)

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
ST9	Immigrant	Sibling of an ST6. (NOTE: The code has been established but the regulations are still being written).	Sec. 101 (a)(15)(T)(ii) of the INA as added by Section 214(n), P.L.106–386, enacted into law on October 28, 2000. Victims of Trafficking and Violence Protection Act (VTVPA)
SU0	Immigrant	Parent of SU6. (NOTE: The code has been established but the regulations are still being written).	Sec. 101(a)(15)(U)(ii) of the INA as added by Section(o), P.L.106–386. Victims of Trafficking and Violence Protection Act (VTVPA)
SU6	Immigrant	Victim of criminal activity (U1 nonimmigrants). (NOTE: The code has been established but the regulations are still being written).	Sec. 101(a)(15)(U)(i) of the INA as added by Section(o), P.L.106–386. Victims of Trafficking and Violence Protection Act (VTVPA)
SU7	Immigrant	Spouse of SU6. (NOTE: The code has been established but the regulations are still being written).	Sec. 101(a)(15)(U)(ii) of the INA as added by Section(o), P.L.106–386. Victims of Trafficking and Violence Protection Act (VTVPA)
SU8	Immigrant	Child of SU6. (NOTE: The code has been established but the regulations are still being written).	Sec. 101(a)(15)(U)(ii) of the INA as added by Section(o), P.L.106–386. Victims of Trafficking and Violence Protection Act (VTVPA)
SU9	Immigrant	Sibling of SU6.	Sec. 801(b) of PL 109–162, Violence Against Women and DOJ Reauthorization Act of 2005 (Jan. 5, 2006)
SY6	Immigrant	Certain Syrian Jewish nationals granted asylum, adjusting status independent of the asylee limit of 10000 (limited to 2000).	Syrian Adjustment Act P.L. 106–378 (Oct. 27, 2000)
SY7	Immigrant	Spouse of SY6	Syrian Adjustment Act P.L. 106–378 (Oct. 27, 2000)
SY8	Immigrant	Child or unmarried son or daughter of SY6.	Syrian Adjustment Act P.L. 106–378 (Oct. 27, 2000)
T-1	Non-Immigrant	Individuals physically present in the United States who are or have been victims of a severe form of trafficking.	Sec. 101(a)(15)(T)(i) of the INA as added by the Victims of Trafficking and Violence Protection Act of 2000, PL 106–386, Division A, Sec. 107(e)(1) (Oct. 28, 2000).

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
T-2	Non-Immigrant	Spouse of T-1.	Sec. 101(a)(15)(T)(ii) of the INA as amended by the Victims of Trafficking and Violence Protection Act of 2000, PL 106–386, Division A, Sec. 107(e)(1) (Oct. 28, 2000).
T-3	Non-Immigrant	Child of T-1.	Sec. 101(a)(15)(T)(ii) of the INA as amended by the Victims of Trafficking and Violence Protection Act of 2000, PL 106–386, Division A, Sec. 107(e)(1) (Oct. 28, 2000).
T-4	Non-Immigrant	Parent of T-1.	Sec. 101(a)(15)(T)(ii) of the INA as amended by the Victims of Trafficking and Violence Protection Act of 2000, PL 106–386, Division A, Sec. 107(e)(1) (Oct. 28, 2000).
T-5	Non-Immigrant	Sibling of T-1.	Sec. 101(a)(15)(T)(ii) of the INA as added by PL 108–193 Sec. 4(b)(1)(B) (Dec. 19, 2003) and as amended by PL 109–162, Sec. 801(a)(2) (Jan. 5, 2006)
T51	Immigrant	Employment creation immigrant (targeted area).	Sec. 203(b)(5)(B) of the INA
T52	Immigrant	Spouse of an noncitizen classified as T51 or T56 (targeted area).	Sec. 203(d) of the INA
T53	Immigrant	Child of an noncitizen classified as T51 or T56 (targeted area).	Sec. 203(d) of the INA
T56	Immigrant	Employment creation immigrant (targeted area).	Sec. 203(b)(5)(B) of the INA
T57	Immigrant	Spouse of an noncitizen classified as T51 or T56 (targeted area).	Sec. 203(d) of the INA
T58	Immigrant	Child of an noncitizen classified as T51 or T56 (targeted area)	Sec. 203(d) of the INA
TC	Non-Immigrant	US - Canada Free Trade Agreement.	Sec. 214(e) of the INA as added by PL 100–449, Sec. 307 (Sept. 28, 1988)
TD	Non-Immigrant	Spouse or child of TN.	Sec. 101(a)(15)(B), (E), and (L) and Sec. 214(e) of the INA as amended by the North American Free Trade Agreement Implementation Act, PL 103–182, Sec. 341(b) (Dec. 8, 1993)

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
TN	Non-Immigrant	Canadian or Mexican citizen professional business person engaged in business activities in the U.S. (North American Free Trade Agreement.)	Sec. 101(a)(15)(B), (E), and (L) and Sec. 214(e) of the INA as amended by the North American Free Trade Agreement Implementation Act, PL 103–182, Sec. 341(b) (Dec. 8, 1993)
TN-1	Non-Immigrant	Canadian citizen professional business person engaged in business activities in the U.S. (North American Free Trade Agreement.)	Sec. 101(a)(15)(B), (E), and (L) and Sec. 214(e) of the INA as amended by the North American Free Trade Agreement Implementation Act, PL 103–182, Sec. 341(b) (Dec. 8, 1993)
TN-2	Non-Immigrant	Mexican citizen professional business person engaged in business activities in the U.S. (North American Free Trade Agreement.)	Sec. 101(a)(15)(B), (E), and (L) and Sec. 214(e) of the INA as amended by the North American Free Trade Agreement Implementation Act, PL 103–182, Sec. 341(b) (Dec. 8, 1993)
TR	Non-Immigrant	Temporary resident.	Sec. 101(a)(15) of the INA as added by PL 99–603 (Nov. 6, 1986)
TS1	Non-Immigrant	Temporary resident.	Sec. 210 of the INA.
TS1	Immigrant	Temporary resident.	Sec. 210 of the INA
TS2	Immigrant	Temporary resident.	Sec. 210 of the INA
TW3	Non-Immigrant	Temporary resident.	Sec. 245(a) of the INA
U-1	Non-Immigrant	Individuals who have suffered substantial physical or mental abuse as victim of criminal activity.	Sec. 101(a)(15)(U)(i) of the INA as added by the Victims of Trafficking and Violence Protection Act of 2000, PL 106–386, Division B, 1513(b) (Oct. 28, 2000)
U-2	Non-Immigrant	Spouse of U-1.	Sec. 101(a)(15)(U)(ii) of the INA as added by the Victims of Trafficking and Violence Protection Act of 2000, PL 106–386, Division B, 1513(b) (Oct. 28, 2000)
U-3	Non-Immigrant	Child of U-1.	Sec. 101(a)(15)(U)(ii) of the INA as added by the Victims of Trafficking and Violence Protection Act of 2000, PL 106–386, Division B, 1513(b) (Oct. 28, 2000)

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
U-4	Non-Immigrant	Parent of U-1.	Sec. 101(a)(15)(U)(ii) of the INA as added by the Victims of Trafficking and Violence Protection Act of 2000, PL 106–386, Division B, 1513(b) (Oct. 28, 2000)
U-5	Non-Immigrant	Unmarried, under 18, sibling of U-1.	Sec. 101(a)(15)(U)(ii) of the INA as amended by sec. 801(b) of the Violence Against Women and DOJ Reauthorization Act of 2005, PL 109–162 (Jan. 5, 2006)
V-1	Non-Immigrant	Nonimmigrant spouse of lawful permanent residents waiting more than 3 years for an immigrant visa based upon an immigrant petition filed on or before the enactment date of the LIFE Act, as of December 28, 2000.	Sec. 101(a)(15)(V) of the INA as amended by the Legal Immigration Family Equity (LIFE) Act as part of the Departments of Commerce, Justice, and State, the Judiciary, and Related Agencies Appropriations Act of 2001, PL 106–553, Sec. 1102(a)(3) (Dec. 21, 2000)
V-2	Non-Immigrant	Child of lawful permanent residents waiting more than 3 years for an immigrant visa based upon an immigrant petition filed on or before the enactment date of the LIFE Act.	Sec. 101(a)(15)(V) of the INA as amended by the Legal Immigration Family Equity (LIFE) Act as part of the Departments of Commerce, Justice, and State, the Judiciary, and Related Agencies Appropriations Act of 2001, PL 106–553, Sec. 1102(a)(3) (Dec. 21, 2000)
V-3	Non-Immigrant	Child of V-1 or V-2.	Sec. 101(a)(15)(V) of the INA as amended by the Legal Immigration Family Equity (LIFE) Act as part of the Departments of Commerce, Justice, and State, the Judiciary, and Related Agencies Appropriations Act of 2001, PL 106–553, Sec. 1102(a)(3) (Dec. 21, 2000)
W-1	Non-Immigrant	Applicant for temporary legal resident status.	Sec. 101(a)(15) of the INA as added by PL 99–603 (Nov. 6, 1986)

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
W16	Immigrant	noncitizen previously granted temporary resident status (legalization) who illegally entered the United States without inspection prior to Jan. 1, 1982.	Sec. 245A(b) of the INA as added by PL 99–603 (Nov. 6, 1986)
W26	Immigrant	Noncitizen previously granted temporary resident status (legalization) who entered the United States as a nonimmigrant and overstayed visa prior to Jan. 1, 1982.	Sec. 245A(b) of the INA as added by PL 99–603 (Nov. 6, 1986)
W36	Immigrant	Noncitizen previously granted temporary resident status (legalization) from a country granted blanket extended voluntary departure (EVD).	Sec. 245A(b) of the INA as added by PL 99–603 (Nov. 6, 1986) and Sec. 902 of PL 100–202 (Dec. 22, 1987)
W46	Immigrant	Late amnesty applicants (IRCA).	Legal Immigration Family Equity (LIFE) Act and LIFE Act amendments of 2000
WB	Non-Immigrant	Temporary visitor for business admitted without visa under the Visa Waiver Program.	Sec. 217 of the INA as added by IRCA, PL 99–603, Sec. 313 (Nov. 6, 1986); revised by the Immigration Act of 1990, PL 101–649, Sec. 201 (Nov. 29, 1990)
WT	Non-Immigrant	Temporary visitor for pleasure admitted without visa under the Visa Waiver Program.	Sec. 217 of the INA as added by IRCA, PL 99–603, Sec. 313 (Nov. 6, 1986); revised by the Immigration Act of 1990, PL 101–649, Sec. 201 (Nov. 29, 1990)
XB3	Immigrant	Noncitizen who is presumed to have been lawfully admitted for permanent residence.	8 CFR, Sec. 101.1 and OI, Sec. 101.1
XE3	Immigrant	Child born subsequent to the issuance of a visa. Parent is employment-based preference immigrant.	Sec. 211(a)(1) of the INA as amended
XF3	Immigrant	Child born subsequent to the issuance of a visa. Parent is a family-based preference immigrant.	Sec. 211(a)(1) of the INA as amended

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
XN3	Immigrant	Child born subsequent to the issuance of a visa. Parent is not a family-based preference, employment-based preference, or immediate relative immigrant.	Sec. 211(a)(1) of the INA as amended
XR3	Immigrant	Child born subsequent to the issuance of a visa. Parent is an immediate relative immigrant.	Sec. 211(a)(1) of the INA as amended
Y64	Immigrant	Refugee in the United States prior to July 1, 1953.	Sec. 6 of PL 83–67 (Aug. 7, 1953)
Z03	Immigrant	Person in whose case record of admission for permanent resident status was created. Must have entered after June 30, 1924 and prior to June 28, 1940.	Sec. 249 of the INA as amended by PL 89–236 (Oct. 3, 1965)
Z13	Immigrant	Cancellation of removal. Noncitizen granted suspension of deportation (other than a crewman) and adjusted as an immediate relative of a U.S. citizen or a special immigrant.	Sec. 244 of the INA as amended by PL 89–236 (Oct. 3, 1965)
Z14	Immigrant	Cancellation of removal. Noncitizen granted suspension of deportation or cancellation of removal pursuant to VAWA provisions.	Violence Against Women Act (VAWA), Crime Bill, PL 103–322.
Z15	Immigrant	Cancellation of removal. Noncitizen granted suspension of deportation or cancellation of removal; case record of LPR created.	Nicaraguan Adjustment and Central American Relief Act (NACARA),Sec. 203 of PL 105–100.
Z33	Immigrant	Person in whose case record of admission for permanent resident status was created. Must have entered prior to July 1, 1924.	Sec. 249 of the INA as amended by PL 89–236 (Oct. 3, 1965)
Z43	Immigrant	Private law, immediate relative of a U.S. citizen or special immigrant.	Private Bill
Z56	Immigrant	Noncitizen granted suspension of deportation who entered as a crewman on or before June 30, 1964 and adjusted as an immediate relative of a U.S. citizen or a special immigrant.	Sec. 244 of the INA as amended by PL 89–236 (Oct. 3, 1965)

Class of admission	Immigrant / Non-Immigrant Status	Description	Section of law
Z66	Immigrant	Person in whose case record of admission for permanent resident status was created. Must have entered on or after June 28, 1940 and prior to Jan. 1, 1972.	Sec. 249 of the INA as amended by PL 89–236 (Oct. 3, 1965) and PL 99–603 (Nov. 6, 1986)
Z83	Immigrant	Foreign government official, immediate relative of a U.S. citizen or special immigrant.	Sec. 13 of PL 85–316 (Sep. 11, 1957)

Other resources

Capturing Non-citizen Information *includes screenshots: A guide to the various steps needed when adding a non-citizen to a case.

Personal injury liens

The intent of the personal injury liens program is to identify personal injury settlement situations to recover funds to reimburse the Medicaid and TANF programs; to comply with federal Medicaid regulations, which require recovery from any liable third-party resource. The Personal Injury Lien Unit (PIL) will also submit claims to automobile no-fault Personal Injury Protection (PIP). Federal law makes cooperation with the PIL program a condition of eligibility for medical assistance. When an individual applies for medical assistance the individual automatically assigns the Department any right for reimbursement.

Responsibility for identifying and reporting personal injury settlements

Individuals and their lawyer, if any, are responsible for reporting filing of a claim when they are involved in a vehicle accident or a personal injury situation to the PIL Unit and the individual's Coordinated Care Organization (CCO). If the vehicle accident or personal injury occurred before applying for public assistance, individuals must report such a claim at the time of application. If the claim was settled prior to applying for benefits, the individual does not have to report the injury. Individuals must pursue all available resources, including any third-party resource that may be liable. Individuals are informed of their responsibility to pursue available resources when they sign the application.

The Personal Injury Liens (PIL) Unit is responsible for identifying situations where an individual may be involved in a vehicle accident or a personal injury situation when the individual fails to report such situations. PIL is also responsible to collect information the individual is required to provide. PIL then uses that information to file a lien to protect the right to reimbursement.

ODHS|OHA staff are responsible for ensuring individual cooperation in making the required reports with the required information. Assist the individual, as necessary, in completing the forms. The preferred method is to submit a report online through the secure web portal at www.reportinjury.org. After completing the online submission, a receipt will be emailed to the individual who submitted the report. This receipt can be used to show the date and time of the submission. The PIL Unit may provide assistance, when needed.

Alternative reporting methods for an individual are to complete the Vehicle Related Personal Injury (MSC 451) or the Non-Vehicle Related Personal Injury (MSC 451NV) form. The forms may be sent to the Personal Injury Liens staff in one of the following ways.

- Electronically to: personal.injury@dhsoha.state.or.us
- Mail to:

  Personal Injury Lien Unit
  PO Box 14512
  Salem Oregon 97309

- Fax to: (503)378-2577

Note: PIL does not require a signed form.

Sources of information

Personal injury settlement situations may be discovered by the ODHS|OHA from the following sources:

- Information from the individual.
- Other sources of information, such as the individual's attorney, local newspaper articles and citizen phone tips.
- MMIS report.
- Notice from the PIL Unit, when any of the following has been discovered:
  - Medical billings indicate an injury due to an on-the-job or motor vehicle accident.
  - Medical billings show a trauma diagnostic code indicating an injury/accident.
  - PIL staff receives information that a potential claim may exist and no MSC 451 or 451NV is on file.

The PIL staff may discover potential personal injury settlement situations from the following sources:

- Data matches conducted with Department of Motor Vehicles;
- Published lawsuits for personal injuries;
- Information from medical provider claims; and
- Notifications from the following:
  - Individuals Attorney
  - Insurance Adjusters
  - Coordinated Care Organizations

The PIL staff will contact individuals directly requesting completion of forms mailed by the program when information is developed from medical provider claims or from data matches with Department of Motor Vehicles to a completed injury form. If the individual fails to respond, eligibility staff will become involved.

PIL staff will:

- Advise the local office when an individual who has not filed a claim will be required to do so to maintain eligibility.

- When notified, eligibility staff will contact the individual about the need to file a claim. ODHS|OHA staff may contact PIL staff for technical assistance in the claim-filing process.
- ODHS|OHA staff will use the www.reportinjury.org web portal to report information to PIL. If the individual uses a MSC-451 or MSC-451NV form staff should scan the form into the individual's case record.

- Determine the amount of ODHS|OHA's lien, if any. The amount of the lien equals the amount of cash and medical benefits received by or paid for the individual from the date of the injury to:
  - The date of satisfaction of judgment; OR
  - The date of payment of the settlement or compromise.
- Will notify any CCO that may have a right to ask for a lien assignment.
- Will file a lien, if appropriate and resolve any issues with the parties involved.,

Penalties

In the Medicaid program only, the person who refuses to cooperate in identifying and pursuing the third-party resource or asset is ineligible for medical benefits. A non-complying individual may also be personally liable for amounts received under ORS 416.610. The remaining family members, such as the children, continue to be eligible for Medicaid. For all other programs except ERDC and SNAP, the penalty for not pursuing assets is ineligibility for the entire filing group (see OAR 461-120-0330).

Penalties end when the individual provides evidence that they are willing to pursue the asset.

Special considerations

- Refer all communications or questions concerning a lien to the Personal Injury Liens staff;
- Accept no payment related to a personal injury lien;
- ODHS|OHA staff may contact Personal Injury Liens staff for technical assistance in assisting an individual in the claim-filling process.

Oregon Administrative Rule(s)

461-195-0301 — Definitions
461-195-0303 — Personal Injury Claim
461-195-0305 — Lien of the Department, Coordinated Care Organization, or Prepaid Managed Care Health Services Organization
461-195-0310 — Notice of Claim or Action by Applicant or Recipient
461-195-0315 — Notice of Determination of Lien by Department
461-195-0320 — Release of Lien for Future Medicals
461-195-0321 — Assigning a Lien
461-195-0325 — Release or Compromise of Lien
461-195-0350 — Procedure Where Injured Recipient is a Minor

Program change chart

This worker guide is intended to help workers determine if a new application is needed when an individual changes

programs.

Program change chart

Break of less than one calendar month in cash/ medical benefits			Break of one calendar month or more in cash/ medical benefits		
FROM	**TO**	**NEW APPL[1]**	**FROM**	**TO**	**NEW APPL[1]**
TANF	ERDC	No[2]	TANF	ERDC	Yes
TANF	EXT	No	TANF	EXT	No
TANF	OSIPM, MSP	Yes	TANF	OSIPM, MSP	Yes
OSIPM, MSP	TANF	Yes	OSIPM, MSP	TANF	Yes
	TANF	Opt.		TANF	Yes
ERDC	TANF	Yes[3]	ERDC	TANF	Yes
Any medical program	ERDC	Opt.	Any medical program	ERDC	Yes

1. A new application is required when an individual is moving from Medical to any other program and used the Oregon Health Plan Application (OHP 7210) originally.

2. Establish a new date of request. The individual may request ERDC by using the 6E notice, with a phone or visit by either the worker or the individual as long as the worker has enough information to reliably predict the individual's future income; and any other method that results in enough information to determine eligibility and gives individuals information needed to participate in the program.

3. A DHS 7470 is required to change to any other program(s). If a DHS 0415F was used, no new application is required as long as the requirements in OAR 461-115-0050 are met.

More information on program changes

When there is a change in the caretaker relative for TANF, a new application must be filled out, unless the caretaker is included on the current application.

The following are examples of situations where it is up to the worker to decide if a new application is needed:

- Reconsideration of eligibility on cash, MSP, or OSIPM cases denied or closed in error within the last 30 days;
- Restoring a suspended case;
- Changing the basis of deprivation of TANF;
- Changes in any program, except from an adult program to ERDC or TANF if:
  - There is sufficient information available to make an eligibility determination for the new program based on the current application form and other documentation provided by the individual; AND
  - Everyone in the filing group is included in the application.

Staff may use various forms to document the program change. The documentation to support ongoing eligibility or a change in program must be available in the case record. Options for documenting eligibility include:

- Change report form Change Report (DHS 943);

- Application for Services (DHS 415F);
- TRACS or Oregon ACCESS narration;
- ONE case note;
- Written statement from the individual;
- Employment Related Day Care (ERDC) and Supplemental Nutrition Assistance Program (SNAP) Application (DHS 7476).

Returned mail

Processing returned mail

There are several steps offices take to ensure participants receive notices and other mail from ODHS|OHA in a timely manner. All participants must provide a valid mailing address. Do not use a ODHS|OHA office address as the participant's mailing address. Even though we take steps to ensure a valid mailing address, the post office sometimes returns mail marked "undeliverable," "unable to forward" or "unclaimed," etc. This returned mail needs to be handled carefully.

Note: This policy does not apply to SNAP cases in SRS or TBA. Take no action on SRS or TBA cases with mail returned for these reasons. However, you may still need to take action on companion cases for other programs.

1. Check TRACS, ACCESS, UCMS, FCAS, ONE and incoming mail that has not been processed and the case file to be sure there is not a more up-to-date address.
2. Check U.S. Postal Service website http://www.usps.com/ to verify accuracy of address.

Note: Other screens such as DMV, SMUX, etc. are not required to be checked as information is not always up to date.

3. If an updated address is located and benefits are not expiring at the end of month, update the mailing address on all open cases and resend the mail to the correct address.
4. Except for ERDC, REF Cash SNAP cases in SRS or TBA and TANF, if there is no updated address available and you have followed the above steps, close the case for the end of the current month and narrate the exact wording on the return label. No notice is required. Use these program-specific procedures:
    - In the SNAP program for cases in CRS:
        - » Use reason code RM. If the case is expiring or going into suspense at the end of the month, narrate only and do not take the close action.
        - » If the participant contacts ODHS|OHA before the case closes, update and narrate the new address, household composition and shelter costs. Act on any changes necessary following the applicable notice requirements;
        - » If the participant contacts the local office during the first month after the case closes (i.e., worker receives returned mail on January 12 and takes action on the system to close the case effective January 31. The first month after the case closes is February), update and narrate the new address, household composition and shelter costs, and reopen the case with a ROP back to the first of the

current month. Do not prorate benefits. Do not take a new application or do a REC action – this is not a recertification. Use the IJ or EJ Rel-ATP codes to issue SNAP;

- » Act on other changes for the following month. If benefits will be reduced, send a timely continuing benefit decision notice before making the changes;
- » If a participant contacts ODHS|OHA more than a month after the closure, they have to reapply.

- For cases in SRS or TBA:
  - » With mail returned as unclaimed or as undeliverable, narrate the receipt of returned mail but take no action on the case. For mail returned with a new mailing address listed on it, or if the new address is reported for another program, update the mailing address on the case. Do not close SRS or TBA cases for returned mail.
- For TANF cases:
  - » With mail returned as unclaimed or as undeliverable, narrate the receipt of returned mail, email the family coach but do not close the case.

Note: For all programs, narrate the returned mail just once, then place in the office shred bin. Do not file the mail in the participant case file and do not repeatedly narrate returned mail from the same address.

- For all programs except ERDC, REF Cash, SNAP and TANF:
  - » End benefits by sending a basic decision notice to the last known address;
  - » Choose the "????" reason from the drop-down menu in ONE;
  - » If the participant contacts ODHS|OHA before the case closes, gather the new address information and any other information that affects the case, such as household composition, and act on the information;
  - » If a participant contacts ODHS|OHA after the closure, the case will remain closed until the participant chooses to reapply for benefits. Establish a new filing date or date of request when the participant reapplies.

Other resources

Returned mail *includes screenshots: Includes guidance and steps to mark a case for having returned mail and subsequent tasks to inform the customer.

Moved out of state

When the post office returns mail and the address listed on the return label is out-of-state, this returned mail is handled differently. This information is considered reported to ODHS|OHA and we have to act on it appropriately:

- For SNAP and JPI, no notice is required. Close the case using the "???" reason from the ONE drop-down menu.
- For all other programs, send a timely decision notice. If the participant becomes eligible for benefits in another state, send a basic decision notice.
- Use the reason "Moved out of State" from the drop-down menu to close the case.
- ONE will automatically send a Notice of Eligibility.

Oregon Administrative Rule(s)

461-105-0020 — Responsibilities of Individuals
461-120-0010 — Residency Requirements

Vital statistics chart

State	Address	Birth cost	Death cost	Contact info
Alabama	Alabama Center for Health Statistics State Department of Public Health PO Box 5625 Montgomery, AL 36103-5625	$15	$15	334-206-5418* Alabama Vital Records website
Alaska	Department of Health and Social Services Bureau of Vital Statistics PO Box 110675 Juneau, AK 99801	$30	$30	907-465-3391* Alaska Vital Records website
American Samoa	American Samoa Government Department of Homeland Security Office of Vital Statistics PO Box 3887 Pago Pago, AS 96799	$5	$5	684-633-4606 684-663-2262
Arizona	Office of Vital Records Arizona Department of Health Services PO Box 6018 Phoenix, AZ 85005	$20	$20	602-364-1300* 888-816-5907 Arizona Department of Health Services website
Arkansas	Arkansas Department of Health Vital Records Section, Slot 44 4815 West Markham Street Little Rock, AR 72205	$18	$14	501-661-2336* Arkansas Department of Health website
California	Office of Vital Records Department of Health Services MS: 5103 PO Box 997410 Sacramento, CA 95899-7410	$25	$21	916-445-2684*
Canal Zone	Vital Records Section Passport Services US Department of State 1111 19th Street NW, Suite 510 Washington, DC 20522-1705	$30	$30	202-955-0307

State	Address	Birth cost	Death cost	Contact info
Colorado	Vital Records Section Colorado Department of Public Health and Environment 4300 Cherry Creek Drive South HSVRD-VS-A1 Denver, CO 80246-1530	$17.75	$20	303-692-2200* Colorado Department of Public Health and Environment website
Connecticut	State-Issued Certified Certificates Department of Public Health 410 Capitol Avenue, MS #11 VRS Hartford, CT 06134	$30 (issued by state) $20 (issued by city/ town)	$20	860-509-7897 Connecticut Department of Public Health website
Delaware	Office of Vital Statistics Division of Public Health 417 Federal Street Dover, DE 19901	$25***	$25***	302-744-4549 Delaware Office of Vital Statistics website
District of Columbia (DC)	Vital Records Division 899 North Capitol Street NE, First Floor Washington, DC 20002	$23	$18	202-671-5000* District of Columbia Department of Health website
Florida	Department of Health Bureau of Vital Statistics PO Box 210 1217 Pearl Street (Zip 32202) Jacksonville, FL 32231-0042	$9	$5	904-359-6900* Florida Department of Health, Vital Records website
Foreign and High Seas Events	For information on births, death, etc., in foreign countries or on the high seas, see: http://www.cdc.gov/nchs/w2w/foreign.htm			
Georgia	Georgia Department of Public Health Vital Records 2600 Skyland Drive, NE Atlanta, GA 30319-3640	$25	$25	404-679-4702* Georgia Department of Public Health websitev
Guam	Money order (personal checks not accepted) to: Treasurer of Guam Office of Vital Statistics 123 Chalan Kareta Mangilao, Guam 96913	$5	$5	671-735-7292

State	Address	Birth cost	Death cost	Contact info
Hawaii	State Department of Health Office of Health Status Monitoring Vital Records Section PO Box 3378 Honolulu, HI 96801-9984	$10	$10	808-586-4533* Hawaii Department of Health Vital Records website
Idaho	Vital Records Unit Bureau of Vital Records and Health Statistics PO Box 83720 Boise, ID 83720-0036	$16 (computer-generated) $21 (photo static copy)	$16 (computer-generated) $21 (photo static copy)	208-334-5988*
Illinois	Division of Vital Records Illinois Department of Public Health 925 E Ridgely Avenue Springfield, IL 62702-5097	$15	$19	217-782-6553* Illinois Department of Public Health website
Indiana	Vital Records Indiana State Department of Health PO Box 7125 Indianapolis, IN 46206-7125	$10	$8	317-233-2700 Indiana State Department of Health websitev
Iowa	Iowa Department of Public Health Bureau of Vital Records Lucas Office Building 321 East 12th Street Des Moines, IA 50319-0075	$15	$15	515-281-4944* Iowa Department of Public Health website
Kansas	Office of Vital Statistics Curtis State Office Building 1000 SW Jackson Street, Suite 120 Topeka, KS 66612-2221	$15	$15	785-296-1400* KDHE Office of Vital Statistics website
Kentucky	Office of Vital Statistics Department for Public Health Cabinet for Health and Family Services 275 East Main Street, 1E-A Frankfort, KY 40621	$10	$6	502-564-4212 Kentucky Department for Public Health, Vital Records, and Genealogy Information website

State	Address	Birth cost	Death cost	Contact info
Louisiana	Office of Public Health Vital Records Registry PO Box 60630 New Orleans, LA 70160	$9/short form $15/long form	$7	504-219-4500 Louisiana Center of State Registrar and Vital Records website
Maine	Maine Center for Disease Control and Prevention #11 State House Station 220 Capitol Street Augusta, ME 04333-0011	$15/certified $10/noncertified	$15/certified $10/noncertified	207-287-3181* Toll free: 888-664-9491* State of Maine website
Maryland	Division of Vital Records Department of Health and Mental Hygiene 6550 Reistertown Road PO Box 68760 Baltimore, MD 21215-0036	$24	$24	410-764-3038* Maryland Vital Statistics Administration website
Massachusetts	Registry of Vital Records and Statistics 150 Mount Vernon Street, 1st Floor Dorchester, MA 02125-3105	$34	$34	617-740-2600* Massachusetts Department of Public Health, Registry of Vital Records and Statistics website
Michigan	Vital Records Request PO Box 30721 Lansing, MI 48909	$20/in-person $32/mail-in State Archives: $3	$20/in-person $32/mail-in State Archives: $3	517-335-8656* Michigan Department of Community Health website
Minnesota	Minnesota Department of Health Central Cashiering – Vital Records PO Box 64499 St Paul, MN 55164	$15	$15	651-201-5980 Minnesota Department of Health website
Mississippi	Vital Records State Department of Health PO Box 1700 Jackson, MS 39215-1700	$15	$15	601-576-7981 601-576-7450

State	Address	Birth cost	Death cost	Contact info
Missouri	Missouri Department of Health and Senior Services Bureau of Vital Records 930 Wildwood PO Box 570 Jefferson City, MO 65102-0570	$15	$13	573-751-6387 Missouri Department of Health and Senior Services, Vital Records website
Montana	Office of Vital Statistics MT Department of Public Health and Human Services 111 N Sanders, Room 6 PO Box 4210 Helena, MT 59604	$12	$12	406-444-2685 Montana Department of Public Health and Human Services website
Nebraska	Nebraska Vital Records PO Box 95065 Lincoln, NE 68509-5065	$12	$11	402-471-2871* Nebraska Department of Health and Human Services, Office of Vital Records website
Nevada	Office of Vital Records 4150 Technology Way, Suite 104 Carson City, NV 89706	$17	$16	775-684-4242* Nevada State Health Division website
New Hampshire	Division of Vital Records Administration Archives Building 71 South Fruit Street Concord, NH 03301-2410	$15	$15	603-271-4654* New Hampshire Department of State, Division of Vital Records Administration website
New Jersey	Please visit the New Jersey Vital Statistics website	$25	$25	866-649-8726
New Mexico	New Mexico Vital Records PO Box 25767 Albuquerque, NM 87125	$15	$15	866-534-0051 New Mexico Department of Health website

State	Address	Birth cost	Death cost	Contact info
New York City	NYC Department of Health Office of Vital Records 125 Worth Street, CN4, Room 133 New York, NY 10013	$15	$15	NYC Department of Health and Mental Hygiene website
New York State (except NYC)	Certification Unit Vital Records Section/2nd Floor 800 North Pearl Street Menands, NY 12204	$30	$30	855-322-1022* New York State Department of Health website
North Carolina	NC Vital Records 1903 Mail Service Center Raleigh, NC 27699-1903	$24	$24	919-733-3000 North Carolina Vital Records website
North Dakota	ND Department of Health Division of Vital Records 600 East Boulevard Avenue Dept 301 Bismarck, ND 58505-0200	$7	$5	701-328-2360* North Dakota Department of Health, Vital Records website
Northern Mariana Islands	Commonwealth Healthcare Corporation Vital Statistics Office PO Box 500409 Saipan, MP 96950	$20	$15	670-236-8717 E-mail: info@vs-cnmi.org
Ohio	Vital Statistics Ohio Department of Health PO Box 15098 Columbus, OH 43215-0098	$21.50	$21.50	614-466-2531* Ohio Department of Health, Vital Records website
Oklahoma	Vital Records Service State Department of Health 1000 NE 10th Street Oklahoma City, OK 73117	$15	$15	405-271-4040* Oklahoma State Department of Health website
Oregon	Vital Records – Certification Unit PO Box 14050 Portland, OR 97293-0050	Mail: $25 Internet/ phone: $44.95	Mail: $25 Internet/ phone: $44.95	971673-1190* Oregon Health Authority website

State	Address	Birth cost	Death cost	Contact info
Pennsylvania	Division of Vital Records Attn: Birth Unit (or Attn: Death Unit) 101 South Mercer Street, Room 401 PO Box 1528 New Castle, PA 16103	$20	$9	724-656-3100* Pennsylvania Department of Health, Vital Records website
Puerto Rico	Department of Health Demographic Registry PO Box 11854 Fernandez Juncos Station San Juan, PR 00910	$5	$5	787-767-9120, ext. 6131
Rhode Island	RI Department of Health Office of Vital Records, Room 101 3 Capitol Hill Providence, RI 02908-5097	$20	$20	401-222-2811* Rhode Island Department of Health website
South Carolina	Office of Vital Records SC DHEC 2600 Bull Street Columbia, SC 29201	$12	$12	803-898-3630 South Carolina Department of Health and Environmental Control website
South Dakota	Vital Records State Department of Health 207 East Missouri Avenue, Suite 1-A Pierre, SD 57501	$15	$15	605-773-4961* South Dakota Department of Health website
Tennessee	Tennessee Vital Records 1st Floor, Central Services Building 421 5th Avenue, North Nashville, TN 37243	$8/short-form $15/long-form	$7	615-741-1763 Tennessee Department of Health website
Texas	Texas Vital Records Department of State Health Services PO Box 12040 Austin, TX 78711-2040	$22	$20	512-776-7111* Texas Department of State Health Services website
Utah	Office of Vital Records and Statistics Utah Department of Health 288 North 1460 West PO Box 141012 Salt Lake City, UT 84114-1012	$20	$18	801-538-6105* Utah Department of Health website

State	Address	Birth cost	Death cost	Contact info
Vermont	Vermont Department of Health Vital Records Section PO Box 70 108 Cherry Street Burlington, VT 05402-0070	$10	$10	802-863-7275* Vermont Department of Health website
Virgin Islands (St Croix)	Department of Health Vital Statistics Charles Harwood Memorial Hospital St Croix, VI 00820	$12/in-person $15/mail-in	$12/in-person $15/mail-in	340-774-9000, Ext 4685/4686
Virgin Islands (St Thomas & St John)	Department of Health Vital Statistics Knud Hansen Complex St Thomas, VI 00802	$12/in-person $15/mail-in	$12/in-person $15/mail-in	340-774-9000, Ext 4685/4686
Virginia	Division of Vital Records PO Box 1000 Richmond, VA 23218-1000	$12	$12	804-662-6200* Virginia Department of Health website
Washington	Department of Health Center for Health Statistics PO Box 47814 Olympia, WA 98507-9709	$20	$20	360-236-4300 Washington State Department of Health website
West Virginia	Vital Registration Office Room 165 350 Capitol Street Charleston, WV 25301-3701	$12	$12	304-558-2931 West Virginia Department of Health and Human Resources websitev
Wisconsin	WI Vital Records Office 1 West Wilson Street PO Box 309 Madison, WI 53701-0309	$20	$20	Wisconsin Vital Records Services website
Wyoming	Vital Statistics Services Hathaway Building Cheyenne, WY 82002	$13	$10	307-777-7591 Wyoming Department of Health website

Chapter 7:
Worker guides

Section 2: SNAP worker guides

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

SNAP worker guides

Introduction

While the chapters within the Oregon Programs Eligibility Notebook are intended to cover all areas of eligibility, there may be miscellaneous pieces of information that do not fit into a single topic. The SNAP worker guides are available as a tool to accompany the rest of Oregon Administrative Rule and the Oregon Programs Eligibility Notebook for these areas regarding the SNAP program.

Effective case notes

Case notes are important for because they provide details on what actions were taken on the case and why.

Case notes with essential information are very beneficial to any person researching the case , including co-workers following up on tasks and other reviewers. Case notes also assist workers to double check their data entry.

In general, ONE records what actions you take. It does not record *why* you take a particular action. If why you do something is important, add a case note.

When to Add a Case Note

You can determine if a case note needs to be added by asking yourself these questions:

- Will someone come behind me to work on the case?
- What essential information isn't included elsewhere?
- What is most important for others to know?
- Did I ask a question?
- Is the information clear?
- Why did I take an action?
- Will the case require further follow up actions?
- What if the case goes to a hearing or is reviewed by Quality Control? Is the necessary information included?

What makes a good case note?

- Clear and Concise
- Includes only essential information not found elsewhere
- Added at the time the action is taken
- Free from jargon and abbreviations

Using the above questions and guidelines will help you know when and what to narrate. If in doubt add a brief note to clarify.

Examples of Case Notes

An Effective Case Note

Situation: Oregonian stated on an application their income, but they estimated the amount.

Case Note: Oregonian indicated they make $1000 per month but based on wage stubs and attestation from the Oregonian during the interview they make $1200 per month

Situation: Application only had one person but there are 3 others that live there

Case Note: Application states there is only one person, based on information gathered in the interview Oregonian did not include their children on the application. They were added to the case.

Situation: Received information from an outside entity (aka: Child Welfare or Community Partner)

Case Note: Received an email from Community Partner that there was an income change on the case. Acted on the information provided after verifying the source.

Forms used in the SNAP program

Following are the forms and their uses, as related to the Supplemental Nutrition Assistance (SNAP) program. The forms with the most high-volume use are grouped by type (for example, applications). The remainder of forms are listed in numerical order.

Forms or notices available on NOTM are in both English and Spanish. For the Spanish forms, go to NOTM,SP.

Applications

Form #	Title/Use	Paper	Forms server		Access	Notice writer
			PDF	fill in		
DHS 415F	Application for Services. Used at initial application and at recertification at self-sufficiency branches for individuals receiving SNAP, cash and/or medical benefits. This form also serves to work register all OFSET mandatory members of the filing group. For initial applications, the form is used with the DHS 6609 packet.	X	X	X		
DHS 415X	Additional space for other people living with you Used to supplement DHS 415F for large households applying for benefits.	X	X			
DHS 415Y	Re-Application for Food Stamp Benefits (Part 1) Used at recertification at self-sufficiency branches to establish a filing date when the individual picks up the DHS 6608 recertification packet.	X	X			

Form #	Title/Use	Paper	Forms server		Access	Notice writer
			PDF	fill in		
SDS 539A	Application Form Used at initial application and redetermination at branches serving the aged/individuals with disabilities when they are applying for multiple programs. The form also serves to work register all OFSET mandatory members of the filing group. Must be used with the SDS 539F		X		X	
SDS 539F	Food Benefit Filing Form Used at branches serving aged/individuals with disabilities to establish the filing date and to gather information to screen for expedited service.		X		X	
DHS 6608	Individual Packet for food benefits redetermination only –NA w/OFSET Prepackaged application packet used for recertification of open SNAP cases and consists of the following forms: DHS 415F: Application for Services DHS 415R: Your Rights and Responsibilities DHS 223: Proof for Eligibility MSC 3400: Information and Referrals for Low-income Households DHS 6608A: Supplemental Nutrition Assistance Program (SNAP) Recertification Interview Information DHS 7280F: OFSET Rights and Responsibilities DHS 9001: Individual Complaint Information MSC 9013: We Want to Serve You Well DHS 1005: Alternate Format Notification	X	X		X paper only (DHS 9013)	

Form #	Title/Use	Paper	Forms server		Access	Notice writer
			PDF	fill in		
DHS 6608AP	Action Needed- It's time to Reapply for Food Benefits Supplemental Nutrition Assistance Program (SNAP) Mailed out to SSP office individuals in the month before their recertification comes due. Notifies the individual when they must reapply.	X		X		
DHS 6608AS	Action Needed- It's time to Reapply for Food Benefits Supplemental Nutrition Assistance Program (SNAP) Mailed out to APD office individuals in the month before their recertification comes due. Notifies the individual when they must reapply and that a worker will contact them to help them with the process.	Victims under the Trafficking Victims Protection Act of 2000. A person who is a victim of a severe form of trafficking is to be treated as a refugee under the Trafficking Victims Protection Act of 2002.	X		X	

Form #	Title/Use	Paper	Forms server		Access	Notice writer
			PDF	fill in		
DHS 6609	Oregon Department of Human Services (ODHS) Application for Services Information and Referral Packet Prepackaged forms that apply to all applicants and is given the DHS 415R filing page is received. DHS 415R: Your Rights and Responsibilities MSC 3400: Information and Referrals for Low-income Households DHS 7254: Oregon Telephone Assistance Program DHS 9001: Individual Complaint Information	X	X			
DHS 6623	Individual TANF/Medical Packet – PA Used by SSP offices when a individual is reapplying for TANF or medical along with SNAP.	X	X			
DHS 7476	Employment Related Day Care (ERDC) Re-Application and Supplemental Nutrition Assistance Program (SNAP) Application Used at redetermination at self-sufficiency branches for individuals receiving ERDC and SNAP. The SNAP certification period and ERDC certification period should match.	X	X			

Pending forms

Form #	Title/Use	Paper	Forms server		Access	Notice writer
			PDF	fill in		
DHS 210A	Notice of Information or Verification Needed Used in rare circumstances when a manual pend is necessary; to request information or verification on an open SNAP case. The notice notifies the individual of the information needed for their continued eligibility and the due date.	X	X	X		GS00210

Form #	Title/Use	Paper	Forms server		Access	Notice writer
			PDF	fill in		
SDS 539H	Notice of Pending Status Used at application at branches serving the aged/ individuals with disabilities to notify the individual of what further information is needed and by what date, in order to determine eligibility.	X	X		X	
DHS 210ABW	Notice of information or verification needed for an Able Bodied Adult Without Dependent Used to request hours or other information from an ABAWD needed to show the month is not a counting month.	X	X	X		

Rights and responsibilities

Form #	Title/Use	Paper	Forms server		Access	Notice writer
			PDF	fill in		
DHS 222	Facility as Authorized Representative Used to notify A&D treatment centers and Group Care Homes of their responsibilities when they are the authorized representative.	None	X			
DHS 415R	Your Rights and Responsibilities Used at self-sufficiency branches with applications to explain individual rights, responsibilities, and reporting requirements.	X	X			
SDS 539R	Rights and Responsibilities Used at branches serving aged/individuals with disabilities with applications to explain individual rights, responsibilities, and reporting requirements.		X		X	
DHS 7280F	SNAP Employment and Training Rights and Responsibilities Used to notify SNAP individuals of their rights in the SNAP E&T programs, the requirements, good cause criteria, and penalties. This form covers all three SNAP E&T programs - OFSET, 50-50 and ABAWD.	X	X			FS7832R

Individual report forms and related forms

Form #	Title/Use	Paper	Forms server		Access	Notice writer
			PDF	fill in		
SNP 069	SNAP Periodic Report form. For cases in a 12-month cert, the report will be sent on the 1st of the 5th month. For cases that are in a 24-month certification with earned income, the report will be sent on the first of the 5th, 11th, and 17th month. For cases in a 24 month certification without earned income, the report will be sent on the 11th month. The form is due back, completed and signed by the end of the month it is sent.	X	X			
DHS 853	Simplified Reporting System Used by individuals in SRS to report changes at times other than the Periodic Report. Send a new DHS 853 to the individual for future change reporting each time one is submitted to ODHS|OHA.	X	X			
DHS 943	Change Report Used by CRS individuals to report all changes. Send a new DHS 943 to the individual for future change reporting, each time one is submitted to ODHS|OHA.			X		
DHS 854	Simplified Reporting System for Able-Bodied Adults Without Dependents (ABAWD) Change report explaining the requirements of SRS for ABAWDs who reside in areas applying the SNAP time Limit (SNAP-e.19) only. It explains what information is needed and how it is used to calculate benefits for cases containing an ABAWD who is subject to the SNAP time limit.	X	X			
DHS 856	Transitional Benefit Alternative Pamphlet explaining the requirements of TBA, what information is needed and how it is used to calculate benefits.	X	X			
DHS 7294	Notice of Income and Benefit Calculation Notice to the individual about how income was averaged or anticipated or counted.	X	X	X		FS07294 CM07294

Form #	Title/Use	Paper	Forms server		Access	Notice writer
			PDF	fill in		
DHS 7351	Educational Income Calculation for ERDC and Food Stamps Worksheet for calculating educational income.	X	X	X		

Employment and Training (E&T) forms

Form #	Title/Use	Paper	Forms server		Access	Notice writer
			PDF	fill in		
NOTM	ABAWD Training and Employment Referral Notice. Available only on NOTM. This notice is sent to mandatory ABAWDs in the time limit areas to inform of the initial orientation appointment with the E&T Contractor.					FSWINVT
DHS 824F	OFSET Appointment Letter #3. Send this letter to individuals who want to volunteer for OFSET or 50-50 activities.			X		FS0824F
DHS 824I	ABAWD Work Activity Attendance (SNAP) Used by mandatory ABAWDs to report the number of hours they have completed in work related activities.		X			
DHS 1467	Employment Assessment: OFSET and ABAWD Determinations. Worker- use- only form to assist with determining if a SNAP individual is exempt from the E&T program requirements.		X			
DHS 7280F	SNAP Employment and Training Rights and Responsibilities Used to notify SNAP individuals of their rights in the SNAP E&T programs, the requirements, good cause criteria, and penalties. This form covers all three SNAP E&T programs – OFSET, 50-50 and ABAWD	X	X			FS7832R
DHS 7450	Proof of Work Hours for An ABAWD ABAWDs may choose to use this form to request their employer provide proof of their work hours.		X			

Form #	Title/Use	Paper	Forms server		Access	Notice writer
			PDF	fill in		
DHS 7832F	OFSET Program Case Plan Used by the E&T contractors to obtain the agreed upon work related activities the SNAP individual is volunteering for. This plan also indicates the amount of support services the individual will receive if they complete the activities.			X		

Miscellaneous

Form #	Title/Use	Paper	Forms server		Access	Notice writer
			PDF	fill in		
MSC 138A	Affidavit Concerning Lost Check Individual's application to have benefits replaced when their SNAP benefits are issued by check and have been lost.	X	X			
DHS 208	How to Use Your Oregon Trail Card (EBT Card Brochure).		X			
DHS 215	Authorization to Cancel Benefits Deposited to an Electronic Benefits Transfer (EBT) Account Worker request to cancel EBT benefits.		X			
DHS 221	SNAP Benefits Computation Worksheet for hand-calculating SNAP benefits when computer systems are not available.	None	X			
AFS 222A	Monthly List of Residents Receiving Food Stamp Benefits Used by A&D treatment centers and Group Care Homes acting as authorized representative to report residents receiving SNAP each month.	None	X			
MSC 223	Proof for Eligibility Explains to the individual what verifications may be required to determine eligibility.	X	X			

Form #	Title/Use	Paper	Forms server		Access	Notice writer
			PDF	fill in		
MSC 231	Designation of Authorized Representative or Alternate Payee Used to designate persons with the authority to apply for benefits on behalf of the SNAP group or to designate persons to get an EBT card and use the benefits. The MSC 231 only needs to be completed when a nonfiling group member is named as AP or AR.	None	X		X	
MSC 284	Overpayment/Overissuance Report Form forwarded to the Overpayment Recovery Unit when an overpayment is written.	None	X	X		
MSC 284A	Overpayment/Overissuance Change Report Form forwarded to the Overpayment Recovery Unit when the amount of a previously written overpayment is adjusted.	None	X	X		
MSC 284BP	Notice of Overpayment and Planned Action for Provider Overpayments Notice to the individual prior to collection beginning on an overpayment.	None		X		
DHS 362	Notice of Restoration of Benefits Notice to the individual when benefits are issued to make up for an ODHS|OHA-caused underissuance of benefits.		X	X		FS00362
MSC 371	Investigation Referral Used to refer a case to the Investigator when information has been received through a community complaint or other source indicating that eligibility is questionable.			X		
DHS 411	Missed Appointment Postcard Postcard sent to appicants when they miss their first intake appointment.	X	X			FSMA411
DHS 414	Notice of Transfer Notice of new branch office, sent to the individual when the case in transferred to a different office or the individual has moved to a new service area.		X	X		GS00414

Form #	Title/Use	Paper	Forms server		Access	Notice writer
			PDF	fill in		
DHS 415Z	Enumeration Request Used to verify that a individual has applied for a new or duplicate Social Security Number, in order to meet the enumeration requirement for eligibility.	X	X			
MSC 443	Administrative Hearing Request Form the individual may use to put a request for a fair hearing into writing (must be completed by ODHS|OHA if it is a verbal request).	X	X	X		
MSC 457D	Voluntary Agreement to Take Action on Case Notice signed by the individual giving ODHS|OHA permission to take action on benefits immediately, which waives the right to a timely notice. Also used to withdraw an application request. Also used to take benefits out of EBT account to avoid an overpayment.	X	X	X		
DHS 475	Job Search Verification Form used by individuals performing job search to verify employer contacts.	X	X			GS00475
DHS 491	Statement of Person Living in the Household Form used to verify the financial arrangements and how food is shared when the individual lives with others.	X	X		X	GS00491
SDS 540	Notification of Planned Action Hand-initiated notice to the individual when benefits are approved, denied, reduced, or closed, and there is no appropriate computer-generated notice.	X	X		X	
SDS 541	Notice of Eligibility and Responsibility Notice tells the individuals they are eligible, and their first and second month's benefit amount.	None	X			

Form #	Title/Use	Paper	Forms server		Access	Notice writer
			PDF	fill in		
DHS 824F	SNAP Employment and Training Referral Letter Form letter used to advise OFSET and 50-50 volunteers of a scheduled appointment. This notice is not used for mandatory ABAWDs in the time-limit counties. Instead, they are to receive NOTM FSWINVT.		X	X		FS0824F
MSC 851	Verification of Earnings Form sent to employers to verify earned income for a specified period. This is generally used to determine if there is an overissuance.		X	X		
DHS 857	Notice for Free Meals or Free Milk at School or Child Care Center or Head Start Program Give to individuals after they are determined eligible for SNAP so their children can get free school meals or WIC.	X	X			
DHS 859C	Paycheck Tracking Calendar Tool for ensuring that individuals report all of their earned income.	None	X			
SDS 905	Notification of Case Transfer Notice of new branch office, sent to the individual when they have moved to an area served by a different branch.	X	X		X	
DHS 1058	Declaration of Indigence Statement of indigence by a sponsored non-citizen, used to exempt the non-citizen from deeming their sponsor's assets.	X	X			
DHS 1219SA	Verification of School Attendance	X	X	X		GS121SA
MSC 1295	SNAP Claim Data Sheet Used to collect and organize case record information to be used in calculating an overpayment.	None	X			

Form #	Title/Use	Paper	Forms server		Access	Notice writer
			PDF	fill in		
DHS 1465	Able-Bodied Adult Without Dependents (ABAWD) Report of Good Cause or Exemption Can be used by the customer to report good cause or an exemption. The report can be verbal instead of using the form.	X		X		
DHS 1467	Employment Assessment: OFSET and ABAWD Determinations Worker tool to assist with determining if an individual is mandatory or exempt for the SNAP Employment programs. CAUTION: This form should not be given to the individual to complete as it does not pass the individual standards.	X		X		
MSC 2099	Authorization for Use and Disclosure of Information Used in instances where the individual is unable to provide necessary verification. The form gives ODHS|OHA permission to contact a specific person or organization and share information about the individual in order to verify eligibility.	X	X	X		
DHS 3400	Information and Referrals for Low-Income Households Given to all SNAP households at each certification and recertification when they have income below 200% FPL.	X	X			
DHS 7254	Oregon Telephone Assistance Program Notice and application to the individual that because they are eligible for benefits, they can apply for a discount on their monthly telephone bill.	X	X			
AFS 7262	Direct Deposit –- A Safer, Easier Way to Put Your Benefits in Your Account Used for individuals in Cash-out counties using direct deposit.		X			

Form #	Title/Use	Paper	Forms server		Access	Notice writer
			PDF	fill in		
DHS 7832D	Oregon Food Stamp Employment & Transition (OFSET) Program Disqualification Referral Contractor to complete and send to SNAP office when recommending disqualification.		X	X		
DHS 7832F	OFSET Program Case Plan Contractor completed case plan with OFSET mandatory individuals.	X	X			
MSC 9001	Individual Complaint Information Form explains individual complaint procedures, should they perceive that they are being treated with discrimination. It is mandatory for use with all applications.	X	X		X	
MSC 9013	We Want to Serve You Well (Contained in individual application packets DHS 6608 & MSC 6623 only) An information only pamphlet that tells individuals how to file a grievance.	X	X			

Outreach publications

Form #	Title/Use	Paper	Forms server		Access	Notice writer
			PDF	fill in		
DHS 848	Your SNAP food benefits may increase by reporting your expenses Individual brochure on expenses which may be used as an income deduction for SNAP	X	X			
DHS 849	Your SNAP food benefits may increase by claiming your medical expenses Individual brochure on medical expenses for SNAP	X	X			
DHS 864	Attention SNAP Participants! Rules are different Poster – About the SNAP ABAWD changes for January 1, 2016	X	X			

Form #	Title/Use	Paper	Forms server		Access	Notice writer
			PDF	fill in		
DHS 9207	Oregon Helps: Now showing at a computer near you Bookmark (4" x 9") on using www.oregonhelps.org to find out if you might be eligible for SNAP benefits	X	X			
DHS 9208	More reasons to sign up for SNAP Explains how SNAP benefits make families eligible for free school meals and two phone assistance programs.	X				
AFS 9211	Food Stamp Expedited Issuance Flier on expedited SNAP benefits.	X paper only				
DHS 9213	Eating Right When Money's Tight – A Guide for Seniors and People with Disabilities Individual brochure for seniors and people with disabilities and the SNAP Program. Includes eligibility guidelines.	X	X			
DHS 9216	Know Your Rights, Individual Bill of Rights Poster - lists rights of SNAP recipients.	X paper only				
DHS 9217	Know Your Rights Flier - lists rights of SNAP recipients.	X	X			
DHS 9221	Spread the word: HEALTHY food is within reach Introduces the new name – SNAP – and gives general information about the program.	X				

Prison discrepancy lists

A person is ineligible for SNAP when they are incarcerated (county and state systems). The OPAR Data Match Unit (DMU) Corrections Project team identifies incarcerated individuals who are receiving SNAP benefits. When warranted, DMU closes the SNAP case according to the procedures below.

Closures by DMU: single person cases

When no release date is listed on the jail Web site, or the release date is beyond the end of the month in which DMU becomes aware of the incarceration, the Corrections Team will close the SNAP benefits when the incarcerated person is the only one on the case.

- When the Corrections Team closes a SNAP case, they will disable the participant's EBT card to preserve benefits for use upon their release;

- Corrections Team staff will send the participant timely notice FSC1PNE. Under Worker Name/Phone, "Contact local branch worker" will be listed;
- TRACS entry will be made on the participant's record to indicate the SNAP benefits were closed.

Inactivation by DMU: single person cases

When no release date is listed on the jail website, or the release date is beyond the end of the month in which the Corrections Team becomes aware of the incarceration and there is not enough time for a timely notice, the team will place the participant's EBT card into an inactive status.

The Corrections Team will make a TRACS entry on the participant's case to indicate that the EBT card was inactivated due to incarceration.

These cases will be reviewed at the beginning of the following month and closed if the participant is still incarcerated. Notice FSC1PNE will be sent. If the participant is no longer incarcerated a TRACS narrative will be entered indicating no action to SNAP.

Cases requiring branch action

The Corrections Team will not take action on any SNAP case with multiple people receiving SNAP benefits.

- When such a case has been identified, the Corrections Team will send an Outlook email advising the home branch of the participant's incarceration status;
- Each branch will have procedures in place so the transfer clerk can forward the email to the appropriate person for necessary case action.

The local office is required to take action when information is received that a person is in prison. This includes sending a close or reduction notice. For SNAP, the notice must always be a timely continuing benefit decision notice (10-day). Workers may use notice FSC1PNE (to close) or FSR1PWE (to reduce) on Notice Writer.

If the person is released before the effective date of the notice and contacts the local office before that date, the worker can do a ROP transaction or add the person to an open case as of the first of the next month. If the contact is made on the first of the next month or later, follow add a person policy for open cases or have the person reapply for closed cases.

Note: If the only adult on the case is incarcerated, the EBT card should be inactivated to protect the participant's benefits until their release.

For cases in CRS or SRS:

1. Regardless of whether the release date is known, send notice to close or reduce benefits and remove the person from the SNAP case.
2. If the person is released before the effective date of the notice and contacts the local office before that date, the worker can do a ROP transaction or add the person to an open case as of the first of the next month. If the contact is made on the first of the next month or later, follow add a person policy for open cases or have the person reapply for closed cases.

For cases in TBA:

1. Determine if the release date is known. If expected to be before the effective date of closure, narrate the incarceration report and that no action is needed due to expected release date.
2. For those persons with no release date or an expected release after the effective date of closure, determine if the person is head of household on the SNAP case.
3. If head of household is incarcerated, send notice of closure and close the TBA.
4. If the incarcerated person is not head of household, narrate the report and do not remove the person from the SNAP case.

Click here for examples: Prison discrepancy lists.

Processing changes for SNAP

Processing the information reported by individuals in a timely and accurate manner is a critical piece in reducing the Quality Control error rate. To be timely, a decision must be made and an action taken within 10 days of receipt of the reported change.

The individual may report one piece of information. That piece of information may impact several areas regarding an eligibility and/or benefit amount. For example, "I moved." The new address is needed to determine residency. However, there are several other areas that are impacted by this statement. We have attempted to list some of these areas below:

Factors to consider with a reported change of address:

- Residency. Reasons for the move. Does the household live in the area or does the case need to be transferred to another branch or closed, if moved out of state?
- Rent or shelter costs. What is the new rent amount? If the new shelter costs are higher than the household income, how will they pay the expenses?
- Utilities. How is the home heated? Is the dwelling billed separately for heating? Who is responsible for the heating costs? Is the responsible party the filing group or another person? Are they entitled to the FUA?
  - If not entitled to the FUA, do they have nonheating utility costs that are allowable; i.e., telephone basic rates? This could make them eligible for the LUA.
- Household composition. Who is living in the home? If there are others in the home, how are they related to each household member? If related, are they required to be a member of the filing group? Remember, if parents and children under age 22 are sharing the same home, they must be in the same filing group. If there are others in the home, do they purchase and prepare meals separately? If a separate filing group, do they contribute to the shelter or utility costs?
- Effective date. The effective date for the change depends on the result of the action. Will the result be to increase benefits, or to reduce or close benefits?
  - Increase. If the change causes an increase in benefits, make the change effective the first of the month following the date the change happened. Do not adjust the benefits retroactively or give a supplement.

Action of changes is always future effective. No notice is needed when the change will increase next month's benefits.

- Reduce or close. Send the timely continuing benefit notice at least 10 days before the first of the next month when the change will reduce benefits.

Factors to consider when a person moves into or out of the household:

- Moved in. Is the person required to be included in the filing group due to relationship? Do they purchase and prepare meals separately? Will they be paying a portion of the rent and utility costs? If must be in the same filing group, does the person have countable income or resources? If not categorically eligible, will the person's income or resources put the case over the countable income/resource limits?
  - An application is not needed to add a new person to a SNAP filing group, so it is imperative that all pertinent information is collected before benefits are issued (date of birth, SSN, OFSET determination, income verification, etc.).
  - If adding a person with their income results in fewer benefits, remember to send a timely continuing benefit decision notice before the effective date.
- Moved out. Remember to remove the person's needs from FCAS along with their income. If this person was paying a part of the rent and utility costs, remember to reevaluate the household costs coded on FCAS.
- Effective date. The effective date for the change depends on the result of the action. Will the result be to increase benefits, or to reduce or close benefits?
  - Increase. A person should be added to the case or removed from the case the first of the next month when it will increase benefits.
  - Reduce or close. If the change will decrease benefits, the person should be added or removed from the case no later than the first of the month following the date the timely continuing benefit notice period ended.

Factors to consider when a person reports a change in employment:

- Job ended. What was the last day of work? When will the final paycheck be received? Why did the job end? If a job quit, and the person is now OFSET mandatory, was there good cause for the job quit? If no, they may be subject to an OFSET disqualification.
- New job. When did the job start? Where is the individual working? What type of work? When will the first paycheck be received? When are the pay periods? How often paid? What are the pay dates? What is the rate of pay? Will they get paid a shift differential? What is the expected number of work hours each week? If employed as a waitress or bartender, what do they expect for tips?
- Increase or decrease in work hours. When does this change in work hours begin? When will they receive the first paycheck that is impacted by this change in work hours? What is the reason for a decrease in work hours? If the individual asked for fewer work hours and was working the equivalent of 30 hours a week at federal minimum wage, and is now OFSET mandatory, was there good cause? There may be a need to apply an OFSET disqualification.
- Change in rate of pay. When does this change in rate of pay begin? When will they receive the first paycheck that is impacted by this change in rate of pay.

- Is the change in income verified upon receipt or required to be reported based on the reporting requirements? The income may or may not need to be verified or acted upon. Refer to the reporting requirements for the individual and determine whether verification is necessary or simply narration.
- Effective date for change reporting or semi-annual reporting or transitional benefit cases: The effective date for the change depends on the result of the action. Will the result be to increase, reduce or close benefits?
  - Increase. If the employment related change will increase benefits, act on the change effective the first of the next month.
  - Reduce or close. If the change will reduce benefits, send the timely continuing benefit notice and code the new income amount on FCAS no later than the first of the month following the date the timely continuing benefit notice period ends.
- Effective date for monthly reporting cases: Continue to process the monthly report as normal. No additional notices are required.

Factors to consider when a person reports a change in a cost:

SNAP individuals are not required to report a change in the amount of deductions, if there is not another change (such as a move). However, if a individual does report a change (e.g., increase in medical deductions or decrease in rent amount), the change must be acted on as quickly as possible. An increase in the deduction may result in more SNAP benefits. A decrease in a deduction may result in fewer SNAP benefits.

SNAP medical deductions

At initial application and at each recertification, use a reasonable estimate of the individual's anticipated medical expenses for the certification period. The estimate should be based on current medical expenses (including any medical insurance premiums) and any anticipated expenses based on the individual's medical history. Verify the costs and code the anticipated or averaged monthly medical expenses on FSMIS.

If the individual incurs and reports medical expenses that were not anticipated at initial application or recertification, these expenses may also be used in determining the individual's SNAP medical deduction. The individual can choose to use the full expense in the month after it is billed or becomes due, or to have the expense averaged over the remainder of the certification period. Medical expenses should be averaged if averaging would be beneficial to the individual. Paid medical expenses can be averaged, beginning with the month after the expense is paid (as long as the expense was paid in the month it became due). Unpaid medical expenses can be averaged beginning with the month after the expense is billed to the individual.

Caution: Changes in medical costs reported during the middle of a certification period can only be used to adjust the next month's benefits. Do not act on reported changes retroactively back to the first of the month.

If the case is in SRS, act on a reduction in medical costs during the certification period only when a one-time cost is used to increase benefits for just one month.

Partially paid SNAP medical expenses that were not anticipated.

Facts: Bob is eligible for SNAP benefits from January through December. He is 70 years old and receives $700 per month in Social Security benefits. He also gets Medicare. His Medicare premium payment is

$88.50 per month. His Medicare Part D cost is $22.50 a month. Other than his Medicare premium, Bob anticipates no medical expenses for the certification period. He chooses not to apply for QMB-BAS. His medical deduction at certification would be $111 = ($88.50 + $22.50)

Situation: In March, Bob tells his worker that he has just started an allergy treatment program. It will cost him $300 after Medicare pays 80 percent of the total cost. Bob pays $200 in March and still owes $100, for which he agrees to pay $20 each month beginning in April. Bob tells his worker to average the $200 he paid in March over the remaining months of his certification period. His March benefits cannot be supplemented to reflect the extra medical expense. The $200 expense is averaged from April through December (nine months) and added to Bob's medical deduction for those months.

Bob's gross monthly medical deduction for April through August (the month in which his allergy treatment will be paid off) is:

($200 ÷ 9) = $22.22 + $20 + $88.50 + 22.50 = $153.22

Bob's gross monthly medical deduction for September through December is:

($200 ÷ 9) = $22.22 + $88.50 + 22.50 = $133.22

Paid SNAP medical expenses that were not anticipated

Facts: Jane is eligible for SNAP from January through December. Jane is 58 and is disabled (GP-A.24). She receives $750 per month in Social Security disability benefits. Her Medicare premium payment is $88.50 per month. Her Medicare Part D premium is $21.70 a month. Other than her Medicare premium, Jane anticipates no medical expenses for the certification period. She does not want to apply for QMB. Her medical deduction at certification would be $110.20 = ($88.50 + $21.70)

Situation: In July, Jane shows her worker that she paid a medical bill of $350. Jane had not anticipated this medical expense. Her July benefits cannot be supplemented to reflect the extra medical expense. The $350 expense is averaged from August through December and added to Jane's medical deduction for August through December. (Jane could also choose to apply all $350 as a deduction in August.)

Jane's gross monthly medical deduction for August through December is:

($350 ÷ 5) = $70.00 + $88.50 + 21.70 = $180.20

Jane pays for some prescription drugs in August (another expense she had not anticipated). She sends a copy of the charges to her worker on August 12. The total amount is $154. She tells her worker to average the amount over the remaining months of her certification period. Her August benefits cannot be supplemented to reflect the extra medical expense. The $154 expense is averaged from September through December and added to Jane's medical deduction for those months.

Jane's gross monthly medical deduction for September through December is:

($154 ÷ 4) = $38.50 + $180.20 = $218.70

Jane is billed for and pays for a pair of eyeglasses on December 2. The eyeglasses cost $65. Jane sends a copy of the eyeglasses bill to her worker on December 6. No additional medical deduction

is allowed for the eyeglasses because Jane paid the cost and reported it in the last month of her certification period, after December 1. Jane's SNAP benefits for December cannot be supplemented because no errors were made in calculating her benefit amount. Jane simply reported the eyeglass expense too late to be used in calculating her December benefits.

Therefore, Jane's gross medical deduction for December is $218.70. Because the bill was paid in December, she is not eligible for a deduction for the glasses in the next certification period starting in January.

Unpaid SNAP medical expenses that were not anticipated

Facts: Harry is eligible for SNAP from January through December. He is 67 and receives $700 per month in Social Security benefits. He also gets Medicare. His Medicare premium payment is $88.50 per month. His monthly Medicare Part D cost is $22.00. Other than his Medicare premium, Harry anticipates no medical expenses for the certification period. He chose not to enroll in QMB. His medical deduction at certification would be $110.50.

Situation: Harry is unexpectedly hospitalized in March. The hospital sends him a medical bill of $850 in April, which he sends to his worker that same month. His worker calls him. He states he did not make an arrangement to make payments each month. The worker explains how the bill is averaged over the remaining months of his certification period, beginning in May (the month after the expense was billed). The worker also explains to Harry that anything that Medicare covers cannot be used as a deduction. Harry says that Medicare has already paid their portion. Harry's gross monthly medical deduction for May through December (eight months) is:

($850 ÷ 8) = $106.25 + $88.50 + 22.00 = $216.75

In July, Harry is billed for two checkups he received in June that were not anticipated. The total amount is $140 after Medicare. His worker receives a copy of the bill on July 6. Harry chooses to have the bill averaged over the remaining months of his certification period, beginning in August. Harry's gross monthly medical deduction for August through December (five months) is:

($140 ÷ 5) = $28 + $216.75 = $244.75

In September, Harry is billed for a lab test that was not anticipated. The amount due is $35. He has not paid the bill yet. He tells his worker that he would like to have the bill used in full for his October deduction.

Gross medical deduction for October only is:

$35.00 + $244.75 = $279.75

Gross monthly medical deduction for November and December is $244.75

Medical expenses change, but are not reported

Facts: Myrtle gets $900 per month Social Security benefits. Her Medicare premium costs $88.50 but it is covered by Medicaid (SMB). At her initial intake, she was expecting office visits with her doctor twice a month, at the cost of $45 per visit. She also expected her cost at $35 per month in prescription medicines.

The worker calculated 2 x $45 = $90 x 20 percent (Myrtle's share) = $18 per month for office visits.

$18 office visits + $35 prescriptions = $53.00 medical deduction for the certification period.

Situation: At recertification, Myrtle reports that four months ago, she began having doctor's office visits only once every other month and her prescription costs (GP-A.18) dropped to $12 per month. The charge for the doctor's office visit continues to be $45 per visit. The worker calculates a new medical deduction for the next certification period as follows:

$22.50 ($45 ÷ 2) office visit + $12 prescriptions = $34.50 medical deduction. Although this amount will not affect Myrtle's SNAP allotment (it is less than $35), it is a good idea to code it on FSMIS.

There is no overissuance for the prior certification period because Myrtle is not required to report changes (SNAP-I.2) in medical expenses.

Medical deduction recalculation: Although Myrtle is not required to report a change in her medical expenses, the worker must recalculate the medical deduction if changes up or down are reported and verified during the certification period for cases in CRS. For cases in SRS, changes must be verified when the reported change will increase benefits.

Medical expenses reported monthly for companion medical case

Facts: Martha is eligible for SNAP from January through December. She receives $1045 a month Social Security benefits. Her $88.50 Medicare premium is picked up by the state and her monthly Medigap plan premium is $124.80 a month. In addition she has other medical costs -- over-the-counter (OTC) costs for prescribed aspirin, vitamins, and Depends of $90.00 a month. She is receiving in-home services.

For the purpose of the SNAP medical deduction her medical program liability is $225.50 $1045 SSB - 604.70 standard - $124.80 insurance costs - other costs of $90.00 OTC). The individual is required to report the other medical costs on a month by month basis for the Medical program. However, the costs are anticipated and averaged for the year for the SNAP program.

The medical deduction is calculated as:

$124.80 insurance + 90.00 other costs + $225.50 liability = $440.30 medical deduction per month of the certification period.

Situation: Martha is reporting other medical costs each month for her medical case. The other medical costs change monthly and thereby change her liability. The costs and liability were anticipated at certification and there are no new costs and therefore, no changes to the medical deduction. However, during April she reports and verifies that her March costs increased because she had a one-time over the counter cost of $20. Because this is a one-time cost, $20 is averaged out over the balance of the certification period (eight months). The expense is included in Martha's medical deduction for May through December.

$20 ÷ 8 = $2.50 + $440.30 = $442.80

In August, Martha reports she purchased glasses that were outside of the two-year cycle and her cost was $250. She has set up a payment plan and will pay $50 a month for five months. The expense of $50 a month is included in Martha's medical deduction for September through December (four months). The remaining $50 can be allowed for a new certification period in January if the $50 is still due and not in arrears.

$50 + $445.30 = $492.80

SNAP reporting systems at-a-glance

The SNAP program uses several report systems. The following are the basics about each report system at-a-glance. Select here for Acting on reported changes.

Change Report System (CRS)

Purpose & Benefits	CRS is a report system with many reporting requirements. While in CRS, SNAP benefits may change each time the household reports a change that is expected to continue.
Who must be in CRS	Any SNAP case that cannot be in one of the other report systems must be in CRS.
Who cannot be in CRS	The participants who cannot be in CRS are: • participants receiving SNAP under Transitional Benefit Alternative (TBA).
Certification Periods	SNAP cases in CRS are limited to a six-month certification period, except: • ERDC/SNAP households may be certified for 12 months if the ERDC certification form is being processed at least once each six months. • Households where all members are elderly or are persons with disabilities and there is no earned income may be certified for 12 months.
Budgeting	Use prospective budgeting. Anticipate the initial month's income considering all that has been received to date and anticipating what will be received yet in the month. For the second and future months of the certification, anticipate or convert the income to a monthly figure in the first month and use that amount continually until a change is reported.
Reporting	Report all required changes as outlined in SNAP-I.2.
Acting on Reported Changes	Act on all reported changes. Reported changes may increase or decrease benefits. Increase benefits = Act immediately for the next month unless more information is needed. If more information is needed, send a Notice of Information or Verification Needed (DHS 210A) requesting the information. Do not act to increase benefits until the proof or information is provided. DO NOT hold benefits for the information. Decrease benefits = Act immediately for the next month's benefits following the timely continuing benefit decision notice period to reduce benefits. If proof of income is needed, make the change and request the required proof via the DHS 210A. A second adjustment may be needed when the requested information or proof is received.
When does CRS end?	CRS is the default report system and ends when the case is placed into another report system.

FSMIS coding	There are no special Trans coding for CRS. The Mand Rpt field is "N."

Simplified Reporting System (SRS)

Purpose & Benefits	SRS is a report system with limited reporting requirements. While in SRS, SNAP benefits will generally remain unchanged for a six-month period.
Who can be in SRS	Any SNAP case not excluded from SRS.
Who cannot be in SRS	The following types of households cannot be in SRS: • A case eligible for TBA. • Certification period for less than four months.
Certification Periods	A 12-month certification is assigned with a few exceptions. A 1-2 month certification is assigned for expedited cases. A 24-month certification is assigned for NED households (No Earned income), and all adults are elderly (GP-A.29) or disabled (GP-A.24)) **NOTE:** Cases processed in ONE will automatically be assigned the appropriate certification period based on expedited or NED criteria. Otherwise 12-month certification is the default length.
Budgeting	Use prospective budgeting. Anticipate or convert ongoing income to a monthly figure in the first month and use that amount continually until a change is reported. For initial month, use actual and anticipated income only if the income is just starting or ending, or will be significantly different in subsequent months.

Reporting	Between report forms, the SRS household must report when: • Income exceeds the SNAP Countable Income Limit (130 percent FPL); • Work hours have been reduced to below 20 hours per week for an ABAWD who is subject to the time limits. • Lottery or gambling winnings of $3750 or more Oregonians will still need to report the changes required in other programs. If they report a change that impacts SNAP; and the change • Was not required to be reported for SNAP and is considered verified upon receipt, the worker will need to act on the case; • Was required to be reported for SNAP, the case will need to be acted on; or • Changes should be coded in ONE and ONE will determine if there are any changes to act upon. All cases certified for longer than six months must complete the Periodic Report form (SNP-069), except those cases with no earned income and all adult filing group members are elderly or are Oregonianss with disabilities The form is due in the 5th month of the certification period and must be processed by end of 6th month for benefits to be received for months 7 through 12. NED cases that are certified for 24 months are required to complete a Periodic report month 11 and it must be processed by end of 12th month of the certification period to receive benefits for months 13 through 24.
Acting on Reported Changes	In addition to acting on The Periodic Report (SNP-069) act on all reported changes that the Oregonian is required to report. For all other changes: Increase benefits = Act on changes that will increase benefits and if all information is needed is received and verified at time of report. If the change requires verification, (i.e., income, or medical) do not act to increase benefits until the proof is provided. Decrease benefits = Do not act on information that will decrease benefits, unless the information is clear and is “verified upon receipt..” Only request proof if a Oregonian reports their income has exceeded the countable income limit. Add case note in ONE. Information is “verified upon receipt” when it is not questionable, and the provider of the information is the primary source. (Examples: employer, SAVE, worker’s compensation, Oregonian’s statement on new shelter costs, etc.) If the information is found to be questionable- enter information into ONE and RFI will be sent for any additional follow up needed.

When does SRS end?	End SRS anytime the participant: • Becomes eligible for TBA; • Becomes ineligible (they may report income that exceeds 185 percent FPL and they are no longer categorically eligible, this may lead to being over income).
FSMIS coding	Cases can only be put into SRS in the following months: **Cert month** — **Can case be put in SRS?** Month 1 — Yes Month 2 — Yes Month 3 — Yes Month 4 — Yes Month 5 — No: SRS report period cannot change in the 5th month Month 6 — Yes Month 7 — Yes Month 8 — Yes Month 9 — No. SRS date must be 6 months from start cert Month 10 — No. SRS date must be 6 months from start cert Month 11 — No. SRS report period cannot change in 11th month Month 12 — No. SRS report period cannot change in 12th month
	Use a transaction code (Trans) of SRS to place the case into or to remove a case from SRS. The Mandatory Reporting (Mand Rpt) field is "S." Use household type code (HH Type) of NED when there is no earned income and all adult members are elderly or are participants with disabilities. Enter the sixth month of the certification period or the last day of the certification period, whichever date comes first, into the date field (Rpt Exp). (Always code last day of certification period if using NED in the HH Type field). Use the ADJ to extend the certification period to the full 12 months when placing the case in SRS that was certified for less than 12 months. Use ADJ to adjust benefits due to reported changes during the six months. Do not use SRS transaction code or touch the "S." Use SRS, ADJ to process the interim report form in the sixth month. Change the Rpt flag from N to Y (as with MRP). Do not touch the "S" or change the Rpt Exp date. Use REC, SRS to extend the certification to the second 12 months of the 24-month certification period once the phone contact has been made. At recertification, use REC, SRS and change the Rpt flag from N to Y. This will change the report expiration date.

Transitional Benefit Alternative (TBA)

Purpose & Benefits	TBA is a report system that freezes SNAP benefits for five months for participants whose TANF cash benefits end for a good reason.
Who must be in TBA	SNAP cases with TANF cash benefits ending and that are not excluded from being in TBA. (No one in the SNAP filing group can be getting TANF.)
Who cannot be in TBA	• Benefit groups that lose cash benefits due to moving out of state. • Failure to comply with reporting requirements or RI or did not report a required change within 10 days). • TANF cases being penalized for noncooperation (JOBS or Support DQ or IPV) and disqualification was not lifted when the case closed due to a new job; or received notice of TANF disqualification and voluntarily ended their TANF cash benefits. • SNAP filing groups with an ineligible member (IPV, QC, OFSET disqualification, fleeing felon, disqualified ABAWD due to the SNAP time limit, etc.) Note: This does not include members ineligible for SNAP due to non-citizen status.
Certification Periods	If the case is due to recertify prior to the end of the TBA period, extend the certification period to match the TBA end date. Do not recertify. TBA households must recertify at the end of the TBA period, even if the certification end date is later.
Budgeting	Use prospective budgeting. Change the TANF grant to $0 and leave the rest of the SNAP case situation as it was the month before TBA begins. Do not code new income unless adding a new person to the case.
Reporting	No required changes to be reported during TBA, except for a working ABAWD who must report within 10 days if their work hours drop below 20 hours a week.
Acting on Reported Changes	Increase benefits = Participant needs to reapply for SNAP. Determine if the new situation will result in more SNAP. If now eligible for more SNAP benefits, end TBA and REC the case. If not eligible for more SNAP benefits using the current situation, continue TBA unchanged to the end of the TBA Period. Decrease benefits = Only act to decrease benefits in one instance. That is if someone moves out of the household and applies for SNAP benefits in another household. In that event, remove them from the TBA case, allowing for the timely notice. Narrate.
When does TBA end?	End TBA early when the benefit group: • Is no longer eligible for SNAP (e.g., moves out of state or requests case closure); • Head of household goes into a facility. • Applies for SNAP benefits and will get more SNAP benefits if not in TBA; or • Re-opens a TANF cash case; • Becomes ineligible for TBA based on the above list (this includes an ABAWD who has exceeded the SNAP time limit).

FSMIS coding	Use a transaction code (Trans) of TBS to enter or remove a case from TBA. The Mandatory Reporting (Mand Rpt) field is "T". Enter the last month, day and year of TBA eligibility in the Report Expiration (Rpt Exp) field. The date is edited and cannot be greater than five months from the TBS effective date (D-Eff). Change the Y Cat El. field to C. Use the ADJ transaction to extend the certification period to match the Rpt Exp date. The end cert (Expr Cert) date must either match the Rpt Exp date or can be further into the future. If this date is not at least five months into the future, the certification must be extended. To remove a case from TBA, use the TBS transaction and change the Mand Rpt type to "N." The system will remove the Rpt Exp date. If the certification period was extended and is longer than 12 months, the system will change the Expr Cert date to the end of the current month. The case must be recertified to continue benefits.

Residents of institutions

Group living arrangements

Residents of a group living arrangements who are blind or disabled (see GP-a.24) and receiving benefits under Title I, Title II, Title X, Title XIV, or Title XVI of the Social Security Act and residents of group living arrangements who are considered residents of institutions may be eligible to participate in SNAP.

A group living arrangement is defined as:

- A community-based residential facility operated by a public or private nonprofit organization, or
- An institution authorized to serve no more than 16 residents.

Some examples of group living arrangements are: Residential Care Facilities (RCF), Mental Health Group Homes and group homes for Developmentally Disabled individuals. In order for residents to be eligible for SNAP the facility must:

- Be certified by an appropriate state agency, such as the State of Oregon, Oregon Department of Human Services (ODHS) under regulations issued pursuant to section 1616(e) of the Social Security Act, or
- Under standards determined by the Secretary of Agriculture, to be comparable to standards implemented by appropriate state agencies.

Ineligible group home population

The following residents of group living arrangements are ineligible for SNAP:

- Individuals residing at ineligible facilities; or
- Residents who do not meet the definition of disabled or blind and who are not receiving benefits under Titles I, II, X, XIV or XVI of the Social Security Act.

Application procedures for group living arrangements

Residents of group living arrangements may apply and be certified:

- Through the use of an authorized representative who is an employee of and designated by the facility, or
- On their own behalf; or through the use of an authorized representative of their choice.

The facility makes the determination as to which method of application will be used, based on the resident's physical and mental ability to handle their own affairs. Some residents of the group home may use an authorized representative while others may not.

Calculating shelter deductions

Residents of group living arrangements may be eligible for a shelter deduction. This allowable shelter cost is the amount of the payment for the room only when the housing cost is separately identified. When the room and board payment is not separately identified, calculate the shelter cost by subtracting the Thrifty Food Plan (TFP) from the room and board cost.

For example, an individual pays $654.00 room and board:
$654 - $250 (TFP) = $404 allowable shelter deduction.

Allow this calculated amount, unless verification is provided that the room cost exceeds the calculated amount. Allow the higher amount once verified.

Group living arrangement as authorized representative

Residents who apply through the facility's authorized representative must have eligibility determined as a one-person household unless they live with their child/ren under 22 years old. The facility must:

- Receive and spend the residents' SNAP benefit allotment for food to be prepared and served to the eligible residents, or
- Allow the residents to use any portion of their allotments on their own behalf; and
- Be knowledgeable about the residents' situation, the facility designated authorized representative is responsible to provide accurate information regarding the residents' situation.

The facility is liable for any overpayment resulting from failing to report and/or inaccurately reported information.

Rights of residents acting on their own behalf

When a resident applies and is certified on their own behalf, or designated an authorized representative of their own choice, the resident may:

- Use the SNAP benefits to purchase meals prepared and served by the facility.; or
- Use any portion of SNAP benefits to purchase and prepare food for their own consumption

Drug and alcohol treatment and rehabilitation programs

Residents of a facility or treatment center that are participating in a drug and alcohol (D&A) treatment and rehabilitation program, may be eligible for SNAP benefits. To receive benefits the resident applies and is certified in

accordance with OAR 461-115-0020, through the use of an authorized representative employed by the facility and designated for that purpose.

Not all facilities meet the requirements for their residents to receive SNAP. The facility must meet the following criteria:

- The drug and alcohol treatment and rehabilitation program is conducted by a private, nonprofit organization or institution, or a publicly operated community mental health center, under part B of title XIX of the Public Health Service Act to receive funds, even if it does not actually receive funding under part B of title XIX. (https://findtreatment.samhsa.gov/); or
- The treatment center or facility is an authorized retailer by FNS (https://www.fns.usda.gov/snap/retailer-locator); and
- Designate an employee to serve as authorized representative on behalf of residents.

Residents of Approved Facilities:

Residents of approved facilities or treatment centers may voluntarily apply for SNAP through the authorized representative at the facility.

The application process is as follows:

- The authorized rep for the facility must have an in-depth conversation with the resident so that they are knowledgeable about the resident's situation.
- The authorized rep submits the SNAP application on behalf of the resident. The resident must designate and sign the MSC 0231 and DHS 222 (MSC 0231 and DHS 222 embed) appointing the facility designated employee as authorized representative for SNAP benefits.
  - The resident can only apply for SNAP benefits with the assistance of the authorized representative designated by the facility.
  - If the resident refuses to designate the facility as an authorized representative and sign the MSC 0231 and DHS 222, they are no longer eligible for SNAP since it is a requirement of the program to designate the facility as their authorized representative. The facility is not able to receive or apply for SNAP benefits for a resident without their knowledge and consent.
- Ensure timely notice or a signed 457D to remove the applicant from any existing SNAP cases and deactivate any cards currently issued to the applicant.
- Each resident is in a separate filing group and there is no need to determine how meals are purchased and prepared;
  - Only the resident and any child/ren under 22 years old also residing in the facility should be on the SNAP case.
  - Spouses and children may reside in the same facility or treatment center. In this circumstance, children under the age of 22 will need to be included in only one parents filing group. The authorized representative will need to discuss and determine with the residents which filing group the children should be included in.
- The AFS 222A (AFS 222A) is required to be updated and submitted monthly reporting the current residents in

the facility receiving SNAP. If form is greater than 30 days old a new AFS 222A is required.

- The DHS 222A (AFS 222A) must be on file at the local branch dated within 30 days.

- On FSMIS, add the facility name on the authorized rep line.
- Request a new EBT card.
  - The card should be issued to the facility as soon as the application/interview is completed.
    - » For instructions on how to designate the card for SNAP/Cash only please contact the SNAP policy unit to get the card updated
- Do not require the authorized rep to give you an SSN to be added as the alternate payee.
- The facility is allowed to take 50 percent of the EBT benefits on the first half of the month, and the remaining benefits on the 16th or after. The facility may not access or remove benefits from the resident's EBT card after they leave the facility.

Exit Procedures:

The household is allowed sole access of any benefits remaining on the card at the time they left the facility. If the resident leaves before the 16th day of the month the facility must ensure that half of the household's monthly allotment is available to the individual. If the household leaves the facility on or after the 16th day of the month there is no requirement that the facility return any benefits already used.

The following are responsibilities when a resident exits the facilities:

1. The Facility:
   (a) If possible, provide a change report form (DHS 853) when the resident exits the facility and advise them to return the report form within 10 days to report new mailing address or any required changes.
   (b) No longer act as an authorized representative for certification or for obtaining or using SNAP benefits.
   (c) Notify the branch of the household's departure from the facility and provide a new address if available.
   (d) When possible, provide the household with the EBT card.
      i. Any EBT cards not returned to the resident must be returned to ODHS by the end of the month.
   (e) When a card is received by the branch from a facility follow destruction of Oregon Trail Card process detailed here.
2. The branch;
   (a) Remove the authorized rep;
   (b) Deactivate any returned EBT cards received from a facility and follows the destruction of Oregon Trail Card process detailed here.
   (c) Verify the facility has not accessed any benefits after the date the household exited the facility.
   (d) Take no additional action on the case during the certification period unless verified information is received or action is required based on the SNAP reporting system requirements.

Facility acting as an authorized representative requirements and responsibilities:

- The facility is responsible for reporting required changes.

- The facility is liable for any SNAP overpayments incurred while acting as authorized representative for a resident.

If there is reason to believe that a facility is misusing SNAP benefits and/or EBT cards in its procession contact SNAP Policy with facility and case information. Take no action against the facility, organization or institution before or after submitting report to SNAP policy.

Residents of ineligible facilities

Residents of an ineligible facility may be eligible for SNAP if meals are separately and they have space to store their food.

If the resident does not purchase and prepare separately from other residents;

- Take action to close the case. Allow for timely closure of the case unless a Voluntary Agreement to Take Action on Case (MSC 457D) form is submitted. When an MSC 457D is completed the closure can happen without timely notice.
- Cancel the EBT card immediately.

Chapter 7: Worker guides

Section 3: TANF worker guides

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

TANF worker guides

Introduction

This section is currently under construction. For tools and guidance pertaining to the TANF program, please click here for TANF Staff Tools.

Chapter 7:
Worker guides

Section 4: Child Care worker guides

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Child Care worker guides

Introduction

While the chapters within the Oregon Programs Eligibility Notebook are intended to cover all areas of eligibility, there may be miscellaneous pieces of information that do not fit into a single topic. The Child Care worker guides are available as a tool to accompany the rest of Oregon Administrative Rule and the Oregon Programs Eligibility Notebook for these areas regarding child care assistance through the ERDC and TANF programs.

Listing child care providers for payment

Overview of the listing process

Child care providers interested in becoming approved to be paid by ODHS for subsidy child care must go through the listing process. The provider must complete the Child Care Provider Listing Form (DHS 7494) to begin this process. Listing does two things:

For families receiving ERDC, the information on the Child Care Provider Listing Form (DHS 7494) is used to set up the connection to the family's case once the provider is approved. Please note that this does not apply for pre-listing forms, or forms without the family's eligibility information entered in the top portion 'Branch Use Only' of the form.

For all ODHS child care programs, the listing process establishes minimum standards of health and safety. This includes criminal history as well as Child Welfare records checks conducted by the ODHS Background Check Unit (BCU).

The provider is only eligible for payment once they have been listed and approved with ODHS. No payments may be made for providers prior to the date of approval, and this may need to be communicated to families needing care with an unlisted provider.

Already licensed providers may be eligible for back-payment after they have been approved with ODHS.

How to check to see if a provider is approved with ODHS:

Open a blank DHR screen and type DPPL,Provider Phone Number (no area code) or DPPL,Provider Last Name, (space)First Name. Press enter two times.

This will bring up a list of providers matching your search criteria. Type any letter in front of the provider's name and press Shift + F5.

This action will bring up the provider information screen, DPPM. Check the List Stat field to see if the provider is eligible for payment.

Provider list status definitions and provider types

List status	Definition	Eligible for payment?
A: Approved	Approved providers may watch children in the provider's home as well as the child's home. All household members age 16 and older have had a background check completed.	Yes. Some providers may have 'exception' coding which allows them to care for only one family. Because of this, it is very important that workers send requests to DPU for child care connections.
I: In Home	In home providers are approved to care for children in the child's home only. Only the provider has gone through a background check. If additional children are going to be cared for at the child's home, it is considered a 'third party' child care situation and all household members age 16 and older must go through a background check.	Yes; but only for a specific family and only in their home. Workers should ask DPU if a parent would like to use an in home provider.
F: Failed	Failed providers have not met ODHS requirements.	No. Providers must submit a new 7494 Child Care Provider Listing Form and become approved for payment.
P: Inactive	Inactive providers may have been approved with ODHS in the past, but are no longer in approved status and are not eligible to be paid by ODHS for care. This status often gets mistaken for Pending, which is not a list status for providers.	No. Providers must submit a new 7494 Child Care Provider Listing Form and become approved for payment.
D: Denied	Denied providers have not met ODHS requirements.	No. Providers must submit a new 7494 Child Care Provider Listing Form and become approved for payment.
S: Suspended	Suspended providers have not met ODHS requirements.	No. Providers are ineligible for payment for a minimum of six months, and after that time may submit a new 7494 Child Care Provider Listing Form to become potentially approved for payment.

List status	Definition	Eligible for payment?
C: Collections	Providers in collections do not meet ODHS requirements due to owing the State of Oregon for overpayments.	No. Providers must re-pay previously owed overpayments and cooperate with the Overpayment Writing Unit & Accounts Receivable prior to submitting a new 7494 Child Care Provider Listing Form to become potentially approved for payment.

If you have questions regarding the ability to connect a provider to a case, please contact the Direct Pay Unit by e-mailing DPU.Childcare@state.or.us or calling 1-800-699-9074 between the hours of 8:30am and 4:30pm.

Any care provided prior to the provider's approval date with ODHS is the family's responsibility to pay.

Provider types

Provider type	Definition	Licensed/License-exempt
FAM	Standard Family Provider	License-Exempt
NQC	Standard Center Provider	License-Exempt
QFM	Enhanced Family Provider	License-Exempt
QEC	Enhanced Center Provider	License-Exempt
RFM	Registered Family Provider	Licensed
CFM	Certified Family Provider	Licensed
CNT	Certified Center Provider	Licensed

Licensed-exempt providers are eligible for payment from the date of their approval and forward. Parents are responsible for any care provided prior to the provider's approval date in addition to their copay amount.

Example: Julie's mother, Grace, wants to provide care for Julie's daughter, Sunny. Julie is eligible for ERDC starting 05/01/18. Grace submits her child care provider listing form (DHS 7494) on 05/07/18. She is approved on 05/19/18. The worker may send a connection request to DPU starting from the date that Grace was approved, 05/19/18, and forward. Julie is responsible for all care that Grace provided prior to 05/19/18 in addition to her ERDC copay.

Licensed providers are eligible for back-payment once they have become approved for ODHS if they are already licensed with OCC and meet all other ODHS requirements. Parents are still responsible for their copay amount each month as well as any charges over ODHS maximum rates.

Example: Samuel is eligible for JOBS Plus childcare starting 04/01/18. He has been using his son's after-school program, K12 Child Care, as his child care provider since 03/12/18. K12 Child Care is not yet listed or approved with ODHS, but they have been licensed with the Office of Child Care (OCC) since 12/01/2017 and meet all other ODHS health and safety requirements. K12 Child Care submits their listing form on 04/05/18 and is approved by ODHS on 04/20/18. Because K12 Child Care was already licensed with OCC prior to when care began, the worker may send a child care connection form to DPU with care starting from the date Samuel was determined eligible for child care, 04/01/18.

For questions regarding a provider's eligibility for payment, please speak with a lead worker, contact DPU at 1-800-699-9074, or email Childcare.Policy@dhsoha.state.or.us.

In-depth review of the listing process for a provider not yet in approved status

When a family is determined eligible for child care assistance, if they have a provider they would like to use but who is not yet listed and approved with ODHS, the worker can complete the top portion of the Child Care Provider Listing Form (DHS 7494) and gives it, along with a copy of the Child Care Provider Guide (DHS 7492) to the parent to give to their provider. It is important for the worker to explain the listing process clearly to the parent as they may incur charges prior to the provider's approval date.

The child care provider completes any necessary trainings dependent on their provider type and requirements (indicated on the Child Care Provider Listing Form), and submits the listing form to DPU within 30 calendar days. All household members age 16 or older, if applicable, to go through a comprehensive background check to ensure child safety.

DPU reviews the listing form for completeness, and does one of the following:

If an answer to a question is incomplete or unclear, DPU will attempt to call the provider to obtain the necessary information. Once the information is obtained, DPU forwards the application to the Background Check Unit (BCU) for a records check.

If there is a reason per OAR 461-165-0180 to fail the provider, DPU codes DPPM to show the provider did not meet ODHS requirements. This generates notices to the provider and family, letting them know that the provider does not meet listing requirements at this time and advising the family to find another provider. In this case, the listing process ends and the listing form is not sent to BCU for a records check.

After reviewing criminal and Child Welfare records for all household members age 16 and older, visitors, and any additional information provided by the child care provider, BCU will make a determination as to whether or not the provider meets the background check requirements. If the provider does not meet the records check criteria, BCU does the following:

BCU sends a denial letter to the provider explaining the denial and their right to request a hearing. Providers must request a hearing in writing within 45 days.

The denial is coded with List Stat: D on DPPM. Notices are sent to the family letting them know that the provider was denied, and advises them to find a new provider. ODHS will not issue billing forms to denied providers.

After the provider is in approved status, the worker will send a completed Electronic Provider Connection form to DPU via e-mail at DPU.Childcare@state.or.us.

ELECTRONIC PROVIDER CONNECTION

Use this only to connect an already listed and approved provider to a client's case for a CCB or JCCB to be issued. You will need to check DPPM first. **Please place the case number in the "Subject" line of your Email.**

- Branch #:
- Worker Load Code:

- Case #:
- Case Name:

- Primary Provider Name:
  Check DPPM - The provider's DPPM screen must show a LIST STAT of A to use this template

- Provider #:
- Date Care Began:

If a provider is newly listed, the billing form for the first month will have pro-rated hours.

- Percentage of CC hours for this provider:
- Related to children?:
- Does this provider replace another provider?
- If yes, who?
- Last Day of Care:

- Secondary Provider Name:
  The provider's DPPM screen must show a LIST STAT of A to use this template
- Provider #:
- Date Care Began:
- Percentage of CC hours for this provider:
- Related to children?:

Billing information

- IF ERDC(M5) – Authorized Hours & Copay:

Or

- If CCB (2 or 82) – Authorized Hours:

Or

- JCCB – Authorized Hours:

Additional Comments:

Listing process responsibilities

Listing responsibilities	Worker	DPU	BCU
1. Check to see if the provider the family would like to use is already approved with ODHS. If yes, send an Electronic Provider Connection form to DPU. If no, complete the top portion of the Child Care Provider Listing Form (DHS 7494) with the family's eligibility for child care assistance and advise the family to give the listing form to their child care provider as soon as possible.	X		
2. Give the parent the Provider Guide for their review and to review with their child care provider. Explain the listing and records check process. It is important to let the parent know that ODHS cannot pay for child care prior to the date that their provider is in approved status. (See Section 4 of this guide for more information regarding payment timelines.)	X		
3. Review the listing form; determine if the provider meets ODHS requirements.		X	

Listing responsibilities	Worker	DPU	BCU
4. Create provider record on DPPM. Return incomplete listing form to provider, or send completed listing form to BCU for background check(s).		X	
5. Fail provider if they do not meet ODHS requirements, including health and safety requirements. Send fail notice to provider and family (if top portion of listing form is completed with family eligibility information).		X	
6. Refer providers requesting assistance with health and safety requirements to the Child Care Resource & Referral network.		X	
7. Conduct criminal and Child Welfare background checks, and respond to complaints regarding listed providers.			X
8. Determine listing status and enter List Stat field on DPPM.			X
9. Send Notice of Fitness Determination to provider and listing status information to DPU.			X
10. Connect parent and provider in system and send child care billings if provider is in approved status, or notice to parent if provider is denied or failed. The hours on the first billing form will be pro-rated based on the provider's approval date.		X	
11. System will send closure notice to the family if there is no provider connected to their case at the cut-off date for mailing of a child care billing form. This notice lets the family know that their case will close at the end of the following month.		X	
12. If the family has not found an approved provider by the end of the next calendar month, their case will automatically close. A second notice is sent to inform the parent.		X	

For questions regarding the listing process, please contact DPU at 1-800-699-9074 or e-mail Childcare.Policy@state.or.us.

Changes in programs, providers and ERDC filing groups

Converting from Temporary Assistance for Needy Families (TANF) child care assistance to Employment Related Day Care (ERDC)

When a TANF customer with earned income on their case and a child care need is exiting off of TANF or is no longer eligible due to income limits, the child care need should be assessed. If there is an ongoing need, the case may be converted to ERDC rather than closed entirely. Workers may convert the case as follows:

- Check WSIT,SSN# or WCCS,SC,UCMS# to check whether the case is receiving child care benefits through a JCCB (JOBS support services) or a CCB with no copay;
- Ensure that JCCBs or CCBs have been issued through the transition month, if the customer was eligible;

- If JCCBs were previously issued, close WSIT effective the end of the transition month;
- Contact the customer to discuss whether or not they would like to apply for the ERDC program, copay, if they need more than one provider (and who they would like their primary provider to be);
  - If the customer states they would like ERDC, this date would be their Date of Request (DOR).
- If the customer can reasonably anticipate future income and hours, a narrated phone conversation can substitute for a completed application and intake for ERDC. Eligibility will still need to be cleared by completing the application process, verifying and narrating all ERDC eligibility requirements. A written application is not required for customers transitioning from TANF to ERDC, however income verification is still required. A phone call to the employer, paystubs, or written statement from the employer may suffice for verification of income;
  - If the customer has started a new job and does not have a full month's worth of income verification, their first paycheck can be used to determine their eligibility if it is reflective of their ongoing hours and pay. Narrate this conversation well and inform the customer of reporting requirements.
  - If there is income from child support remember to update the income type coding on UCMS for the child support from CSP/PSP to SUP when transitioning a family from TANF to ERDC. The system will not count the child support on the ERDC case if this is not updated correctly.
- Once income is verified, use a COMPUTE action to convert the case to M5 effective the first of the month following TANF case closure;
  - If the customer is eligible for a Reduced Copay, code RCP in the N/R for the parent with the third month following their ERDC case being opened. Please review the case as well to check whether the parent may also be eligible for Transitional Benefit Reporting (TBS) for SNAP and Employment Payments (EP1, EP2, EP3) for TANF transitional benefits.
- Enter the monthly authorized child care hours on UCMS (using the highest number of verified work hours from the source/time period used to determine ERDC income). When authorizing 172 hours or less, the system will add travel time automatically. If you are authorizing EXH hours you will need to manually calculate and add the travel time into the EXH coded hours);
- Complete the Child Care Connection form and submit to the Direct Pay Unit (DPU) with updated eligibility information for ERDC;
  - Make sure to note that the month following TANF case closure will be a CCB instead of a JCCB, if JCCBs were previously being issued under JOBS support services for a TANF customer.
  - Be sure to have a conversation with the caretaker regarding their relationship to the provider they have chosen. It is important that their relationship be reported to DPU as accurately as possible as it effects processes when approving and connecting the family to the provider.
- Send reduction/closure notice to the customer as appropriate for their TANF case and JOBS support service payments.

Converting from Employment Related Day Care (ERDC) to Temporary Assistance for Needy Families (TANF)

When a family receiving ERDC assistance becomes eligible for TANF due to a reduction in income or loss of

employment, local procedures for TANF applications/intakes should be followed.

While there are many ways to handle this transition, it is important that continuity of care be maintained. This can be done in several ways:

- The outstanding CCB may be used for care that was provided in the final month of ERDC benefits, as well as for new JOBS activities;
- The customer may be eligible for Authorized Work Search (AWS) if they have good cause for their job loss. This allows the customer to keep their ERDC case open and maintain the same number of authorized child care hours with no copay for 3 months following their job loss, instead of applying for TANF. This requires a conversation with the customer so they can make an informed decision based on what is best for their family situation;
- Check the customer's authorized child care hours on UCMS. If additional hours are required due to eligible JOBS activities as outlined in the customer's new JOBS case plan, e-mail DPU to cancel and reissue the billing form;
  - If the majority of hours are from working for that month, a CCB with no copay will be issued, or
  - If the majority of hours are from JOBS activities, a JCCB will be issued.
- E-mail DPU to request the connection to the child care provider be closed at the end of the transition month, if the customer is not yet in a JOBS case plan with eligible case activities;
  - If the customer engages in a JOBS case plan and is eligible for child care assistance, update their case plan on TRACS and e-mail DPU to connect the customer to their child care provider via the WSIT system. Some branches may also allow Family Coaches to complete this step independently of DPU. Check with your branch leadership for guidance.

Although it is the customer's responsibility to maintain communication with their child care provider, ensure the parent understands how this transition may affect their child care benefits. The provider may also need reassurance from the ODHS worker that ODHS can potentially continue to pay for child care during the transition period.

For further questions about how to handle transition situations, contact CHILDCARE.Policy@state.or.us, TANF.Policy@state.or.us, or consult your local leadership team.

Child Care cheat sheets

If child care hours are needed to support:	Issue a…
TANF JOBS activities only	JCCB
TANF JOBS with WO step only	JCCB
TANF JOBS with WO step & other JOBS activity steps combined, but majority WO hours	JCCB
TANF JOBS with WO step & other JOBS activity steps combined, but mostly JOBS activity hours	JCCB
ERDC	CCB
TANF JOBS Plus contract	JCCB

Cases transitioning from TANF/JOBS to ERDC:

- **If the transition month was majority JOBS activity hours:** Check authorized child care hours on WSIT and any billing forms that have already been issued. If additional hours are needed for employment, cancel the reissue the JCCB. Close WSIT at the end of the transition month and e-mail DPU with updated ERDC information for the month in which ERDC eligibility begins with the Child Care Connection form.
- **If the transition month was majority working (WO step) hours:** If additional hours are needed for employment, e-mail the DPU and request for the JCCB to be cancelled & a CCB re-issued with higher hours. Verification is required for increased hours.
- Complete a COMPUTE action and transition the case to M5 for the month following TANF case closure. Make sure to add updated EML N/R, and RCP N/R if the customer is eligible for reduced copay. Workers should also check for TBA/EP payment eligibility when customers are transitioning off of TANF.
- Send closure/reduction notice for TANF and applicable JOBS support service payments with 10-day notice.
- Close JOBS steps & plan on TRACS effective the TANF closure date.

Cases transitioning from ERDC to TANF/JOBS:

- Have a conversation with the customer about Authorized Work Search (AWS) and keeping their ERDC case open. If the customer is given good cause for their job separation and their job loss was reported timely, the customer may choose tokeep their ERDC case open rather than applying for TANF. If the customer receives AWS, they will be eligible for up to three months of no copay with the same number of authorized monthly child care hours to look for work.
- **If the transition month was majority working (WO step) hours:** Check authorized child care hours on UCMS. If additional hours are needed for employment, e-mail the DPU and request for the CCB to be cancelled & re-issued with higher hours. Verification is required for increased hours.
- Complete a COMPUTE action and transition the case to M5 for the month following TANF case closure. Make sure to add updated EML N/R, and RCP N/R if the customer is eligible for reduced copay. Workers should also check for TBA/EP payment eligibility when customers are transitioning off of TANF.
- Send closure/reduction notice for TANF and applicable JOBS support service payments with 10-day notice.
- Close JOBS steps & plan on TRACS effective the TANF closure date.

Miscellaneous tips

If the provider is already listed with ODHS and their list status is 'A' for approved on DPPM, you may give the customer the Child Care Provider Letter (DHS 7494E) for their provider.

If the provider is not yet listed or their list status is anything other than 'A' on DPPM, you may give customers the Child Care Provider Listing Form with pre-filled information at the top with the individual's eligibility for ERDC. This information ensures providers that customers are eligible for child care assistance.

Please note that this may not reflect ongoing eligibility, and it is the customer's responsibility to inform their provider of their authorized hours and copay amount.

JCCBs should never be cancelled due to customer non-participation.

The Copay Not Met (CNM) coding may only be removed after verification from either the customer or the provider is obtained and verified by DPU. Call DPU at 1-800-699-9074 for assistance. Select here for Processing unmet copays.

Changing providers in the ERDC Child Care Program

When a customer receiving ERDC reports a change in child care providers, DPU should be notified as soon as possible. They will need to ensure billing forms are no longer being sent to the previous provider, and make sure billing forms can begin being sent to the new provider. There are two ways of notifying DPU of this change:

- If the provider is not yet listed with ODHS with a list status of 'A' for approved, workers may complete the Branch Use Only heading of the Child Care Provider Listing Form (DHS 7494) with the customer's ERDC eligibility noting the change in providers. This section asks if a previous provider is being replaced, and if so, when. It is important to complete this entire section.
- If the new provider is already listed and approved with ODHS, a new listing form is not needed. Workers may send an e-mail to DPU.Childcare@dhsoha.state.or.us with the Child Care Connection Form completed to inform DPU of the change in providers.

Changing the primary provider

If a customer has more than one child care provider, one of the providers is designated as the primary provider. The primary provider is usually the provider who receives the copay amount from the parent, and should be the provider who cares for the most amount of time. It is important to have a discussion with the customer about who they would like to be their primary provider. The copay may be split between two providers, but generally is the exception and not the norm.

Example: Joelle has two children, Maya (8) and Edgar (3). Maya attends an afterschool child care program at her school, while Edgar is cared for by Joelle's sister, Martina. Both Martina and Maya's school are listed and approved with ODHS. The worker will send a Child Care Connection Form to the Direct Pay Unit (DPU) to inform them of the correct percentages.

In this scenario, 100% of Maya's care is provided by the afterschool child care program, and 100% of Edgar's care is provided by Martina. As Edgar is 3 and will be cared for full-time, the primary provider should be Martina since she is providing most of the care for Joelle's family.

When a provider is denied in the listing process

A provider who is denied (list status 'D') by ODHS due to a records or background check, or failure to correct a health & safety problem, will not be paid by ODHS. The family is notified by letter that their provider does not meet listing requirements if the top portion Branch Use Only on the listing form was completed by the worker. They are also informed that they will need to find a new child care provider. In order to receive ODHS child care assistance, the family has the following options:

- Find a provider who is already listed and approved with ODHS
- Find a provider who may meet the requirements, who is willing to be listed
  - Please note that payment will not be made by ODHS if the new provider is not approved. Payment will only begin from the date of their approval in the listing process and forward; no back-payment will be

made to the provider. Customers have 60 days to be connected to an approved ODHS provider or their ERDC case will automatically close due to No Provider Connected.

- Continue to use the denied provider for a period of time. This only applies to providers who were previously in approved status while caring for the eligible child, and were subsequently denied. Unless the child appears to be in imminent danger, the family may choose to have the provider continue care for the child until the end of the period covered by the current billing form.This is a difficult situation for most families, and they may need help deciding what to do next. Refer families to 211info, who can help by suggesting what qualities to look for in a provider and helping the family to find a new provider. Families may contact 211 by phone at 2-1-1, or visit www.211info.org.
  - If the family would like to continue to use the denied provider, ODHS cannot issue payment and the family's case may close due to no eligible provider connected to their case. The provider may contact the ODHS Background Check Unit at 503-378-5470 or toll-free at 1-888-272-5545 to inquire about the reason for their denial.
  - ODHS will not issue payment to the provider for the period of time they were not in approved status. The parent will be responsible for any charges issued by the child care provider for this duration of time.

Adding or removing a person from an ERDC case

When someone joins or leaves an ERDC filing group, the change would typically take effect the first of the month following the month in which the change is reported. However, there are situations where earlier action may be required to meet the family's child care needs, and other situations where action should be delayed to allow for timely notice of reduction of benefits.

When a child who needs child care moves in with the filing group during the month, this usually requires taking action before the end of the month

If the family's provider is caring for the new child, the CCB will need to be canceled and reissued to add the child to the billing form. E-mail DPU.Childcare@dhsoha.state.or.us with a completed Child Care Connection Form to inform them of the change.

If the new child is being cared for by a different provider, the provider must be listed and in approved status with ODHS before billing forms can be issued.

If the copay will go down, the lower copay will take effect the following month. The copay would not ordinarily be reduced on a reissued CCB unless the CCB was sent out before the worker had time to add the child to UCMS.

If the copay will increase because the child has unearned income, the copay should be increased for the following month only if there is enough time for timely continuing benefits notice.

Remember to add the child to the UCMS case before compute deadline, so their name will be on the CCB for the following month.

When an adult or a child who does not require child care joins the filing group

They should be added to UCMS case effective the first of the following month. If they have income, this will result in a lower copay. However, the CCB should not be canceled and reissued to the provider with the lower copay unless

the family has expressed an inability to pay (must cause a difference of $25 or more to the copay) and the change was reported timely, within 10 days.

The billing form may also be canceled and reissued if the worker did not have time to add the person to the case before the CCB went out and the difference in copay is $25 or more.

To cancel and reissue a CCB, e-mail DPU.Childcare@dhsoha.state.or.us with a completed Child Care Connection Form to inform them of any changes. You may also call DPU at 1-800-699-9074 with questions, or consult local branch leadership for guidance on how to e-mail DPU.

If the person joining the filing group has income that will result in a higher copay

Add the income to UCMS the following month if there is enough time to send a timely benefit reduction notice, or do a first of the month action the following month to add the income for the next month.

If a person leaves the filing group and this will result in a lower copay:

This change will take effect the first of the month following the month in which the change is reported. No notice is needed as this is an increase in benefits.

Child care program forms

This worker guide lists the primary forms and pamphlets used in the Oregon Department of Human Services (ODHS) Child Care assistance programs. For more information about any of the below mentioned forms, please e-mail CHILDCARE.Policy@state.or.us.

Form number	Title and information
DHS 419	Requesting ERDC During CAPI Interview. When a worker is processing an application through CAPI, this form is used when an individual requests ERDC benefits. The completed form can be copied directly into TRACS once the interview is complete.
MSC 862	Change Report for Employment Related Day Care (ERDC). This form is used by customers to report changes when they are receiving ERDC benefits.
DHS 7294	Notice of Income and Benefit Calculation. This form is used to show how the monthly income was calculated from the customer's reported income at intake. Eligibility workers can send a copy of this form to show the customer how their income was calculated if needed.
DHS 7351	Educational Income Calculation for ERDC and SNAP. Eligibility workers may use this form to calculate educational income for ERDC and SNAP programs. After calculating the monthly amount on this form, workers transfer the figure to the DHS 7294 to average it over the certification period. Workers may send a copy of this form to the customer to demonstrate how the educational income average was calculated.

Form number	Title and information
DHS 7476	Employment Related Day Care (ERDC) and Supplemental Nutrition Assistance (SNAP) Application. This form is mailed to ongoing ERDC customers at compute deadline prior to the last month in their certification period. Customers report their income and may also report other household changes on this form. This information is used to calculate the copay for the next period, and determine authorized child care hours. It is also used to re-certify SNAP for a companion SNAP case.
DHS 7486	Special Need Child Care Verification. This form may be mailed to the customer or hand-given, and is used for both ERDC and TANF customers who have a child with special needs and are requesting a higher rate of pay at the Special Needs Rate (SNR) pay type. The customer and the provider indicate why the child needs care at the SNR pay type and submit it to the eligibility worker for the case. Additional medical documentation is required for families to qualify for the Special Needs Rate (in addition to the Special Need Child Care Verification form).
DHS 7492	Child Care Provider Guide. The Child Care Provider Guide is used to educate and inform child care providers and parents. This guide is given to providers and parents when the parent applies for ERDC benefits, and can also be given to the provider as a resource at any time it is requested. The Child Care Provider Guide gives information about provider requirements, the listing process, billing, ODHS rates, instructions, and samples of completed listing and billing forms. There is also additional important information included, such as pre-service trainings, recognizing & reporting child abuse, and preventing the spread of infectious disease.
DHS 7494	Child Care Provider Listing Form. The Child Care Provider Listing Form is the first step in a provider becoming listed & in an approved status to care for children on an ERDC case. The listing form is completed by the child care provider, and is submitted to the Direct Pay Unit (DPU) for processing. DPU determines based on the information listed on the form whether or not the provider meets ODHS requirements. If the form is complete and the provider does meet all ODHS requirements, the form is sent to the Background Check Unit (BCU) for background checks on all household members age 16 and older in the home where care is being provided. The form can be left blank as a 'prelisting form' without customer information, or if there is already an open ERDC or TANF case eligible for child care assistance, the worker may fill out the top portion of the form to establish a child care connection once the provider is listed with ODHS and in approved status to receive payment. Please refer parents and providers with any questions regarding the listing process or the Child Care Provider Listing Form to contact the Direct Pay Unit (DPU) at 1-800-699-9074.
DHS 7496	Provider Report Form. This form is used by child care providers who are reporting a change in name, address, phone number, household composition; or tor report arrests, convictions, or involvement with DHS Child Welfare. A perforated copy of this form is also available in the Child Care Provider Guide (DHS 7492). The Direct Pay Unit (DPU) may also mail these forms to child care providers upon request.

Child care roles

Worker responsibility

- Determine eligibility (ERDC)
- Determine if there is a copay not met (CNM):
  - Review the case to determine if the case was closed because of an unmet copay;
  - Check for a CNM case descriptor on UCMS and an N in the copay met field on DPCS;
  - The ERDC case remains closed until the copay is met, the provider agrees satisfactory arrangements have been made or after three years have lapsed from the month the copay was not met.
- Discuss child care need:
  - What is their work schedule – is it consistent or variable? Do they work daytime, evenings, weekends, overnight? Narrate the work schedule.
  - Are there two parents in the home – what days/times do their work schedules overlap? Narrate work schedules and overlapping hours.
  - What are the ages of the children? This will help determine the hours of care and child care cost. For school age children compare the work schedule to the school schedule. Explain ODHS requirements for school age children: no billing during school hours (unless the child is sick); cannot bill for home schooled children during school hours.
  - Understanding the need is important for accurate eligibility – compare copay to cost of care.
  - Explain proper use of child care subsidy, provider can bill for hours at work and travel to and from work only. Note: Authorized work search is allowed if job loss occurs during the certification and good cause exists.
  - Offer information about high needs care if parent expresses difficulty finding care, keeping child care or has a child with special needs.
- Eligibility decisions are accurate and explained to the customer; a Notice of Income and Benefit Calculation (DHS 7294) is given.
- Narrative and computer entry is completed in a timely manner. Delays in processing directly impact provider payment, potentially putting the family at risk of losing child care. The goal is to have the billing form issued before the care is provided whenever possible.
- Reporting requirements are explained – including requirement to report provider changes.
- Assess family's child care arrangements (ERDC and TANF)
- Ask for their provider information (name, address and phone number) – including back up care providers and percentage of care for each provider. Encourage back up care arrangements if not yet established;
- Determine if provider is currently in approved listing status – provider screen guides are available and DPU can also help explain how to use the provider screens;
  - If the provider is in approved listing status:
    - » Give a completed DHS 7494E and instruct the customer to give it to their provider. This verifies the

family's eligibility for the provider;

  - » Send an electronic connection request to your DPU representative. Be sure to include the copay amount (or zero copay for TANF), the authorized hours for the initial and ongoing months, and voucher type (CCB or JCCB). Use the DPU template when sending the connection request;
  - » If the case is pended, narrate the provider information and take the above actions as soon as eligibility is cleared.

- If the provider is not in approved listing status (or in-home, "I" status, for another family):
  - » Give a Provider Listing form (DHS 7494) with the ODHS section completed;
  - » A pre-listing Provider information Sheet (DHS 7494D) is given if eligibility has not been determined (case is pended);
  - » Give the Parent Flyer (DHS 7485) and explain the payment effective date. ODHS cannot pay for any care provided before the listing approval date – this means the provider must complete the listing form (and any required pre-service training), submit the form to DPU and meet all the provider requirements including passing criminal history and child welfare records checks. Background checks are required for the provider and individuals who may have access to children in care;
  - » Inform the customer to give the listing form to their provider immediately;
  - » Offer a Child Care Provider Guide (DHS 7492) – this is a great resource for the provider because it explains the provider requirements, listing process, ODHS rates, payment process and includes other resources. If the customer thinks the provider would prefer an electronic version, it's available on the ODHS child care website http://www.oregon.gov/ODHS/children/pages/publications/index.aspx#childcare. The website is included on the listing form;
  - » If the provider is in denied (D), failed (F), or in collection (C) status, consult DPU. The customer needs to understand if their provider may not be eligible. If they are in failed status, they can reapply right away and will be reviewed to ensure they meet all requirements. If they are in denied or collection status, they may not be able to reapply and therefore not eligible.
- If the family does not have a provider:
  - » Refer to CCR&R and tell them to report provider information when they select one;
  - » Explain the benefits of selecting an approved provider – give the DHS 7485;
  - » Explain timeframes for ERDC case closure. Once a case is approved online the system will send a closure notice at end of month cut-off. The effective date of the closure is the end of the following month. If no provider is connected the system will close ERDC on the end of month cut-off for the second month. If a provider is connected the auto-closure will not happen.

- Discuss the importance of quality care (ERDC and TANF) – even if they already have a provider
  - Quality child care can be so much more than just supporting a working parent. It is important for the success of the entire family and can be vital in helping children to succeed in school. Quality early childhood education is linked to higher graduation rates, higher employment rates and lower crime rates;
  - Safe, reliable child care is important for parents to feel secure when they go to work. It helps them to focus on their job rather than being worried about their children;

- Quality child care means the provider offers an environment that helps the children by meeting their emotional, developmental and educational needs;
- Early learning is important for kindergarten readiness. Many providers offer preschool curriculum and educational activities;
- Quality care for school age children can include enriching activities and homework help;
- ODHS offers contracted child care slots in some areas through local Head Start or Oregon Program of Quality designated child care sites for children ages 0 to 6. The contracted slots offer many benefits including protected ERDC eligibility, reduced copay, and children can still attend full-time even if the parents' work hours drop.

- Share local CCR&R information (ERDC and TANF) – even if they already have a provider
- Explain the services available to families through 211:
  - Help finding providers who offer contracted child care slots;
  - Help finding a back-up provider;
  - Information about quality child care;
  - Training opportunities for their provider (First Aid/CPR, Food Handlers, Recognizing and Reporting Child Abuse).
- Offer informational handouts from the local CCR&R so the customer can make an informed choice about child care arrangements that will work best for their family;
- Offer local CCR&R contact information
- Billing (ERDC and TANF)
  - Explain how ODHS child care payments work, including how to properly utilize the approved hours, when to sign the billing form and how much the family is responsible to pay. They will need to know if there is a copay (and how much) plus any overage amount;
  - Encourage families to talk to their provider about how much they charge for child care, if they accept ODHS rates, and any other fees the provider may charge. This is an important conversation to have before care begins.
- Actions during the certification (ERDC and TANF)
  - Act on reported changes (following policy guidelines; for ERDC, see FSM CC-E.7; for TANF, see FSM-TANF-K);
  - Provider changes need to be acted on immediately;

Send electronic connection to DPU for new provider who is in approved listing status (include percentage of care if multiple providers and date care ended if replacing a provider);

When there are outstanding billing forms for a previous provider, DPU will issue a billing form to the new provider for the remaining hours in that month. DPU may not be able to issue a billing form to the new provider if payment has already been made to the previous provider. Consult DPU for help.

Sometimes a billing form will need to be reissued. This occurs when a change is not acted on before the billing form is mailed or when an ODHS|OHA error occurred. Update changes on the case and send the replacement

request to DPU and include details about the reason for replacement, copay amount, authorized hours and month(s) needed. Billing forms can only be replaced if the benefit is increasing or when a child is being added. Consult DPU if the billing has already been paid – a payment adjustment may be needed.

Communications with child care providers (ERDC and TANF)

Verify the provider/family connection before releasing any information. This can be verified through the provider connection in the system, in TRACS or the recent application if the provider is not yet connected and the family reported their provider information;

Share information needed to confirm the family is eligible for child care benefits and which children are eligible (including authorized hours and the copay amount). When explaining the authorized hours, be sure to include the 25 percent for travel and meal time. Explain ODHS can pay up to the max rate and let them know where to find this information if they need it (DHS 7492). Also explain the payment effective date, (consider provider listing date and multiple providers – DPU can help);

Share information on the billing form, when it was mailed or when they can expect to receive the billing form (consult DPU if needed). Refer to DPU if they have questions about the payment process. Also mention the Provider Guide (DHS 7492) as another resource for information.

Disputes with the number of hours:

- Explain the amount authorized is based on the work hours or approved self-sufficiency activities and includes the 25 percent added for travel/meal time;
- You may need to review the hours to determine if they were calculated correctly. Review potential need for extra hours. Are they working more than 40 hours a week, do they need sleep time (single parent households only), are they working a split shift or do they have excessive travel time?
- Ask the provider to have the family report if there has been a change or if they have questions about how the hours were calculated;
- Let them know the family will be responsible for hours that exceed the amount authorized by ODHS (in addition to the copay and any other overage such as when the provider charges more than the ODHS max rate).

If the family has not reported their provider you cannot share information. Let the provider know you do not have them listed as a provider with the family they have indicated. Ask them to have the family contact their worker if they are eligible for child care subsidy to report their provider. Also explain the family may contact their local office to apply for child care subsidy if they are not currently eligible.

Considerations for TANF case planning and child care:

Discuss child care arrangements and allow time to locate appropriate care. Stable quality child care is important as they transition to employment. They should feel comfortable leaving their children and know they are in a healthy and safe environment, (refer to CCR&R).

Case plan and child care needs are in balance

- Individual district support service budgets may have limits on the amount of support services for child care

that can be offered;

- Consider the child care need, cost of care and how much ODHS can cover when developing the case plan. Be sure to include time for travel;
- The plan activity hours cannot exceed the authorized child care hours unless there is no child care need. For example, if the family has school age children, they will not need child care during the school day. In this instance the activity hours can exceed the support services for child care. They still may need some child care hours for any activities that are outside the school day or for days when school is not in session.
- Explain authorized hours, the amount ODHS will pay, and any out-of-pocket costs for which they will be responsible. Out-of-pocket costs occur when the provider charges more than the ODHS rates. Also explain proper use of authorized child care hours (for authorized plan activities and travel/meal time);
- Billing forms are issued to the provider before care begins: WSIT Situation Screen needs to be in "A" status for auto issuance. They should not be in "R" status to review a customer's participation prior to issuance; this is in violation of the child care provider Collective Bargaining Agreements with SEIU and AFSCME that may result in a grievance. These agreements require ODHS to issue out billing forms in advance. This is also important for customer service for families and providers;
- Include information and appropriate forms relating to quality care, CCR&R services, provider listing and billing (see above).

Direct Pay Unit (DPU) responsibilities

- Review listing form; determine if provider meets the requirements and enter providers into the system;
- Fail provider if they do not meet requirements, including health and safety. Send notice to provider and family;
- Refer providers requesting assistance with health and safety to the CCR&R Network;
- Forward a copy of the listing form to BCU to determine eligibility;
- Send billing forms to providers (CCB and JCCB). No billings can be sent if child care eligibility is not entered on UCMS;
- Answer billing questions for the provider and parent;
- Replace billing forms and process payment adjustments as needed;
- Process provider changes. Providers must report certain changes to DPU within five days – such as new address or new people in the home/facility, any new criminal arrests, charges or convictions and any new child welfare involvement;
- Process provider report of copay not met. This includes ending the ERDC benefits (following 10-day notice requirements), coding CNM in the system and narrating. (See Processing Unmet Copays.)
- Refer providers and families to the worker when they have questions about the child care case or are requesting changes to the billing form. Referral reasons include: no eligibility on system, questions on the amount of hours or not enough hours, questions on how the copay was calculated or copay too high, child not included on the billing form, requesting special needs rate (SNR not coded on UCMS);
- DPU also supports workers by explaining information on the provider screens and answer questions about the billing and listing processes;
- DPU Processes email requests from eligibility workers when billing forms need to be forced out or changed.

Background Check Unit (BCU) responsibilities

- Conduct criminal and Child Protective Services (Child Welfare) records checks, and respond to complaints about listed providers. (See http://www.oregon.gov/DHS/children/pages/childcare/bcu.aspx);
- Fail or deny listing on records check and enter the denial code on DPPM. On re-evaluations, this stops CCBs from going out to this provider and generates a notice to the parent(s). On new providers, no payment will be made from ODHS.

Child Care Resource and Referral (CCR&R) responsibilities

- Maintain accurate and updated database of child care providers in your area. These include centers, preschools and family child care providers;
- Have accurate and current information on the Office of Child Care regulation process for centers and family child care; including licensing requirements;
- Offer training and classes for providers on many topics;
- Respond to providers with ODHS rates and other information, support and technical assistance regarding the business of child care, discipline issues, other community resources;
- Produce and distribute newsletters for providers with information on upcoming events, advocacy, classes and announcements about regulation changes and activity ideas for their programs.

211 info responsibilities

- Provide consultations and referrals to child care for parents. Parents get verbal and written material on how to select quality child care;
- Offer parent information about ODHS subsidies.

ERDC eligibility guide

All countable earned and unearned income received in the last 30 days;

If new job and no pay stubs have been received - employer statement including anticipated hours, pay dates and rate of pay.

Eligibility requirements:

- Residency;
- Citizen/non-citizen status of child to receive care;
- Immunization for child(ren) needing care;
- Caretaker (no relationship to child required);
- Age to receive care;
- Child care need;
- Satisfactory copay arrangement.
- Provider must:
- Not be in the filing group;

- Not be the parent of any child in the filing group;
- Be listable; and
- Meet requirements for direct pay.
- Income limit:
- At initial certification – 200% FPL;
- During the certification and at recertification – the income limit is higher (250% of FPL or 85% SMI, whichever is higher – see DHS 5530);
- Copay must also be less than amount the Oregon Department of Human Services (ODHS) will pay; otherwise customer is ineligible.

Verification requirements

- At initial application:
- All countable earned and unearned income – use a month's worth of recent representative income verification (if you do not use the most recent income, be sure to narrate why), unless it is a new job;
- If new job and no pay stubs have been received - employer statement including anticipated hours, pay dates and rate of pay;
- Child care hours (usually included on the pay verification);
- Second parent unable to provide adequate care;
- Citizenship or non-citizen status of a child(ren) needing care;
- Need for special needs rate;
- Need for child care of child(ren) ages 12-17 (verify and document every 12 months);
- Proof of school registration and class schedule if requesting student child care hours.

When verification can be waived:

- Verification of income can be waived during the 45-day application processing time frame for families who meet all of the following:
- Meet priority processing requirements (see CC-B.6) of being homeless or applying for child care for a child receiving foster care;
- Do not have proof of income readily available; and
- The worker is unable to obtain this verification by calling the employer.

During the certification:

- Verification requirements will depend on the type of change reported:
- Filing group changes – verify income sources and status for non-citizens for any new members;
  - Income changes:
    - » Customer requests lower copay – verify decreased income (do not adjust child care hours); if verification is not received no action is taken;
    - » Customer requests more child care hours – verify the increase in hours only (do not adjust the copay);

if verification is not received no action is taken;

- » Any change to the provider's name or address including any location where care is provided;
- » Income exceeds ongoing limit – no verification is needed (unless unknown); close with timely notice. When the customer is not sure send a copy of the ERDC change report (DHS 862).

At reapplication:

- All countable earned and unearned income – use a month's worth of recent representative income verification (if you do not use the most recent income, be sure to narrate why.);
- If new job and no pay stubs have been received - employer statement including anticipated hours, pay dates and rate of pay;
- Child care hours;
- New or continued need for second parent unable to provide adequate care;
- New or continued need for Special Needs Age (SNA) or Rate (SNR);
- Proof of school registration and class schedule if requesting student child care hours.
- In all cases: Any questionable information.

When verification can be waived:

- Verification of income can be waived during the 45-day application processing time frame for families who meet all of the following:
  - Meet priority processing requirements (see CC-B.6) of being homeless or applying for child care for a child receiving foster care;
  - Do not have proof of income readily available; and;
  - The worker is unable to obtain this verification by calling the employer.

Eligibility determination groups

EDG Group for ERDC consists of all filing group members, including adults, non-citizens, and older children not receiving child care when coding # in ERDC. Unmarried children in the care and custody of the caretaker, who are under age 18 or 18 and attending secondary school or vocational training at least half time, are included in the benefit group.

Income calculation

- If representative of future income, use a month's worth of recent representative income verification (if you do not use the most recent income, be sure to narrate why) to project future income;
- If not representative, estimate future income based on best information available to customer;
- Remember to include all earned income - e.g., bonuses, tips, commissions, and any unearned income - in calculation;
- See special rules on treatment of self-employment income;
- Compare countable income to income charts: 200% FPL at initial certification and the ongoing and recertification income limit during the certification and at recertification. If over, customer ineligible.

Listing

- Provide parent with a copy of the Parent's Guide to Child Care (DHS 7478) and a copy of the Child Care Provider Guide (DHS 7492) to give to provider;
- If customer's provider is not listed, give the Child Care Provider Listing form (DHS 7494) if eligibility is cleared or the DHS 7494D if eligibility is not cleared. The listing process includes a background check that is necessary for child safety. It is important to explain this to the parent and inform them to give the listing form to the provider immediately. The provider is required to complete and return the listing form within 30 calendar days from the date the listing form is issued to the customer. The worker will record the date given on the listing form. The provider must be listed and approved before billing forms can be sent to the provider.
- If already listed, give customer the Child Care Provider Letter (DHS 7494E) to give to provider after customer's eligibility is cleared. DHS 7494E serves as guarantee of customer's eligibility. Send an electronic provider connection request to DPU to link already listed provider to case;
- Explain services offered by CCR&R are to help providers with the listing process and with ODHS training requirements Oregonccrr.com;
- If a customer needs help locating a provider, they may contact 211Info by dialing 211, text the keyword "children" to 898211, email children@211.org or visit 211Info.org.

Special needs rate and high needs rate

Special needs rate is for child(ren) who require a level of care over and above norm for age due to physical, behavioral or mental disability. Criteria must be verified with written documentation however the Special Need Child Care Rate Request (DHS 7486) is not required. If rate exceeds special needs rate due to children with very high needs, refer to Benefit Eligibility Specialist in your area.

Computer screens to check

- UCMS and DPCS-Does customer have unmet copay?
- DPPM-Is provider currently listed?
- UCMS
- Is # in ERDC correct? (# should include all filing group members)
- Are CC Wrk Hrs coded? (Including SLF working hours and authorized student hours.)
- Is all income (EML, SSI, SLF or SUP) coded?
- Are non-citizen children and children not receiving child care coded as 'NO' Ingnt?
- If Special Needs Rate verification met - is child coded with N/R code of SNR with an end date that matches the certification end date?
- If care for older child (age 12-17) authorized - is child coded with N/R code of SNA with an end date that matches the certification end date?
- FCAS
- If companion SNAP case exists, have you adjusted CC deduction? See SNAP policy for information on CC deduction, i.e., maximums, when allowed, etc.

Child care hours

- Code child care hours (include work time, self-employment and authorized student hours) . Computer calculates extra percentage for travel and meal breaks;
- Use highest month's verified hours in certification period. Do not average. When calculating authorized child care hours ALWAYS round up;
- See special rules on calculating hours for two-parent families (work hours must overlap);
- See special rules on authorizing extra hours;
- See special rules on authorizing student hours (must be working; hours; may be limited based on employment hours);
- See special rules on calculating hours when income is less than minimum wage.

Authorizing extra hours

For full-time employment, maximum of 40 x 4.3 or 172 CC Work Hrs allowed. System adds 25% for 215 hrs max. If customer's actual hours exceed 215, check to see if situation meets criteria for authorizing extra hours. If so, code UCMS with actual number of child care hours the customer needs in CC Wrk Hrs field and code EXH C/D and N/R on payee with an end date that matches the certification end date. Extra child care work hours have a maximum of 323 hours. System will not add 25 percent for travel when EXH is used. (EXH not allowed for student hours or self-employment.)

Changes customers are required to report

- No longer working due to job loss or medical leave;
- Increase in income at or above the ongoing income limit;
- Someone moves in or out, including a child, spouse or parent of an unborn;
- Changes in address;
- Changes in providers
- New or returning to employment when on Authorized Work Search(AWS), Authorized Medical Leave(AML) or Authorized Military Transition (AMT);
- Student hours are needed;
- Discharged military member returning from active duty in a war zone.

Acting on changes

- Close ERDC with timely notice, when income is at or above the ongoing income limit;
- The copay is adjusted down when income decreases (do not adjust for increase in income (even when verified);
- Adjust work hours up if work hour increase is verified. Do not adjust down (even when verified) – this is important for continuity of care;
- When a job loss occurs: determine the reason and follow policy for Authorized Work Search (AWS), Authorized Medical Leave (AML) and Authorized Military Transition (AMT).

- Always narrate reported changes and action taken.

Caution: If companion SNAP case exists, follow SNAP policy for acting on changes for SNAP case.

Work schedule

The work schedule (days of the week, start and end times) is needed to determine the caretaker's usual times at work. The schedule may be reported by the individual on the application or through the interview. The schedule is used for program integrity purposes such as identifying inconsistencies with payments to providers. Work schedules are NOT used to determine the authorized child care hours. Can be accepted with participant statement.

ERDC payments to multiple providers

Designating a primary provider

All families receiving ERDC must choose a primary provider. The family should designate their primary provider as the provider who is giving the most amount of care, as copay amount is deducted from their payment. DPU cannot issue a billing form for ERDC unless a primary provider has been designated.

To indicate which will be the primary provider, the worker checks 'yes' in the Primary Provider field in the ODHS Use Only box on the Child Care Provider Listing Form (DHS 7494). If a secondary provider sends in their listing form first, no billing forms will be issued until the primary provider has been approved for payment.

Unless there is a break in eligibility, the designation of the primary provider remains in effect per DPU records until a different primary provider is selected, and the family or branch staff contacts DPU. If a family ends care with their primary provider but still has a secondary provider, no billing forms will continue to be issued unless a new primary provider is designated by the family.

Copay splits: When a family uses multiple providers, their total copay cost is assigned automatically to the primary provider. However, if the primary provider bills for less than the family's copay amount, DPU may split the copay amount in future months between the primary and secondary provider(s).

Example: Iris has a monthly copay of $150.00; her total child care bill is $250.00. Violet, her primary provider, bills $125.00 for the month. Iris's secondary provider, Lily, also bills $125.00. The system pays $0.00 to Violet, because the copay amount that Iris is responsible for is higher than what Violet has billed. The system pays Lily the entire $125.00 she bills, because her CCB has a $0.00 copay. ODHS does not collect the other $25.00. Unless the family has a conversation with DPU, then DPU assumes this arrangement will continue. The copay percentages are split for future months, and Violet and Lily will receive their ongoing CCBs with a copay of $75.00 each (50/50% split of the copay amount). If next month both providers bill $125.00 again, each provider would receive $50.00. Each provider would be responsible to collect the $75.00 copay from Iris directly.

Proration of percentages in special situations: DPU may manually change the percentages of care to multiple providers for future months if the combined amounts being billed by both providers are over the maximum amount that ODHS can pay. This is to avoid overpayment.

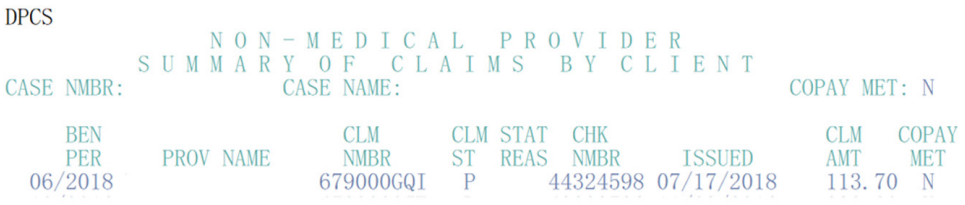
Processing unmet copays

Re-applying for child care assistance after an unmet copay

When a family's ERDC case closes due to an unmet copay and they later re-apply for child care assistance, the worker must determine if the copay is still unmet by reviewing the case to see if there is a 'CNM' case descriptor. If there is still a 'CNM' case descriptor, the worker should refer the parent to DPU to assist them in resolving this.

If the parent states that they cannot locate their provider to pay the copay, or their provider will not accept payment, the worker may assist the parent in re-opening their care by taking the following steps:

Review the billing history by typing DPCS,UCMS# into a blank DHR screen. On the right hand side, there should be a 'COPAY MET' field. Scroll to the line listing an 'N' for a copay not met, mark in this field, and hit SHIFT + F11.

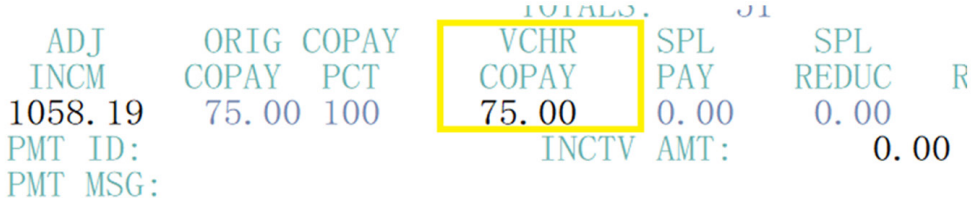

DPCS

N O N - M E D I C A L P R O V I D E R
S U M M A R Y O F C L A I M S B Y C L I E N T

CASE NMBR: CASE NAME: COPAY MET: N

BEN PER	PROV NAME	CLM NMBR	CLM ST	STAT REAS	CHK NMBR	ISSUED	CLM AMT	COPAY MET
06/2018		679000GQI	P		44324598	07/17/2018	113.70	N

Look for the copay amount for that month and year by viewing the bottom left 'VCHR COPAY' field. It is important to look at the voucher copay amount rather than the original copay amount.



ADJ INCM	ORIG COPAY	PCT	VCHR COPAY	SPL PAY	SPL REDUC	R
1058.19	75.00	100	75.00	0.00	0.00	

PMT ID:
PMT MSG:
INCTV AMT: 0.00

Review TRACS for any payments made towards the copay (these payments will be made by DPU); deduct this amount from the voucher copay amount to determine the current amount owed.

Attempt to contact the provider by calling the last known number listed on DPPM. Narrate your conversation on TRACS if the provider answers. Do not give the customer's information until you know that you are speaking with the correct provider.

If you reach the provider:

(a) Explain that the parent/caretaker would like to pay an unmet copay, but cannot reach the provider.

(b) Verify the month and the amount of the copay.

(c) Get the provider's permission to give their phone number or address to the parent/caretaker.

(d) Explain that we will need a receipt or signed, dated statement verifying that the copay has been met or that satisfactory arrangements have been made.

If you cannot reach the provider:

Send a speedy note. Give your contact information, not the parent or caretaker's.

Explain that the copay will be considered met if the provider does not contact the office; give ten days. Create a reminder.

If the provider makes contact, follow the directions above.

If the date of the notice has passed, narrate on TRACS that the family has made a good faith effort to pay, and contact DPU to clear the CNM case descriptor from the system.

Narrate all actions and conversations in TRACS. Title the final narration CNM PAID or CNM CLEARED, depending on the outcome.

Some providers may not want to give out their contact information. Some other options are to provide a PO box, use a third-party contact person or mailing address, set up a meeting time at a public place, or they may offer their own satisfactory arrangement.

ODHS will not accept or mail payments on behalf of the family to the child care provider. It is the responsibility of the parent/caretaker and provider to work out payment arrangements.

Provider confidentiality

General information regarding confidentiality

ODHS does not employ child care providers, but it does provide subsidy payments to providers on behalf of eligible families. ODHS child care provider and household member information may be disclosed upon request without specific authorization from the provider in any of the following scenarios:

- It is being used in support of the administration of ODHS programs;
- It is being used in support of the administration of Office of Child Care (OCC) programs;
- The provider requests, in writing, that the information be released to their Union representative;
- Reporting on open warrants for Law Enforcement agencies;
- The information is a matter of public record.
- ODHS will not release information about the provider, even in the above listed scenarios, if either of these exceptions apply:
  - The information belongs to another division, department, medical professional, individual, or entity operating in an official capacity which prohibits redisclosure;
  - Complaints or statements received by the Child Care Policy team (which may only be shared with ODHS Investigations, ODHS Hearings, OCC, or SCF).

This information is shared only on a need-to-know basis as determined by ODHS, and the information will be used only for purposes for which it was made available. For further information, please contact an ODHS Child Care Policy Analyst at Childcare.Policy@dhsoha.state.or.us.

Frequently asked questions and how to answer them

What is the provider's social security or tax ID number?
The requestor needs to obtain that information from the provider directly. ODHS, and anyone who has access to ODHS information, is unable to disclose provider social security or tax ID numbers.

Why was the provider denied by ODHS?

ODHS is unable to release specific details regarding denial decisions. The provider may be able to obtain more specific information by calling the ODHS Background Check Unit at 1-888-272-5545 or 503-378-5470 (Salem).

For questions regarding denial of payment on a billing form, the provider should call DPU at 1-800-699-9074.

Who should be contacted when there is a complaint to report on a provider?
If the provider is licensed (provider type RFM, CFM, or CNT) with the Office of Child Care (OCC), the report should be made to OCC at 1-800-556-6616 or 503-947-1400 (Salem). If the provider is license-exempt (provider type FAM, QFM, NQC, or QEC), the report should be made to the Direct Pay Unit (DPU) at 1-800-699-9074 or 503-378-5500 (Salem).

For all parents attempting to locate an ODHS listed and approved provider, please refer to 211info.org or encourage them to call 211 directly. Child care providers interested in becoming listed with ODHS may contact DPU or their local Child Care Resource & Referral office (link here).

Chapter 7:
Worker guides

Section 5: TA-DVS worker guides

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

TA-DVS worker guides

Introduction

This section is currently under construction. For tools and guidance pertaining to the TA-DVS program, please click here for TA-DVS Staff Tools.

Chapter 7:
Worker guides

Section 6: MSP worker guides

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

MSP worker guides

Introduction

While the chapters within the Oregon Programs Eligibility Notebook are intended to cover all areas of eligibility, there may be miscellaneous pieces of information that do not fit into a single topic or that supplement other topics. The Medicare Savings Programs (MSP) worker guides are available as a tool to accompany the rest of Oregon Administrative Rule and the Oregon Programs Eligibility Notebook for these areas. This Section of OPEN is a work in progress. If you cannot find what you need here, please check Quick Reference Guides (QRG).

Other resources

Oregon Supplemental Income Program – Medical (OSIPM) and Medicare Savings Programs (MSP): Contains overview of OSIPM and MSP programs, including Income and Resource Standards, Eligibility Criteria, and Medicare Part A/B/C/D breakdown and description.

Non-MAGI Tasks: Contains information on many Non-MAGI tasks and task types for Eligibility Workers, including Benefit Decrease Review, PMDDT Referral Response, SELG Updates, LTC Hardship Approval, etc.

Medicare buy-in

Buy-in refers to the process of the state paying for either the Part A and/or Part B Medicare premium for an individual. To be eligible for buy-in, the individual must first be receiving or be eligible to enroll in Part A or Part B of Medicare. Oregon sets up buy-in for individuals receiving QMB, SMB, or SMF benefits.

Note: Oregon does not pay Medicare Part B premiums when an individual's LTC service liability is more than the current Medicare Part B premium.

Other resources

Medicare Enrollment and Buy-In: Describes the process for facilitating Part A and/or Part B premium buy-in and Medicare enrollment.

Part A buy-in

Receiving Medicare Part A hospital insurance is an eligibility requirement for all Medicare Savings Programs (QMB/SMB/SMF). Individuals that have less than 40 work quarters may have to pay a significant premium for the coverage.

QMB recipients are a required buy-in group for Oregon. That means we have to pay their Part A premium if they have an adjusted income of less than 100% of the FPL. Oregon does not buy-in Part A for any individual who has adjusted income over 100% of the Federal Poverty Level (FPL).

Note: DW is another QMB program that pays for the Medicare Part A premium. However, DW recipients are not eligible to receive OSIPM at the same time. Because every individual eligible for DW would also be eligible for OSIPM-EPD (even if they choose not to receive it), they cannot qualify for DW. That is why we do not have any DW recipients currently in Oregon.

Part B buy-in

The following people are eligible for Part B:

- People age 65 or over who have Medicare Part A (Hospital Insurance).
- All other people age 65 or over who are U.S. residents and are either U.S. citizens or non-citizens lawfully admitted for permanent residence who have resided in the U.S. continuously during the five years immediately preceding the month they apply for enrollment.
- People under age 65 who have been receiving monthly Social Security disability benefits (Title II) or railroad disability benefits for 24 months.
- People under age 65 who are eligible for Medicare because they have chronic kidney disease.

In addition, the State of Oregon must pay the Part B premium for everyone who receives Medicare and full Medicaid benefits (OHP Plus). This is established in Oregon's Medicaid State Plan that is filed with CMS. If the individual also qualifies for one of two MSP that pay the Part B premium and can coexist with OHP Plus (QMB and SMB), then the state will be reimbursed by CMS for a portion of the Part B premium. Those who are over income for QMB and SMB are categorized as State Buy-In (SBI), meaning the state will pay the Part B premium but not receive reimbursement from CMS. You will see this most commonly with Employed Persons with Disabilities (OSIPMEPD) and individuals receiving long-term care service benefits. We do this because Medicaid is always the payor of last resort, so paying the Part B premium to keep Medicaid individuals enrolled in Medicare is a good investment

Note: We do allow some LTC recipients to pay their Part B premium themselves and instead receive an equivalent reduction of their service liability. This is called Client Buy-In (CBI).

When an individual becomes eligible for buy-in, several other records are affected. If the individual is receiving a Social Security payment, the Part B premium will no longer be deducted from the benefit, resulting in a higher monthly Social Security payment. If the individual was not receiving a Social Security payment, but was being billed directly, direct billing will cease. In both cases, the individual will receive a refund of any premiums deducted or paid for the months they were approved for buy-in. Such premium refunds are not to be considered income when determining or reviewing eligibility for benefits.

See here for more information on how buy-in works with ONE.

When buy-in coverage begins

Most people's buy-in coverage will begin the first month the individual is eligible for both Medicaid and Medicare benefits, and is a resident of Oregon.

Buy-in coverage does not, however, always align itself with Medicare Savings Program eligibility.

The QMB effective date, for instance, is the first of the following month all eligibility requirements are met and verified, while SMB and SMF-only recipients are potentially eligible for retroactive coverage back 3 months from the

effective date.

Except for the SMB and SMF recipients, buy-in coverage does not extend to periods of retroactive medical eligibility unless the individual had Medicare and the Buy-In unit was unaware of it. In that case, the buy-in may go back to the original date of Medicaid/Medicare eligibility. MSP eligibility does not, however, go retro in this case at all.

Under buy-in, ODHS|OHA or SSA may enroll the individual even though they do not wish to enroll. A recipient cannot terminate State buy-in coverage.

If the individual previously refused Part B of Medicare or withdrew from it, entitlement will be established or reestablished effective with the first month the individual is eligible for buy-in. When assistance is terminated and buy-in ends, the individual has the option to then withdraw the Part B coverage. If the individual does not withdraw, the Part B premium will be the base amount, even if the individual had been paying a higher penalty premium for late enrollment prior to being on buy-in.

See here for more information on how buy-in works with ONE.

Medicare Modernization Act

Medicare prescription drug coverage, also called Medicare Part D, is available to anyone with Medicare Part A and/or B. This includes people age 65 or older, and some younger people with disabilities.

Any eligible person who wants to have Medicare prescription drug coverage has to enroll in a Medicare Prescription Drug Plan (PDP) or Medicare Advantage Prescription Drug Plan (MA-PD) that serves the area in which they live. Enrollment can be done through the plan or on Medicare's web site, www.medicare.gov.

When an individual becomes eligible for Medicare Part A or B, any medical coverage that the individual has through ODHS|OHA will change. People who have Medicaid (the Oregon Health Plan/OSIPM) will have very limited prescription coverage from the state after they become eligible for any portion of Medicare. Medicaid will pay for limited over-the-counter (OTC) medications.

The Low-Income Subsidy (LIS) and copayments

The amount a person pays depends on their income, whether they use generic or brand name drugs, and whether they are institutionalized or not. Individuals may fall into 3 categories for the Low-Income Subsidy (LIS).

Full dual-eligible individuals with income above 100% of FPL fall into LIS Category 1, paying $3.95 for generic drugs and $9.85 for brand name drugs (in 2022). Those individuals with income at or below 100% of the federal poverty level fall into LIS Category 2, paying $1.35 for generic drugs & $4.00 for brand name (in 2022). Institutionalized and/or home and community-based, full-dual individuals fall into LIS Category 3, which eliminates copayments.

Medicare Savings Program individuals, who do not also have full Medicaid, will always be in LIS Category 1. See the 2022 LIS Reference Sheet.

Others with limited income

Other Medicare beneficiaries with limited income, including SNAP-only individuals, may apply for the Low-Income

Subsidy through the Social Security Administration (SSA). They complete the application form by providing their income, resources, and family size. Applications can be completed at www.ssa.gov. If the Social Security Administration determines that an individual is qualified for the extra help, they will fall within one of the categories outlined in the LIS Reference Sheet. The Social Security Administration does not have an Estate Recovery Program for any LIS assistance. If an individual falls within the following guidelines, they should be referred to SSA:

- Annual Income limited to $19,320 for an individual or $26,130 for a married couple living together in 2022 (updated each March).
- • Resources limited to $15,510 for an individual or $30,950 for a married couple living together in 2022. Resources include such things as bank accounts, stocks and bonds. We do not count their house and car as resources.

People with Medicare and Medicaid, Medicare Savings Program (MSP) enrollment, or those receiving Supplemental Security Income are automatically eligible for the extra help. People in these programs are "Deemed Eligible". They do not need to apply for the LIS and do not need to meet the resource limit (as of 2016).

If a person with Medicare loses their state medical assistance or MSP eligibility prior to July, they will no longer be automatically eligible for the extra help for the next calendar year. The individual must apply for the extra help with the Social Security Administration (SSA) to continue receiving low copayments for their Medicare Part D covered drugs for the following year.

LIS effective dates

The Low-Income Subsidy is effective the first day of the month of dual eligibility status.

Example: An individual applies on August 10th, but does not get all of the paper work in until September 5th would have Medicaid effective on August 10th and LIS effective retroactively to August 1st.

The exception to this rule is for any individual "institutionalized" for MMA purposes. The institutionalized LIS Level 3 is not effective until the 1st of the month in which it is reasonably expected that the dual-eligible individual will remain in the facility for a full calendar month, in which Medicaid is paying.

Example: A private pay individual in a facility meets the OSIPM criteria on May 7th and becomes a dual-eligible on that date. The LTC payments begin on that date, as well. It is believed that the individual will not be leaving the facility for several months. The LIS level 3 for this individual would begin on June 1st.

It is critical that the case is properly coded with the "ISI" case descriptors when it is anticipated that the individual will be in a facility for a full month. The "ISI" case descriptor should be removed as soon as the individual leaves the facility.

Choosing a Prescription Drug Plan (PDP) or a Medicare Advantage Plan (MA-PD)

Unlike most of Medicare, private insurance plans offer prescription drug coverage. Plans choose drugs they will cover, their network pharmacies, and their monthly premiums. The plans must be approved by the Centers for Medicare and Medicaid Services (CMS) but each plan has flexibility in its design.

Each plan has a list of covered drugs called a formulary. The list must include both brand name and generic drugs. People should review the plan materials carefully to make sure their drugs are covered and that their pharmacy is

in the plan's pharmacy network.

These private Medicare plans can provide coverage:

- A Stand-alone **Prescription Drug Plan** (PDP), covers the Medicare Part D prescription drugs only, and no other medical costs.
- A **Medicare Advantage Prescription Drug Plan** (MA-PD) provides all Medicare benefits in one plan, including prescription drugs. MA-PDs cover Medicare Parts A, B, and D. Only people with Medicare Parts A and B may enroll in a Medicare Advantage Plan.
- A **Medicare Advantage-Special Needs Plan** (SNP) serves particular groups (such as people with specific diseases or conditions, people in nursing facilities, or people with Medicaid).

Both MA-PDs and SNPs can be coordinated care plans that offer Medicaid benefits in coordination with all the individual's Medicare benefits. Individuals undergoing a continuing treatment of dialysis for End-Stage Renal Disease are not eligible for either of these plans. An individual wishing to participate in these plans should choose both the Medicaid Managed Care plan/Coordinated Care Organization (CCO) and the Medicare Advantage plan offered by that company. Very few Fully Capitated Health Plans will allow an individual to remain in the Medicaid managed care plan if the individual does not enroll in the Medicare plan offered by that company. CCOs, however, will allow individuals to enroll regardless of whether they are also enrolled in their Medicare Advantage affiliated plan.

2022 Medicare Advantage Plan Prescription Drug Plan List

2022 CCO and Affiliated Medicare Advantage Plan List

Enrolling in a Plan

CMS lists the names of the plans offering the prescription drug benefit in the annual Medicare & You handbook. Plan information can also be accessed on Medicare's website www.medicare.gov, or by calling 1-800-633-4227. In order to enroll, you must have individual's full name, address, DOB, and the individual's Medicare Part A and/or Part B effective dates. When enrolling, be sure to mark the individual's eligibility for Medicaid/Medicare Savings Programs, so that there is no delay in the individual's coverage, and so that you can determine which plans are "benchmark plans" and will not charge the individual a monthly premium for their Part D benefit. **It is critical that dual-eligible individuals enroll in benchmark plans to avoid a monthly premium. When conducting an individualized plan search for an individual these plans will be evident by the $0 premium on Medicare's website**.

2022 Oregon Medicare Part D Stand Alone Plans

Enrollment can occur directly with a PDP or MA-PD. **Medicare Advantage plans that work with a Fully-Capitated Health Plan prefer that the 7208M form is filled out and faxed to them when enrolling a full dual-eligible**. This ensures that individuals are more quickly established in the plan's eligibility and payment systems. Additionally, this form tells the plan that the individual is dual eligible and should not be charged the standard copayments and premiums.

There are several different enrollment types and times in which someone can enroll in a plan. These are:

- Initial Enrollment Period-beginning 3 months prior to an individuals eligibility for Medicare;

- Auto Enrollment;
- Facilitated Enrollment: Limited Income Newly Eligible Transition (LI Net);
- Special Enrollment Period;
- Annual Enrollment Period;
- Seamless Enrollment; and,
- Retroactive Enrollment

Auto enrollment

Dual eligible individuals will be automatically assigned to a PDP serving in Oregon. **However, this enrollment can take up to 3 months to occur and may not meet the individuals' needs**. To ensure that individuals are able to get immediate access to their prescriptions, local eligibility offices should assist all dual-eligible individuals with choice counseling and enrollment assistance within the 3 months prior to the individuals' Medicare A/B effective date(s).

Facilitated enrollment—Limited Income Newly Eligible Transition (LI Net)

If individuals are not enrolled in a Part D plan, they should be able to get their prescriptions by taking the following steps at any time:

- Individuals will need to verify their dual-eligibility status at the pharmacy. The pharmacist can verify Medicaid eligibility by calling the ODHS MMA Hotline at 1-877-585-0007.
- The pharmacist will submit the claim to the Medicare Limited Income Newly Eligible Transition (LI NET) and dispense the individual's prescriptions.
- The LI NET Contractor will enroll the individual immediately with the temporary plan.

To ensure individuals receive their medications through the LI NET, workers may send an MMA Problem Solving Referral Form to Central Office (see Problem Solving section). The Central Office MMA Hotline Team will work with the pharmacy to ensure that individuals are able to access their medications.

Special enrollment period

People with Medicare and Medicaid (and those who receive state help for their Part B premiums and/or cost-sharing) can change plans as often as once a month. However, the individual should be enrolled in their new plan early in the month to avoid problems with enrollment. The plan will take effect the first day of the following month.

If a person loses the Low-Income Subsidy from one year to the next, the individual may change plans until March 31st of the new year.

Annual enrollment period

In October each year, CMS will announce the PDPs and MA-PDs available in the next calendar year. Enrollment for the next year's coverage begins October 15th of each year.

CMS will re-assign some individuals each year during the Annual Enrollment Period. Individuals will need to be contacted to receive choice counseling and enrollment assistance if any of the following situations applies to them:

- If an individual had been auto-enrolled into their current plan and that plan will not be a LIS premium-free plan for the following year, the individual will be re-assigned by CMS into a plan that does have a full premium subsidy.
- If the individual enrolled on their own or with assistance, CMS will not re-assign the individual, unless the plan is no longer serving in the area. Those individuals in plans that are increasing monthly premiums will need to either change plans or pay a monthly premium for their coverage.
- If a person is enrolled in a plan that will not exist in coming year, CMS will enroll that person in a $0 premium plan.

Seamless enrollment

Seamless enrollment can occur when an insurance company that offers an MA-PD or SNP is already providing coverage to an individual who is not yet Medicare eligible, either through an employer, or another plan, including Medicaid. When the individual becomes Medicare eligible the plan can simply enroll that individual into their MA-PD or SNP without the need to have an enrollment form signed. The plan must send a statement to the individual giving them notice of the planned action and allow the individual to enroll into another plan.

Several of the Medicaid managed care plans have made the election to enroll individuals in this manner. It is critical to work closely with the plans to ensure that individuals are not being enrolled into SNPs, when they might only be eligible for a Medicare Savings Program (QMB, SMB, or SMF) after the Medicare is established. An individual, who is later found not to be eligible for the plan, will have difficulty accessing their medications and possibly other medical services.

Retroactive enrollment

Medicare rules allow for all dual eligible individuals to have continuous coverage in the Medicare Prescription Drug Program. If an individual has a lapse in coverage, it is possible to get coverage retroactively. Retroactive enrollment is necessary when individuals have outstanding prescription bills or have had to pay more than the LIS level of copayments for their prescriptions. The MMA Hotline Advocates can help with retroactive plan enrollment. See MMA Problem Solving section for more information.

Medicare Prescription Drug Plan coverage and exclusions

PDPs and MA-PDs are required to cover a list of prescription drugs called a formulary. Finding the right plan requires comparing plan formularies. You can use Medicare's formulary finder at www.medicare.gov: to show if covered drugs are limited by "Formulary Tools", such as Prior Authorizations (PAs) or Quantity Limits.

There are also drugs that may be covered by Medicare Part A or B. Medicare Part A drugs are administered during a Medicare Part A hospital or Nursing Facility stay. Part B covers some drugs including those related to Medicare-covered transplants, some chemotherapy related drugs, and some drugs used in connection with Part B-covered durable medical equipment (such as drugs administered through a nebulizer).

Medicaid covered drugs

For full-dual eligible Medicaid individuals, who also have Medicare, the state will continue to provide coverage for one class of drugs: Limited over-the-counter medications (OTCs).

Appeals and exceptions

If a individual's drug is not one of the drugs on the plan's formulary, then the individual, the doctor, or the individual's designated representative can contact the plan to ask for an exception.

If a individual has been stable on a medication prior to enrolling into a plan, the plan must cover one 30-day supply within the first 90 days. This "transitionary supply" allows the individual and the doctor time to process any exceptions or appeals, or consider alternative medications.

Exception timeframes

- Standard: 72-hour turnaround, and
- Expedited: 24-hour turnaround.

If an exception is granted, then it remains in place for the calendar year. If the exception is denied, the individual can appeal that decision. Appeals follow the normal Medicare appeals process.

- Redetermination by the plan;
- Reconsideration by an independent company contracted with CMS;
- Review by an administrative law judge;
- Review by Medicare Appeals Council;
- Review by Federal District Court.

While Medicare Advantage plans can provide beneficial coordinated care for individuals, it is important to understand some of the payment parameters and requirements, before individuals enroll in the plans. There has been confusion regarding how individuals are able to access their QMB-only benefits through ODHS|OHA when receiving their Medicare A, B, and D benefits from a private Medicare Advantage Plan. ODHS|OHA does not pay the Medicare Advantage premium (if any), but will continue to pay for Part B and, if applicable, Part A premiums to the Centers for Medicare and Medicaid Services (CMS).

ODHS|OHA pays for co-insurance and deductibles for Medicare covered medical services where a Medicare Advantage plan paid in lieu of Original Medicare, if the services are received from an ODHS|OHA enrolled provider, and within ODHS|OHA's fee schedule. (OAR 461-135-0730(1)) ODHS|OHA will not pay copayments for Medicare Part D covered drugs.

Claims that have been paid primary by an MA plan are paid in a different manner than other DMAP claims. There is not a "cross-over claims" process as with Original Medicare. (Crossover claims require only one action from the provider, who receives both the primary and secondary payments from that single action.) Providers should be referred to DMAP Provider Services Unit to receive assistance with filing these claims.

When choice counseling MSP eligible individuals, please review the following educational QMB-MMA flyer with the individual. (Important Information For People in the QMB Program).

Medicare and other third-party insurance

If a person has good private health insurance that covers prescription drugs, they may not need to enroll in a PDP or MA-PD. Health insurance companies will notify their customers when they first become eligible for Medicare.

The notice will say if the insurance is as good as or better than Medicare's prescription drug coverage available to the general Medicare beneficiary. This is called creditable coverage. **Most plans that are considered creditable will NOT have prescriptions copayments at the LIS level**.

Creditable coverage can be in the form of Retiree or Employer plans, such as PERS or Railroad Retiree Board plans, or government benefits like Veteran's or Tricare benefits. If you cannot determine whether the individual's coverage is creditable, or whether the plan should provide the LIS level of copayments for a individual, please submit a referral to the MMA Hotline Team for investigation. (See MMA Problem Solving Referral Form - SDS 0728).

MMA problem solving

Many individuals have trouble accessing their medications through the Medicare Part D program when there are changes in their status or changes in their plan selections. Some of the common problems that individuals will run into are: pharmacy does not know which plan to bill, copayments are not correct, plan denies specific drugs, individuals have no plan in place, the pharmacy is not able to determine whether the medication is covered by Part B, Part D, or Medicaid. Some problems are easy to fix, such as letting the pharmacy know that an individual is dual eligible, or telling the pharmacy what plan an individual is in. Other problems are much more extensive. These may require as much as several hours of time to resolve one individual's issue. To help improve the speed in which individuals are able to access their medications, MMA problem solving referrals should be sent to Central Office for any individual that is having a problem that you cannot resolve in 20 minutes or less.

Urgent problems

Individuals that are currently out of medications, or will be within 3 days should be sent as "Urgent" cases to the Central Office. It is critical that the MMA Hotline Team receive the cases as early as possible to provide enough time to resolve the problem. If a case was previously sent as non-urgent, but has since become urgent, please call 1-877-585-0007 to upgrade the status to an "Urgent" case.

MMA Problem Solving Referral Form

In order to best assist the individual, each field in the Referral Form should be filled in to the best of your ability. All of the information is important, but mandatory information includes: Individual Name, Prime, Contact Information, Case Worker, Branch, Phone #, Pharmacy Name, Pharmacy #, Drugs that individual needs, Date that the individual was or will be out of medication, and the description of the problem.

The MMA Problem Solving Referral Form (SDS 0728) can be emailed.

The Hotline Team will notify ODHS|OHA when the case is received and entered into the MMA Database. If you have not noticed any narration in Oregon Access within a day, you should contact the team by calling 1-877-585-0007 to make sure that the case has made it to the team. As the team works the case, narrations will be made regarding the status. Many cases take several weeks to get resolved. Reimbursements due to individuals and retroactive enrollment issues can sometimes take up to 3 months or more.

Eligibility for residents of a public institution

Click here for Eligibility for residents of a public institution.

Other resources

Incarceration *includes screenshots: Explains program policy for incarceration and steps to take when acting on a report of incarceration or release from incarceration

Chapter 7: Worker guides

Section 7: OSIPM worker guides

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

OSIPM worker guides

Introduction

While the chapters within the Oregon Programs Eligibility Notebook are intended to cover all areas of eligibility, there may be miscellaneous pieces of information that do not fit into a single topic or that supplement other topics. The OSIPM worker guides are available as a tool to accompany the rest of Oregon Administrative Rule and the Oregon Programs Eligibility Notebook for these areas. This Section of OPEN is a work in progress and may not include all OSIPM worker guides. If you cannot find what you need here, please check APD Staff Tools.

Other resources

Oregon Supplemental Income Program – Medical (OSIPM) and Medicare Savings Programs (MSP): Contains overview of OSIPM and MSP programs, including Income and Resource Standards, Eligibility Criteria, and Medicare Part A/B/C/D breakdown and description.

Non-MAGI Tasks: Contains information on many Non-MAGI tasks and task types for Eligibility Workers, including Benefit Decrease Review, PMDDT Referral Response, SELG Updates, LTC Hardship Approval, etc.

Verifying assumed and protected eligibility

This worker guide is intended to help workers determine if an individual has assumed eligibility under 1619(b) or protected eligibility under the Pickle Amendment, as a Disabled Adult Child (DAC), or as a widow or widower.

1619(b) status

This is an assumed eligible category. Section 1619(b) of the 1987 SSA legislation provides for continued Medicaid eligibility for individuals whose incomes are too high to qualify for an SSI cash payment, but are not high enough to offset the loss of Medicaid or publicly funded attendant care. Individuals will be assumed eligible under 1619(b) Medicaid status if the sole cause for SSI payment cessation is increased earnings over the break-even point.

SSA determines 1619(b) status. In order to qualify for 1619(b) an individual must meet all of the following:

- Must have been eligible for an SSI cash payment for at least one month
- Must still be disabled
- Must still meet all other eligibility rules, including resources
- Must need Medicaid in order to work
- Must have gross earned income that is insufficient to replace SSI, Medicaid and any publicly funded attendant care

SSA will ask the individual if they need Medicaid in order to maintain their employment. It is important that they answer yes to that question. If they do not, they will not be determined eligible for 1619(b).

An individual who is determined to be 1619(b) eligible is assumed to meet the financial and citizen/non-citizen requirements for Medicaid. This means that the individual will receive OSIPM for as long as they are 1619(b) eligible and meet all the non-financial requirements. Resources do not have to be considered. They still must

meet residency and pursuit of health care coverage and cash medical support requirements. **Verify at initial application and at each redetermination that the individual is still 1619(b) eligible**.

Individuals may lose 1619(b) by earning too much or they may go back on SSI or SSDI. If they lose 1619(b) eligibility, you need to determine eligibility for other Medicaid programs. An individual who has lost 1619(b) status because of their earnings should be looked at for EPD.

Disabled adult child status

This is a protected eligibility category, which means we make certain concessions by disregarding all or part of the individual's SSB, but the individual must still meet all other financial and non-financial eligibility requirements. Section 1634(c) of the Social security act and 42 U.S.C (United States Code) 1383c provide Medicaid eligibility for Disabled Adult Children (DAC). In order for an individual to qualify for this program, they must meet the following eligibility components:

- The individual must be over 18 years old;
- The individual was determined to be blind or disabled as defined by SSA before they were 22 years old;
- The individual was receiving SSI at age 18 or older and lost that eligibility after July 1, 1987 (they only have to receive one month of SSI at age 18 to be eligible but they must have been receiving SSI and lost it)
- The individual lost their SSI because they started receiving benefits on a deceased, disabled or retired parent. The loss of SSI can be due to receipt of this benefit or because the benefit increased.

Clues that an individual might be DAC eligible. These are just clues. You cannot be certain that an individual meets the criteria as a Medicaid protected DAC unless all eligibility components have been verified.

- Individual is receiving benefits under an SSN that is not their own
- Individual is over 18 years old
- There is a 'C' code after the SSN they are receiving benefits under (ex. xxx-xxx-xxxxC3)

It is important to note that SSA has their own eligibility criteria for individuals they refer to as DAC's or CDB's (Childhood Disability Beneficiaries). When determining eligibility for a Medicaid protected DAC, unless all eligibility components can be verified by other means, SSA must be contacted and asked specific questions related to eligibility for the program we offer. The specific questions staff should ask SSA are as follows:

- Was this individual determined to be disabled or blind prior to age 22?
- Did this individual receive SSI (title XVI) payments at age 18 or older (only one month of payment is needed to meet the requirement)?
- Did this individual lose their SSI on or after July 1, 1987?
- Was the loss of the SSI due to receipt of or an increase in child's insurance benefits (DAC payments)?

If the answer to each question listed above is yes, staff can look at DAC eligibility. The individual must ALSO meet the other eligibility requirements in order to be considered a Medicaid protected DAC.

Other eligibility requirements that must be met:

- The individual would continue to be eligible for SSI if they were not receiving the DAC benefit:

- This means the financial group's adjusted income is below the current OSIPM standard. If the individual (or a spouse in the financial group) has other income besides SSB, they could potentially be over income (and thus ineligible) for OSIPM.
- After the appropriate amount of DAC payments are excluded (see Calculating Countable Income) and the total countable income is determined, apply the normal deductions to come up with adjusted income.

- The individual (or the individual's financial group) must have resources within the SSI limit.
- They must meet residency requirements, disability requirements, pursuit of assets, etc., so it is possible for an individual to lose their DAC entitlement based on these other requirements.

Reasons that a DAC might lose their eligibility include:

- The individual may at some point earn enough to start receiving benefits under their own SSN. Usually, a DAC's own earned income does not affect their DAC status. However, when the individual's own SSB is higher than the DAC SSB (that is based on the parent's benefits), the DAC benefits end and the individual is no longer eligible as a DAC. You can verify that the DAC benefits have ended by confirming that current benefits are being paid under the individual's SSN followed by an "A" code (there is no longer any "C" code for child's benefits based on the parent's benefits).

  Note: Sometimes the individual will begin receiving both benefits under their own SSN and an adjusted amount of DAC benefits. In that case, the individual's SSN followed by an "A" code will have a CP P-st (pay status) on BEIN, and the DAC SSN followed by a "C" code will have an AD P-st. The AD indicates the payment was adjusted for dual eligibility, and the individual continues to receive DAC payments and be DAC eligible.
- The individual may have a medical improvement such that they no longer meet the impairment criteria to qualify for SSI.
- The parent on whose case the individual was receiving benefits is no longer disabled.
- The individual gets married to someone with too much income
- The individual starts receiving other sources of income that put him/her over

Cases that have been determined to meet DAC status should be reviewed yearly to determine that the individual continues to meet ALL the eligibility factors for a Medicaid protected DAC.

When an individual is determined to meet all the eligibility components as a Medicaid protected DAC, it should be narrated to clearly indicate how the eligibility criteria have been verified. A person who has met the requirements as a Medicaid protected DAC is considered deemed eligible. This means that we protect their Medicaid eligibility from income, but they must meet all other eligibility factors to be considered eligible. An individual who is determined to be a Medicaid protected DAC does not have to contribute towards their cost of services, unless they are receiving nursing facility services. If a person loses their DAC status, they would need to qualify for OSIPM under a different program.

An individual who loses SSI for a reason other than those listed above, would not be eligible for protected Medicaid under DAC criteria.

Calculating countable income

The following is intended to assist in determining how much of the Title II DAC benefits are countable when determining total countable income. If the individual has other income, it would be added to the amount determined below to determine total countable income.

Note: The individual must be receiving Title II Social Security Benefits (SSB). Receiving railroad retirement benefits (RRB) is not countable as DAC income—it must be SSB.

To calculate DAC income, the amount of the individual's countable SSB income is determined as follows:

- For an individual who loses SSI as a result of receiving an initial award of Title II DAC benefits, the original Title II DAC benefit amount, including any subsequent COLAs, that creates ineligibility for SSI is excluded.
  - For example, John received a monthly SSI payment of $686.78 while a parent was working. When John's father retired, a Title II DAC benefit payment of $900 began. The following month, the $900 DAC payment being received made John ineligible for SSI. When John applies for Medicaid, the entire initial DAC payment of $900 will be disregarded when his Medicaid eligibility is determined and any subsequent COLAs that created ineligibility for SSI.
- For an individual who received both SSI and Title II DAC benefits and who lost SSI as a result of receiving an increase in Title II DAC benefits, the disregard is determined as follows:
  - For individuals who received a non-COLA-related increase to Title II Disabled Adult Child benefits that created ineligibility for SSI, the amount of the increase, and any subsequent COLAs, is excluded and the amount received prior to the increase is used as the countable income amount.
    - For example, Judy is an SSI recipient. While a parent worked, Judy received a monthly SSI payment of $686.78. When Judy's father retired and began receiving social security retirement, Judy began receiving a Title II DAC benefit payment of $500 a month. While the SSI payment decreased, the initial DAC payment did not cause Judy to lose SSI eligibility. When Judy's father died, a DAC payment began of $750 a month. The increased amount put Judy over the SSI income limit, and SSI payments ended. Judy applies for Medicaid. ODHS|OHA must disregard the secondary increase of $250 ($750 - $500 = $250) because it was that increase that caused Judy to lose SSI eligibility. ODHS|OHA would count only $500.00 of Judy's DAC payment (and any other countable income) to determine Medicaid eligibility.
  - For an individual who lost SSI due to an annual Title II COLA, all COLAs received since the last month that the individual was eligible for and received both Title II DAC and SSI benefits are excluded.
    - For example, Billy received SSI and DAC benefits concurrently and then lost SSI eligibility. ODHS|OHA would disregard any a COLA received for any DAC payments received since the last month that Billy was eligible for and received DAC and SSI benefit concurrently.

Pickle Amendment eligible individuals

The Pickle Amendment was initiated by Representative J. J. Pickle who introduced Public Law 94-566 to Congress to deal with the situation where an individual receiving SSI has a minimal increase in income that results in the unintended consequence of losing their SSI and Medicaid eligibility. Therefore, this Public Law became known as the Pickle Amendment. Congress provided for the Pickle exception because they realized that an individual who was formerly eligible for SSI could not obtain or afford medical coverage just because of a small increase in income.

In order for an individual to meet the Pickle Amendment requirements for OSIPM, all of the following must be met:

- The individual must currently be receiving Title II Social Security Benefits (SSB for the aged, survivors or persons with disabilities). An individual who receives railroad retirement benefits (RRB) does not meet this requirement--it must be SSB.
- The individual was eligible for and receiving SSI or state supplement payments and became ineligible for those payments after April 1977. The reason the individual became ineligible for the SSI or state supplements is not relevant and they do not have to have been continuously eligible (they could have been married and then divorced, for example.) Also, the individual must have been receiving SSI or state supplements and been eligible for SSB in the same month, prior to losing the SSI or state supplement payments.
- The individual's current Title II Social Security income would be within the SSI standard if the cost of living adjustments (COLA) were deducted from the current SSB income.
- Married individuals must be income eligible independently from their spouse prior to determining financial eligibility for the financial group's total adjusted income.
- The financial group's total adjusted income is below the current applicable OSIPM adjusted income standard:
  - After an individual's SSB income is "Pickled" (and the spouse's SSB also, if applicable, see below), the total amount of the Pickled SSB (rounded down because SSB amounts are only paid in even dollar amounts) is added to the financial group's other countable other income (if any) to determine total countable income.
  - The applicable deductions are applied to determine total adjusted income.
- The individual meets all other financial (resource limit) and non-financial criteria for OSIPM.

The benefit of being Pickle eligible is when a Pickle-eligible individual needs long-term care services, they do not need to pay a liability when in a waivered service setting (see 461- 160-0610). However, they will need to pay a liability in other care settings (for example, in a nursing facility).

Determining Pickle eligibility

Individuals who have never received SSI cannot be Pickle eligible. If the information is not available on the W204 screen or SOLQi the eligibility worker will need to contact Social Security to find out what month the individual both received SSI and was eligible for SSB. If the SSB amount from that month is known, no Pickle calculation is necessary. Use the SSB from that month and add it to the individual's current income to see if the individual's income exceeds the SSI standard. If the individual's spouse also had Social Security benefits at the time the individual lost SSI benefits, the spouse's SSB amount at that time is considered the spouse's countable income.

> **Example 1:** Gloria was eligible for both SSI and SSB in June 1999. SSI payments terminated and an award letter was provided verifying receipt of $648 SSB beginning in July 1999. The SSB that is being received now ($875) is Gloria's only income. The current SSI standard is $841 + $20 (standard deduction) = $861. The $648 SSB that Gloria was eligible for in the month that SSI was also received in 1999 is less than $861, so Glora is Pickle eligible.

In many cases, the amount of SSB that was received in the month when the individual was simultaneously eligible for SSI is not known. When the amount of SSB from that month is unknown, the eligibility worker must use the chart from 461-135-0780 to calculate the amount. In other words, the current SSB amount must be "Pickled" to

find out what it used to be. The "Pickled" amount of SSB plus the individual's other income (countable unearned and adjusted earned) cannot exceed the current SSI standard plus $20. If the individual's spouse also had Social Security benefits at the time the individual lost SSI benefits, the spouse's SSB amount at that time is considered the spouse's countable income.

> **Example 2:** Horace last received SSI in March 1978 when eligible for both SSI and SSB. Horace currently receives $928 SSB and also has a private pension of $295.

From the chart, we see that the relevant multiplier is .240. $928 X .240 = $222.72 (round down to $222). Next, $222 + $295 (Horace's other countable unearned income) = $517. The current SSI standard $841 + $20.00 = $861 and $517 is less than that standard, so Horace is Pickle eligible if all other OSIPM criteria is met.

> **Example 3:** Elsie last received SSI in April 1993 and was eligible for both SSI and SSB in that month. Elsie currently receives $790 SSB and also earns $265 per month answering the phone part time for the local church.

From the chart, we see that the relevant multiplier is .548. $790 X .548 = $432.92 (round down to $432). After allowing the $65 earned income deduction and ½ of the remainder, there is $100 adjusted earned income to count. $432+ $100 = $532. $532 is less than the current SSI standard, so Elsie is Pickle eligible if all other OSIPM criteria is met. With the earned income, should Elsie ever become ineligible for OSIPM under Pickle, we must evaluate eligibility under EPD.

> **Example 4:** Alvin last received SSI in June 2004 and was eligible for both SSI and SSB in that month. Alvin currently receives $1350 SSB.

From the chart, we see that the relevant multiplier is .711. $1,350 X .711 = $959.82 (round down to $959). $972 exceeds the current SSI standard, so Alvin is not Pickle eligible.

Loss of Pickle eligibility. Individuals who have been determined Pickle eligible can lose the status when their situation changes. For example:

- They could accumulate or receive resources in excess of the $2,000 resource limit.
- They could get married to a spouse with countable assets that causes them to be over-income or over-resources.
- They could have other income increase or start receiving income from another source that makes them over-income.

For this reason, it is very important to check the individual's income and resources at each review. Also, when the individual has changes in their situation that could affect the individual's countable income or resources, re-check the Pickle calculation.

Widows/widowers eligible individuals

This is a protected group for an individual with a disability who was receiving SSI, but their spouse or ex-spouse passed away, and the resulting amount of Social Security widow/widower's benefits based on the deceased spouse's work history caused the SSI to terminate.

History. This protection was established by Congress effective July 1, 1988. Therefore, individuals cannot be

eligible prior to that date. However, because it is only for individuals who are not eligible for Medicare Part A, it only affects individuals who have recently begun receiving Social Security benefits.

A widow or widower receiving Title II benefits from the Social Security Administration claim of a deceased spouse or deceased former spouse is eligible for OSIPM if the individual meets all of the following:

- The individual must not be entitled to premium-free Medicare Part A (Hospital coverage).
- The individual must have received SSI, but lost the SSI when their spouse or ex-spouse passed away because the resulting Social Security widow/widower's disability benefit exceeded the SSI amount.

Note: The individual must be receiving Title II Social Security Benefits. Receiving railroad retirement benefits (RRB) is not countable as widow/widower income---it must be Social Security Benefits.

The individual is deemed to meet the SSI income limit, but must continue to meet all other SSI eligibility criteria (including resources).

There is no longer any age limit for this protected group.

When a protected widow/widower needs long-term care services, they do not need to pay a liability when in a waivered service setting or in certain mental health settings (see 461-160-0610). However, they will need to pay a liability in other care settings (for example, in a nursing facility).

Widow/widower OSIPM eligible individuals are usually receiving SSI and Medicaid when their spouse dies. When the widow/widower Social Security benefits begin, the amount exceeds the SSI amount, which causes the SSI to terminate. If the individual is not eligible for premium-free Medicare Part A, authorize protected eligibility under this policy.

For any widow/widower determined eligible, be sure the details of the determination are clearly noted. This makes it possible for anyone else reviewing the case to easily identify how the determination was made and prevents questions about eligibility in the future.

For example, you might need to add a case note with the following:

- Individual lost their SSI October 2007 because they began receiving widow/widower's benefits in a higher amount.
- Individual is not eligible for premium-free Medicare Part A.

Widows/widowers who have been determined OSIPM eligible can lose the status when their situation changes. For example:

- They could accumulate or receive resources in excess of the $2,000.00 resource limit.
- They could get married to a spouse with countable assets that causes them to be over-resources.
- They could become eligible for premium-free Medicare Part A.
- For this reason, it is very important to update the individual's resources at each review.

Other resources

OSIPM Protected Eligibility Covers OSIPM Protected Eligibility and provides guidance to staff on how to enter these cases into ONE. It also provides guidance on 1619(b) cases and the SSI Discontinuance screen.

Presumptive Medicaid (PMDDT) procedures

When an individual alleges a disability that would meet the SSA disability requirements for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefits, **Oregon is required to make a presumptive Medicaid disability determination within 90 days** of the individual's Date of Request (DOR). If an individual has already been determined to be disabled by the Social Security Administration (SSA) they already meet the Basis of Need requirements and to not need to be referred to PMDDT.

If a non-SSI/non-SSDI applicant meets the financial and nonfinancial eligibility requirements for OSIPM, ODHS must make a disability determination using Social Security's disability criteria. This is because State of Oregon elected to become a non-1634 state. This means ODHS|OHA retains responsibility for making Medicaid-related disability determinations.

Presumptive Medicaid disability determinations are made, when needed, for all OSIPM programs, including Employed Persons with Disabilities (EPD) and Long-Term Care (LTC) services.

Using administrative medical examinations

When ODHS|OHA is responsible for making a decision of OSIPM disability or blindness, allow the individual to select a qualified medical provider to complete the medical evaluation. Authorize payment for an administrative medical examination as needed. See DMAP Worker Guide for information on these exams.

A decision to deny or end benefits may be reconsidered when additional medical documentation relevant to the decision is received by ODHS|OHA within 30 days of the original effective date of denial or termination.

Medical documentation

Medical documentation must be written and contain:

- A diagnosis in medical terminology
- A prognosis
- Clinical evidence

Workers would not accept a brief note from a doctor saying the individual is disabled or blind. Determining eligibility is ODHS|OHA's responsibility.

To determine eligibility, ODHS|OHA will accept evaluations from the following sources:

- Medical evaluations only from medical and osteopathic doctors.
- Visual evaluations from optometrists.
- Mental evaluations from licensed clinical psychologists.

For casework planning (e.g., service planning, referrals to other agencies, or JOBS planning) and supplemental

information, ODHS|OHA will accept:

- Licensed Social Worker evaluations.
- Physical capacity evaluations from licensed Physical Therapists and licensed Occupational Therapists.

The individual must provide or cooperate in obtaining sufficient medical documentation for ODHS|OHA to determine eligibility.

Other resources

Presumptive Medicaid Disability Determination Team (PMDDT) and State Family Pre-SSI (SFPSS) Referrals: Walks through the Presumptive Medicaid Disability Determination Team (PMDDT) and State Family Pre-SSI referral process within ONE. Each referral is separate in the document. SFPSS referrals are completed by family coaches.

Treatment of annuities

This worker guide is intended to help workers with the determination as to whether the purchase of an annuity is a disqualifying transfer of assets for less than fair market value for individuals applying for or receiving long-term-care.

Remember, to ensure that you have detailed information about the annuity necessary for making an eligibility determination, make a copy of the entire annuity for the case file. You will need to know not only the date and amount of the purchase, amount it pays out, etc., but also who is named as the remainder beneficiary, for example.

Note: When the OSIPM annuity rule, OAR 461-145-0022(10), says that an annuity purchased after 7-1-06 must name as the first remainder beneficiary ODHS|OHA "for up to the total amount of medical benefits paid on behalf of the individual," this means that the state will recover all sums allowed under the ruling by the Court of Appeals for the Ninth Circuit, in Hutcherson v. Arizona Health Care Cost Containment Sys. Admin. (9th Cir., 2012): The state's right to recover against a community spouse's annuity for the institutionalized spouse's medical costs is not limited to the amount the state paid for the institutionalized spouse's medical costs as of the date of the community spouse's death. Rather, the state can be reimbursed from the annuity for the cost of the medical assistance paid on the institutionalized spouse's behalf after the community spouse's death, as well. For this reason, CAREFULLY REVIEW the policy to see how ODHS|OHA is named as beneficiary. The following language is **NOT ACCEPTABLE**: "The Oregon Department of Human Services to the extent of medical benefits provided to my spouse; the primary beneficiary's claim amount ends on the date of death of the owner/annuitant." If you find such limiting language:

- OAR 461-145-0022(11): Under the circumstances set forth in the rule at (11), to the extent to which there is a disqualifying transfer of assets under this section, the annuity is not counted as a resource. See (11) for an explanation of when there is a disqualifying transfer, and how to calculate its length.
- OAR 461-145-0022(12): The annuity is counted as a resource when it does not meet all of the requirements of section (10)(b) or (10)(c) of the rule.

Click here for Annuity flowchart.

Annuities purchased by individuals (or their spouses) before January 1, 2006

Calculate a disqualification if the annuity pays out beyond the expected lifetime of the annuitant (individual or community spouse).

Example 1

Two males, one 65 and one 80 years old, each buy $10,000 annuities in May 2005 to be paid over the course of 10 years. Looking at the tables below we find the 65-year-old is expected to live 16.67 years and the 80-year-old 7.62 years. Because the 65-year-old is expected to have the annuity paid out during his lifetime, there is no transfer of asset issue. The 80-year-old, however, is not expected to live long enough to benefit fully from his annuity. There is a transfer of asset issue with him we must explore. The question is how much of his investment is he going to get value from? He is expected to live 7.62 years, the annuity pays out over 10 years. So, there is a penalty on 26.9% of the original value. This is the percentage of the value he is not expected to receive (10-7.62 = 2.38 years. 2.38 years /10 years = 23.8%) of the original value. So, $10,000 X 23.8% = $2,380. This amount is the uncompensated value.

The disqualification period is the number of months equal to the uncompensated value divided by the amount defined by rule for various time periods.

For applications received after October 1, 2008, for instance, the uncompensated value is divided by $6,494 (461-140-0296). In the above example, we would have: $2,380 (Uncompensated Value) divided by $6,494 to find out how many months the disqualification period is. Since $2,380 is less than $6,494, there are 0 months of disqualification. Count the monthly annuity payments as unearned income.

Example 2

This same 80-year-old individual with a $120,000 annuity with everything else the same would result in:

- $120,000 X 23.8% = $28,560
- $28,560 divided by $6,494 = 4.4

So, he would be disqualified for 4 months from May 1, 2005. The disqualification period is past and there is no disqualification to serve at application.

Summary

If an annuity is expected to pay out longer than the person's life expectancy, there is a potential disqualifying transfer. Figure out the percentage of time the individual isn't expected to get the benefit of the annuity. Multiply this by the original amount of the annuity and plug this figure into the transfer of resource penalty calculation as illustrated above.

Annuities purchased by individuals (or their spouses) on or after January 1, 2006 when the individual is in a standard living arrangement and purchased from January 1, 2006 through June 30, 2006 when the individual is in a non-standard living arrangement

If the annuity meets the criteria of the rule (461-145-0020(4)(b)(C) or 461-145-0022(8)), count the monthly annuity payments as unearned income. If the annuity does not meet the criteria of the rule, count the annuity as a resource.

Example 1

A single female individual who is 76 years old applies for Medicaid in February 2006. She purchased a $62,000 irrevocable annuity from an insurance company on January 15, 2006. The annuity will pay out $584 per month for 12 years. The individual's non-disabled adult child is the first remainder beneficiary. The individual does not have any other children. How would this annuity be treated?

Answer: First determine whether the annuity meets all of the criteria of 461-145-0020 (4)(b)(C). The annuity is irrevocable and was purchased from a business. The individual's life expectancy is 12.11 years and the annuity will pay out in equal installments over 12 years, so the annuity meets the first 3 criteria. However, the annuity does not meet the 4th criterion because a child under age 21 or child any age with a disability or ODHS|OHA is not named as the first remainder beneficiary.

If the individual agrees to change the first remainder beneficiary to ODHS|OHA (up to the amount of medical benefits provided), count the $584 per month income only; the $62,000 resource is excluded. If the individual does not agree to change the first remainder beneficiary, the annuity counts as a resource. The resource exceeds the $2000 limit so Medicaid eligibility must be denied.

Example 2

A female community spouse who is 69 years old purchased a $100,000 irrevocable annuity from an insurance company on March 15, 2006. The annuity will pay out $725 per month for 17 years. The community spouse's non-disabled adult child is the first remainder beneficiary. The community spouse does not have a child under age 21 or a child any age with a disability. The individual applies for Medicaid for April 2006. How would this annuity be treated?

Answer: First determine whether the annuity meets all of the criteria of 461-145-0020 (4)(b)(C). The annuity is irrevocable and was purchased from a business. The community spouse's life expectancy is 17.08 years and the annuity will pay out in equal installments over 17 years, so the annuity meets the first 3 criteria. However, the annuity does not meet the 4th criterion because a child under age 21 or child any age with a disability or the individual/ODHS|OHA is not named as the first remainder beneficiary.

If the community spouse agrees to change the first remainder beneficiary to the individual, and ODHS|OHA (up to the amount of medical benefits provided) should the individual not survive the community spouse, count the $725 per month as the community spouse's income only; the $100,000 resource is excluded. Both the individual and ODHS|OHA as a contingency must be named as remainder beneficiaries, in that order. If the community spouse does not agree to change the first remainder beneficiary, the annuity counts as a resource. Determine the value of the resource per 461-145-0020 (3) and include it in the couple's resource assessment.

Annuities purchased by individuals (or their spouses) in non-standard living arrangements on or after July 1, 2006

Individuals in nonstandard living arrangements must agree by signing the application that ODHS|OHA will be a preferred remainder beneficiary on all annuities purchased on or after July 1, 2006. The individual must verify that the remainder beneficiary designation meets the requirements of 461-145-0022 before determined eligible. A notice should be sent to the annuity issuer advising them that ODHS|OHA is a remainder beneficiary. Use form SDS 0545 to notify the insurance company. Upload the notice into the electronic file and add a case note that the notice

was sent.

Annuities must meet the criteria of 461-145-0022(10) in order to count the monthly annuity payments as unearned income. If the criteria are not met, count the annuity as a resource. If the individual is eligible even counting the annuity as a resource, determine whether a disqualification for a transfer of assets must be applied.

Example 1

A single male individual who is 63 years old applies for services and Medicaid in October 2006. He purchased a $45,000 irrevocable and non-assignable annuity from an insurance company on July 15, 2006. The annuity will pay out $392 per month for 10 years. The individual's non-disabled adult child is the first remainder beneficiary. The individual does not have a child under age 21 or a child any age with a disability. How would this annuity be treated?

Answer: First determine whether the annuity meets all of the criteria of 461-145-0022(10). The annuity is irrevocable and non-assignable and was purchased from a business. The individual's life expectancy is 18.11 years and the annuity will pay out in equal installments over 10 years, so the annuity meets these criteria. However, the annuity does not meet the final criterion because a child under age 21 or child any age with a disability or ODHS|OHA is not named as the first remainder beneficiary.

If the individual agrees to change the first remainder beneficiary to ODHS|OHA (up to the amount of medical benefits provided), count the $392 per month income only; the $45,000 annuity is not a disqualifying transfer of assets and it is not a countable resource. If the individual does not agree to change the first remainder beneficiary, the annuity is both a disqualifying transfer of resources and counts as a resource. The individual cannot serve a disqualification until he is otherwise eligible for Medicaid, so first count the annuity as a resource. The fair market value most likely exceeds the $2000 limit for Medicaid eligibility and the individual is ineligible. When the individual reapplies at a later date when he is resource-eligible, impose a disqualifying transfer of assets disqualification if the individual still has the annuity. Per 461-140-0300, there is no disqualification if the annuity that would have caused a disqualification is rescinded.

Example 2

A female community spouse who is 74 years old purchased a $74,000 irrevocable and non-assignable annuity from an insurance company on August 1, 2006. The annuity will pay out $535 per month for 12 years. The individual is named as the first remainder beneficiary. The community spouse does not have a child under age 21 or a child any age with a disability. The individual applies for services and Medicaid for November 2006. How would this annuity be treated?

Answer: First determine whether the annuity meets all of the criteria of 461-145-0022(10). The annuity is irrevocable and non-assignable and was purchased from a business. The spouse's life expectancy is 12.95 years and the annuity will pay out in equal installments over 12 years, so the annuity meets these criteria. However, the annuity does not meet the remainder beneficiary criterion because the spouse cannot name the individual (The individual could name the spouse, however).

If the community spouse agrees to change the first remainder beneficiary to ODHS|OHA (up to the amount of medical benefits provided), count the $535 per month as the community spouse's income only; the $74,000 is not a disqualifying transfer of resources and is not a countable resource. If the spouse does not agree to change the

first remainder beneficiary, the annuity is a disqualifying transfer of resources and counts as a resource. Count the annuity as a resource and include it in the couple's resource assessment. Deny the case if the individual is over resources. If the resource limit is met, approve the case. This is because the annuity must be part of the community spouse's resource allowance (CSRA), if it doesn't cause the individual to be over resources. Section (4) of the rule says when an annuity is part of the CSRA, ODHS|OHA does not need to be named as a remainder beneficiary.

Life expectancy table

Follow this link to the "Period Life Table" published by the SSA. There are columns for males and columns for females. Use the "Life expectancy" column to determine if an annuity pays principal and interest out in equal monthly installments within the actuarial life expectancy of the annuitant. Use the age that the individual or community spouse was on the date that they purchased the annuity.

Effect of purchasing annuities to spend down resources

If a legally married couple effects a "spend down" by purchasing a Medicaid-compliant annuity, this will have an effect on the monthly maintenance needs allowance (the LDS) that the institutionalized spouse will be able to divert to the community spouse thereafter. This is because OAR 461-160-0620(3)(d)(B) says: "… The countable … income of the community spouse is subtracted from the maintenance needs allowance determined in step 1. The difference is the income allowance …"

Therefore, when the spend down has occurred and an annuity has been purchased, enter the annuity as unearned income in for the annuitant. Also enter the annuity as a resource on the case. Be sure to answer questions correctly so the annuity is not counted both as a resource and as income. Run eligibility and review the Patient Liability Summary to see how this new information has affected the CSIA. Also review to see how it might have affected lower-priority deductions (461-160-0620[3]) from income, such as allowances to dependents and medical expenses. Note that it might very well increase the patient liability.

Understanding trusts

This guide is not meant to replace OAR 461-145-0540, Trusts, or OAR 461-140-0020(2)(e), Availability of Resources. Staff should always refer to the actual rules when making an eligibility determination. This is a guide to explain the more common trusts staff might encounter.

This guide will discuss trusts containing resources and/or income of the financial group as well as trusts containing resources and/or income of a third party such as the applicant's parent. In all cases, be sure to refer to the OAR for more detailed information.

Terminology

Grantor – A person who creates a trust.

Beneficiary – A person who benefits from the trust (Usually, Grantor and Beneficiary is the same person for the purpose of an Income Cap Trust).

T**rustee –** A person who holds a position of trust or responsibility for the benefit of another (generally, this is a

Medicaid applicant/individual's representative, money manager, etc.).

S**uccessor trustee –** A person who would step in or replace the original trustee.

Note: You might be presented with a "deed of trust" or "trust deed," which is a type of mortgage and not the sort of trust dealt with here.

Trusts funded with income/resources of the financial group

There are 5 kinds of trusts you might come across that contain resources and/or income of the financial group. These include:

- **Generic trusts**
    1. Revocable
    2. Irrevocable
- **Medicaid-specific trusts**
    3. Under 65 Disability Trust
    4. Pooled Trust
    5. Income Cap Trust

Generic trusts

Revocable Trust

The total value of this type of trust is considered a resource available to the individual. 461-145-0540(8).

Note: If the home of the applicant or applicant's spouse is the resource in the trust: Since the home is an excluded resource if the individual is living there, the individual will not be over resources if the home is the resource in the trust.

Irrevocable trust

There are three types of irrevocable trusts that are Medicaid-specific trusts. There are also irrevocable trusts that are non-Medicaid specific. First we will talk about the non-Medicaid specific irrevocable trusts.

Be sure to read the entire trust. **There must be no circumstances under which the trust can be revoked**.

- If the assets of the irrevocable trusts are available to the individual, under any circumstances, the trust will be treated as an available resource.

  For example, if Bill's trust says, "If Bill is ever elected president of the United States this trust can be revoked," then the trust is considered an available resource. Even though we know Bill will never (and I mean NEVER) be elected president of the United States, Bill put this clause in the trust when it was created. He could have written the trust with no provisions for revocation, and he elected not to do so. Therefore, it becomes an available resource. OAR 461-145-0540(9)(b).
- If the assets of the irrevocable trust are not available to the individual then the assets in the trust are subject

to the transfer of resources rules.

For example, most trusts would say "for the benefit of" your applicant. If the trust is for the benefit of someone other than the applicant, it may be a disqualifying transfer. 461-145-0540(9)(a).

Medicaid-specific trusts

Under 65 disability trusts

This trust is set up by a parent, grandparent, guardian or conservator or the court system. Also, for trusts established on or after December 13, 2016, a competent, adult, individual may create the trust. The trust is set up for a person who meets the SSI disability criteria. It must have been created and funded before the person was 65. There must be a provision in the trust that any money remaining after the death of the individual will be returned to the state. You would not count this type of trust as a resource to the individual. Send a 647 Property Referral form to EAU so they can monitor any funds remaining in the trust when the individual dies. 461-145-0540(10)(a).

Note: The trust must be funded using the financial group's assets.

Pooled trusts

A "pooled trust" is an umbrella trust that many people can join. A Pooled Trust must be established and managed by a non-profit association (e.g., The ARC of Oregon). For our purposes, the individual, a parent, grandparent, legal guardian or the court system can join the pooled trust on behalf of the individual. The trust is set up for a person who meets the SSI disability criteria and the trust must have been created and funded before the person was 65. There must be a provision in the trust that any money remaining after the death of the individual will be returned to the state. You would not count this type of trust as a resource to the individual. Send a 647 Property Referral form to EAU so they can monitor any funds remaining in the trust when the individual dies. 461-145-0540(11).

Note: You are unlikely to see the full trust. What you will see is the "joinder agreement."

Income cap trust

These trusts are for the benefit of a individual whose income is above 300% of the SSI standard. It must contain all of the individual's income. There must be a provision in the trust that any money remaining after the death of the individual will be returned to the state. You would not count this type of trust as a resource to the individual. Send a 647 Property Referral form to EAU so they can monitor any funds remaining in the trust when the individual dies. According to federal guidelines, a individual is able to use an ICT to meet the income limit because the individual has given up direct access to and control over that income (State Medicaid Manual 3259.7). For this reason, the individual should not be the trustee of their ICT.

An ICT is not considered a transfer of resources as long as the balance in the trust does not exceed the appropriate divisor from OAR 461-140-0296.

The income deposited in the trust may only be distributed as outlined in OAR 461-145-0540(10)(c). The following is what is currently allowed by this rule:

(a) An earned income deduction of $65 from earned income.

(b) The deductions under the plan for self-support as allowed by OAR 461-145-0405.

(c) Personal-needs allowance and applicable room and board standard. If your individual moves from a

nursing facility to CBC be sure to adjust the personal needs allowance from the PIF standard to the OSIP maintenance standard.

(d) Reasonable administrative costs, not to exceed a total of $50 per month (see the rule for further details).

(e) Community spouse and family monthly maintenance needs allowance (and you will have determined what these numbers are).

(f) Medicare and other private medical insurance premiums (as determined and verified by you).

(g) Other incurred medical (as determined and verified by you). Monitor this as expenses get paid off.

(h) Child support, alimony, and income taxes.

(i) Irrevocable burial plan with a maximum value of $5,000.

(j) Home maintenance in the very few cases where this is allowed (see the rule for details).

(k) Patient Liability (not to exceed the cost of care).

Note: You have the discretion to make the determination that this trust is within the OAR. For instance, if you can verify a medical cost of $200 and the trust has a medical cost of $500, you have the right to only allow $200 for the medical cost.

Note: If there is a change in the individual's income, the applicable standards, etc it is not necessary to involve an attorney. You should re-evaluate what is allowed and recalculate the individual liability accordingly. Be sure to send proper notice.

Note: If there's money left in the trust each month after the individual pays their liability you must monitor the funds. The individual may need to reimburse for past assistance, purchase needed medical equipment or go off of Medicaid for a month, if the funds in the trust exceed the amounts in 461-140-0296 (2).

The effective date for an income cap trust is the first day of the month in which the trust document is signed. 461-180-0044.

- Income Cap Trust process for staff
- Income Cap Trust template for applicants
- Income Cap Trust process for applicant or representative
- Instructions to get Tax ID number on IRS website

Trusts funded with income/resources of someone other than a financial group member

Trusts funded with income/resources of a third party

This is a type of trust that does not include the individual's income/resources. It is often set up by a parent for the benefit of a child applicant.

This type of trust would be treated as an available resource to the individual unless the trust is irrevocable or restricted and cannot be used to meet the basic monthly needs of the financial group. OAR 461-140-0020(2)(e).

Here is an example of language that might indicate that the trust is restricted and therefore would not be considered an available resource:

"My son is disabled and is on public assistance. This trust is not for basic needs, but only for supplemental needs."

If you have any questions about trusts, please contact APD Policy. If you contact Policy, please be able to discuss the type of trust you are reviewing and specific questions or concerns that are not addressed in OAR 461-145-0540 or this worker guide. Most questions should be able to be answered by reviewing this guide.

Long-term care insurance

This worker guide covers the treatment of long-care term care (LTC) insurance for ongoing individuals and the treatment of resources for an applicant who has utilized LTC insurance purchased through the LTC insurance partnership (a qualified partnership policy).

Long-term care insurance

The circumstances around LTC insurance payments vary greatly from insurance company to insurance company. Some policies start payment immediately upon placement and others must have a waiting period before payments begin. Policies pay different rates depending on the type of policy the individual has purchased and some types of care may not be covered. Policies most often pay by the day, resulting in payment amounts that vary from month to month. Most policies pay directly to the individual, while others pay directly to the facility.

By signing the application, the individual has assigned their rights to medical insurance payments to ODHS|OHA, as required by 461-120-0315. When the individual is placed in a care setting covered by the individual's LTC insurance policy, the worker must make sure the individual applies for all insurance payments.

Be sure to inform the individual or the representative of the process for dealing with long term care insurance payments. Individuals who fail to obtain their LTC insurance payments and provide those payments either to ODHS|OHA or the facility (depending on the care setting as explained below) are not eligible for Medicaid.

Long-term care insurance payments for home or community-based care placements

For individuals in home or community-based care settings, it is acceptable for the LTC insurance payments to be made directly to the individual or their representative. However, the individual must turn the payment over to ODHS|OHA when it is received. ODHS|OHA receipts the payment in as a reimbursement of past assistance, per the procedure described in the Support Staff Assistance Manual, Section II-G-3. The receipt code is 121. This code ensures that the payment will be credited against the individual's estate claim.

Send these payments to:

Medical Payment Recovery Unit
PO Box 14023
Salem, OR 97309

If allowed by the individual's LTC insurance provider, the individual can designate ODHS|OHA as the payee for the LTC insurance payments. These checks should be made payable to the "Oregon Department of Human Services." When ODHS|OHA is the payee, turning in the payments each month is not necessary, but completing the paperwork

to get each payment issued is still required.

Sometimes when LTC payments are paid directly to ODHS|OHA, the insurance carrier issues a 1099 in ODHS|OHA's name at the end of the year. If you receive such 1099, scan it into EDMS and shred the confidential document.

For these care settings, ODHS|OHA continues to pay for the individual's services, less any liability for the individual's share. ODHS|OHA's payment to the facility is not interrupted or delayed due to the LTC insurance payments. Once a payment has been turned over to ODHS|OHA, it is no longer counted as income.

Long-term care insurance payments for nursing facility placements

Individuals placed in nursing facilities must either designate the facility as the payee so that the facility will receive the LTC insurance payments directly, or turn any payments received by the individual or their representative over to the facility when they are received.

It is the facility's responsibility to adjust ODHS|OHA's bill as payments are received.

ODHS|OHA's service payment to the facility may be denied or delayed due to the LTC insurance payments. If the individual's MMIS record shows that LTC insurance payments are available, the facility's claim will not be paid unless the claim shows a third-party resource adjustment or denial from the insurance provider.

Long-term care partnership resource exclusion

A Qualified Partnership Policy (QPP) is an LTC insurance policy that would afford extra benefits to individuals who utilize the LTC payments prior to applying for Medicaid. Having a QPP is an incentive for individuals to plan ahead and purchase LTC insurance.

QPPs are transferable from state to state. That means if an individual purchased a QPP while the individual resided in another state and after the effective date for that state's partnership program, the individual will receive the same benefits described in this worker guide as if the policy had been purchased in Oregon.

Per 461-160-0855 the individual is eligible for a special resource exclusion in an amount equal to the amount of payments received under a QPP at application for Medicaid. The worker will be able to recognize a QPP issued in Oregon because the individual will receive a notice with their LTC policy stating that it is a QPP. The worker can verify the total payments a individual has received under a QPP issued in Oregon by the individual's "explanation of benefits" (EOB). The EOB will verify the total payments to date from the Partnership Policy and if there are any benefits remaining. If the individual does not have their EOB, they can request a replacement from their insurance company.

If a policy was issued in another state and the individual claims it is a QPP, the worker will need to verify with the other state that it is a QPP. The individual gets the same resource exclusion for an out-of-state QPP as they would get from a QPP purchased in Oregon, unless the QPP was purchased in California. For this state, there is no required reciprocity agreement, so the individual does not get any resource exclusion in Oregon. For out-of-state QPPs that qualify for resource exclusion, the EOB or other verification from the insurance company can be used to verify the total payments received too.

The Insurance Division has also created a form that the individual can use to send to the LTC insurance company to verify QPP information. Contact the APD policy unit if you need help verifying this information with the other state.

Note: If the individual has home equity that exceeds $525,000 and causes ineligibility, QPP payments cannot be used to reduce the countable home equity. When excluding all other resources based on the receipt of QPP payments, first always exclude resources that would otherwise be countable. This will allow the individual to become eligible for Medicaid sooner.

Assets that are excluded due to the receipt of QPP payments may be gifted without penalty (OAR 461-140-0220). However, if the individual chooses to gift the assets prior to applying for Medicaid, then the amount of the assets excluded in the eligibility determination must be reduced. There could still be a transfer penalty to serve if the individual transfers more assets than are excluded by the QPP payments.

Example 1: Nadene gave $40,000 to her son a year ago when her QPP was paying for her nursing facility placement. She has now received a total of $130,000 QPP payments and is applying for Medicaid. The gift to her son is not disqualifying, but the amount of the resources that can be excluded in the eligibility determination is $130,000 QPP payments minus $40,000 gift = $90,000.

Example 2: Leroy gave $160,000 to his grandchildren a year ago when his QPP was paying for his nursing facility placement. He has now received a total of $130,000 QPP payments and is applying for Medicaid. $130,000 of the gift is not disqualifying due to the QPP payments received, but Leroy's gifts of $160,000 exceeds the QPP amount by $30,000, so Leroy still needs to serve a disqualification for $30,000 before he will be eligible for Medicaid.

The eligibility worker has the option of using the Resource Calculation when there are QPP Payments (SPD 3404) to help them calculate resources that are excluded and whether the individual's resources meet the Medicaid limit. If the worker chooses not to use this form, they can narrate the calculation.

If the QPP pays benefits in such a small amount that the individual is not able to use the payments prior to applying for Medicaid, then the individual is not eligible for any resource exclusion.

Example 3: Helen purchased a QPP that pays benefits of $100 per day. Years later, Helen was in a car accident and suffered injuries that required nursing facility care at the cost of $195 per day. Helen does not have enough income to make up the difference in coverage of $95 per day, so she applies for Medicaid. At application, she is in her 60-day waiting period and has received no QPP payments to date. Even though Helen has a QPP, she is not eligible for any resource exclusion because she has received no QPP payments. The eligibility worker narrates that Helen has a QPP, but she has received zero payments so there is zero resource exclusion allowed.

If the individual has accessed only part of the QPP payments prior to applying for Medicaid, then the individual is eligible for a resource exclusion only for the amount of total benefits received to date.

Example 4: Bernie purchased a QPP that pays benefits of $120,000 over 2 years. When Bernie applies for Medicaid, he has received $50,000 in LTC insurance payments. He also has countable resources of $240,000 now, but had $270,000 countable resources when care began. His spouse Irene lives in the couple's home, so it is excluded. When doing the resource assessment, the worker excludes $50,000 due to QPP payments received, so the countable resources are reduced to $190,000. Irene's community spouse resource allowance (CSRA) is $109,560 because ½ of $270,000 when care began exceeds the maximum. The eligibility worker determines that $190,000 (countable resources after QPP exclusion) - ($2000 individual resources + $109,560 CSRA) = $78,440 that the couple has now that exceeds the resource limit. After the couple has spent down this excess, Bernie will be eligible for Medicaid.

Remember – part of the spend down will be met by additional QPP payments Bernie receives while spending down. The individual is entitled to a resource exclusion for the total QPP payments received at the time of the initial month of eligibility. The eligibility worker clearly narrates the total amount of resources excluded due to the receipt of QPP payments, when the case is approved. The worker also notifies the individual by 3402 and Estate Administration by the "Remarks" section of the 647.

If the individual has accessed all of the LTC payments prior to applying for Medicaid, then the individual is eligible for a resource exclusion for the total value of the policy.

Example 5: Milo, who is married to Gertrude, is applying for services. Milo exhausted his $120,000 QPP prior to applying for Medicaid. The couple has countable resources of $280,000. When doing the resource assessment, the eligibility worker determines that ½ of the resources ($140,000) exceeds the maximum, so Gertrude's community spouse resource allowance (CSRA) is $109,560. The eligibility worker determines that $280,000 countable resources minus ($120,000 QPP exclusion + $2000 individual resources + $109,560 CSRA) = $48,440 that the couple has now that exceeds the resource limit. After the couple has spent down this excess, Milo will be eligible for Medicaid with resources of $122,000 for Milo and $109,560 for Gertrude = $231,560 total. The eligibility worker clearly narrates that $120,000 in resources were excluded due to the receipt of QPP payments, when the case is approved. The worker also notifies the individual by 3402 and Estate Administration by the "Remarks" section of the 647.

Example 6: Howard has exhausted his $120,000 QPP prior to applying for Medicaid. He now has countable resources of $121,500. The worker excludes $120,000 and finds Howard eligible because his remaining countable resources are $1500. The eligibility worker clearly narrates that $120,000 in resources were excluded due to the receipt of QPP payments, when the case is approved. The worker also notifies the individual by 3402 and Estate Administration by the "Remarks" section of the 647.

The individual's QPP amount can change, if the Medicaid case is approved with a QPP exclusion, the case closes (for 30 days or more) and the individual receives more QPP payments, and the case is subsequently approved again.

Example 7: Wanda has a QPP and receives $70,000 in payments before being determined eligible for Medicaid. The eligibility worker narrates that Wanda is eligible for a QPP exclusion of $70,000 and sends a 3402 to Wanda and a 647 to Estate Administration. Wanda continues to receive QPP payments while she is on Medicaid, and those are reimbursed to ODHS|OHA. Wanda then receives a $120,000 inheritance and her case closes for 6 months. When she again becomes eligible for Medicaid, the eligibility worker determines that the cumulative QPP payments are now $150,000. The worker narrates that Wanda is eligible for a revised QPP exclusion of $150,000 and sends a 3402 to Wanda and a 647 (indicating the amount of the QPP protection in the "Remarks" section) to Estate Administration.

Note: Be sure to verify the value of resources excluded due to QPP payments at redetermination. If the resources have grown to exceed the resource limit, give notice to close the case. The individual will need to spend the excess or reimburse ODHS for past assistance to avoid case closure.

If the excluded resources have decreased in value due to no action on the individual's part (such as losing value due to the economy), additional assets may be excluded up to the entire QPP amount. If the excluded resources have decreased in value due to an individual's action to spend or gift the resources, then the amount of excluded

resources due to the QPP payments is reduced accordingly. For example, if the individual had $140,000 excluded resources due to QPP payments but you find at redetermination that $60,000 has been spent, then only the remaining $80,000 in resources continues to be excluded. In addition, the EAU must be notified of the reduced amount of excluded resources (See the Estate Administration Claim Exclusion below).

Estate administration claim exclusion (461-160-0855 and 461-135-0835)

An individual who utilizes a QPP is also eligible for the amount that was excluded in the eligibility determination, to be excluded from the estate administration claim, when the individual passes away. This is true as long as the individual did not transfer or spend all or part of the amount that was excluded prior to their death. The resources excluded due to QPP payments are not subject to transfer of asset disqualifications, so the individual may spend the resources or gift them away without a penalty (461-140-0220). If all or part of the amount of resources are spent or gifted away, however, the individual's estate will no longer be protected from collection for that amount of resources. It is very important for the eligibility worker to designate the amount of resources excluded by QPP payments in the narrative, and by notifying the individual via 3402 and Estate Administration by the "Remarks" section of the 647 so that the same amount will be protected from the estate claim process. If the worker later learns that the individual has gifted all or part of the amount of excluded resources, this needs to be clearly narrated so that Estate Administration can adjust ODHS|OHA's claim accordingly.

Example 8: In example 6 for Howard above, he has $121,500 total countable resources and $120,000 is excluded due to the receipt of QPP payments. The worker narrates this, notifies the individual by 3402 and sends a 647 (indicating the amount of the QPP protection in the "Remarks" section) to Estate Administration to exclude $120,000 from the estate claim process. At application, Howard owned a home that was excluded, $40,000 RV, $65,000 CD, $13,000 savings and the remaining $3500 was in his checking account (he also has an excluded life insurance plan to cover burial). The eligibility worker determines that $40,000 RV + $65,000 CD + $13,000 savings + $2000 checking = $120,000 excluded due to QPP payments. The home is excluded because Howard lives there and the remaining $1500 in the checking account is less than the $2000 resource limit. Before Howard dies, he gives the RV and the CD to his son and the worker notes this in the narrative. Therefore, when he dies his estate consists of the home, $13,000 savings and $3500 checking. Because Howard gifted $40,000 + $65,000 = $105,000 before he died, his QPP Estate Administration protection of $120,000 is reduced by $105,000 to $15,000.

Example 9: Marjorie has exhausted her $180,000 QPP prior to applying for Medicaid nursing facility services. She now has $1800 countable cash resources and an excluded home with equity value of $270,000 (the home is listed for sale). The worker narrates that Marjorie is eligible for $180,000 to be excluded due to QPP payments, sends a 647 (indicating the amount of the QPP exclusion in the "Remarks" section) to Estate Administration and finds Marjorie eligible because the home is an excluded resource and her remaining countable resources are $1800. Marjorie passes away and the home never sells. When the estate claim is made, the most ODHS|OHA could collect from the home equity would be $270,000 minus $180,000 excluded due to QPP payments = $90,000 and the $1800 cash to reimburse ODHS|OHA for the cost of Marjorie's medical care.

If an individual receives Medicaid benefits before the receipt of QPP payments, those benefits are not protected in the Estate Administration collection process.

Example 10: Stanley is an individual who had a stroke at age 55 and was eligible for Medicaid services. He received Medicaid for a year, and then was determined no longer eligible because he made a great recovery. After

his case closed, he began working again and purchased a QPP for $200,000. At age 65, his health deteriorated again and he exhausted his QPP. When he is again determined eligible for Medicaid, the eligibility worker narrates in Oregon ACCESS that $200,000 is excluded due to the receipt of QPP payments and sends a 647 (indicating the amount of the QPP exclusion in the "Remarks" section) to Estate Administration. When the estate claim is made, only Medicaid benefits received after age 65 are protected from collection and not the Medicaid benefits received at age 55.

Eligibility for residents of a public institution

House Bill 3536 mandates ODHS|OHA suspend Medical benefits on any individual who is receiving Medicaid and who becomes incarcerated. This bill extends the process created under SB913, where benefits of individuals who have a severe mental impairment were suspended. 461-135-0950

A resident of an institution is an individual who is:

- Confined involuntarily in a local, state or federal prison, jail, detention facility, or other penal facility, including a person being held involuntarily in a detention center awaiting trial or a person serving a sentence for a criminal offense;
- Residing involuntarily in a facility under a contract between the facility and a public institution where, under the terms of the contract, the facility is a public institution;
- Residing involuntarily in a facility that is under governmental control;
- Receiving care as an outpatient while residing involuntarily in a public institution;
- Released from the public institution during a temporary period of hospitalization in a medical institution outside of the correctional facility; or
- Court ordered to live in a supervised community residential facility such as a halfway house or transition center.

An individual is not considered to be a resident of a pubic institution when:

- The person is released on parole, probation, or post-prison supervision;
- The person is on home- or work-release, unless the person is required to report to a public institution for an overnight stay; or
- The person is staying voluntarily in a detention center, jail, or county penal facility after their case has been adjudicated and while other living arrangements are being made for the individual.
- The person is court ordered to reside at Northwest Regional Reentry Center on the Aid & Assist program.

A public institution is any of the following:

- A state hospital (as defined by ORS 162.135) such as the Oregon State Hospital and any other hospital established by law for similar purposes, including the "SAIP" means Secure Adolescent Inpatient Program (SAIP), and the Secure Children's Inpatient Program (SCIP). See the Residents of State Hospitals and Training Centers Worker Guide for exceptions to ineligibility for individuals entering the state hospital.
- A local correctional facility (as defined in ORS 169.005): a jail or prison for the reception and confinement of

prisoners that is provided, maintained and operated by a county or city and holds persons for more than 36 hours.

- A Department of Corrections institution (as defined in ORS 421.005): a facility used for the incarceration of persons sentenced to the custody of the Department of Corrections, including a satellite, camp, or branch of a facility.
- A youth correction facility (as defined in ORS 162.135):
  - A facility used for the confinement of youth offenders and other persons placed in the legal or physical custody of the youth authority, including a secure regional youth facility, a regional accountability camp, a residential academy and satellite, and camps and branches of those facilities; or
  - A facility established under ORS 419A.010 to 419A.020 and 419A.050 to 419A.063 for the detention of children, wards, youth, or youth offenders pursuant to a judicial commitment or order.

As used in this rule, the term public institution does not include:

- A medical institution as defined in 42 C.F.R. 435.1009;
- An intermediate care facility as defined in 42 C.F.R. 440.140 and 440.150;
- A publicly operated community residence that serves no more than 16 residents, as defined in 42 C.F.R. 435.1009; or
- A child-care institution as defined in 42 C.F.R. 435.1009 with respect to:
  - Children for whom foster care maintenance payments are made under title IV-E of the Social Security Act; and
  - Children receiving TANF-related foster care under title IV-A of the Social Security Act.
- A supervised community residential facility such as a halfway house or transition center.

  Note: Supervised Community Residential Facilities can be publicly or privately operated and often house residents with a variety of legal statuses. Some may be on probation and voluntarily residing at the facility, others may be there as part of their sentencing (involuntarily), still others may be on work release. It is important to gather information about the facility and resident to determine if the applicant is a resident of a public institution involuntarily.

If this policy indicates that the medical benefits of an individual are suspended, the effective date is the date the decision is made to suspend the benefits and the date the notice is sent.

When the individual is released, Medicaid will be reinstated if ODHS|OHA is notified within 10 calendar days of the release, and individual is still eligible for assistance; Medicaid eligibility is not extended to an ineligible person. Not all individuals will be eligible upon release. Individuals who had been receiving home and community-based services may need a new assessment before benefits can be reinstated. If SSA has terminated Medicare benefits, an MSP individual would need to provide verification that Medicare Part A has been reinstated or is still in effect before their MSP case can be reopened. No application is required to restart benefits, unless there is no application on file.

Residents of a public institution who are released temporarily in order to receive treatment in a hospital or other medical facility can be eligible for medical benefits during the time that they are temporarily released.

Jails will be asked to inform individuals who have had their benefits suspended to contact their local office. Residents of a public institution must contact the local office within 10 days of their release.

Other resources

Incarceration *includes screenshots: Explains program policy for incarceration and steps to take when acting on a report of incarceration or release from incarceration.

Trust & Agency (T&A) accounts

Click here for information: Trust & Agency accounts.

Chapter 7:
Worker guides

Section 8: Quick reference guides

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Quick reference guides

File a Complaint for Oregonians

Provides quick reference for different forms and complaint areas available for submission.

File Clearance / Member Match

Overview of using File Clearance and Member Match to prevent creation of duplicate individuals and cases in ONE; details using Quick Search to access Member Match and check existence of individual or case in ONE. *includes screenshots

Benefit Decrease Review Task

Describes the Benefit Decrease Review task, how it is generated, how workers should complete this task, and an example walk through of the task. *includes screenshots

BENDEX SDX SOLQi Overview of Screens

Provides an overview the Beneficiary and Earnings Data Exchange (BENDEX), State Data Exchange (SDX), and State On-Line Query Internet (SOLQi) screens in ONE and describes some of the most commonly used fields. *includes screenshots

Case Summary

Detailed overview of Case Summary screen components, including Case Individuals, Task History, Appointments, Contact Information, EDGs, Renewals, Community Partners, etc. *includes screenshots

Eligibility Override & Special Circumstance

Describes when an override is needed and when a special circumstance is needed. Provides a table of common situations and explains whether an override or special circumstance fits that scenario. *includes screenshots

Eligibility Results

Provides an overview of the Eligibility Summary screen showing results of EDBC in ONE; results may be Approved, Denied, Pending, Discontinued. Provides general guidance for how to determine the cause of and, if needed, fix unexpected eligibility results. *includes screenshots

Updating Demographic Information

Describes how to update demographic information and when leadership is needed to make those updates. *includes screenshots

COVID-19 Alternative Processes

Detailed overview of COVID policies, including restriction of benefit termination, restriction of benefit reduction, self-attestation verification, SNAP interview waiver, changed resource limits and SSN requirements for TANF, etc.

Dates

Detailed overview of different date fields required in ONE, including Date of Request, income dates, verification dates, etc.

Quick Search

Introduces the Quick Search functionality and describes the different types of searches that can be conducted.

Chapter 8: Examples

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Chapter 8: Examples

OREGON PROGRAMS ELIGIBILITY NOTEBOOK (OPEN)

Chapter 2, Eligibility

Section 1: Application

Date of request

Multi-program example 1

Gena calls the office on 10/15 requesting SNAP, ERDC and TANF.

SNAP DOR does not apply to the SNAP program.

TANF DOR does not apply to the TANF program.

ERDC The DOR is 10/15 for ERDC.

REF DOR does not apply to the REF program.

MSP The DOR is 10/15 for MSP.

OSIPM The DOR is 10/15 for OSIPM.

HSD The DOR is 10/15 for HSD medical programs.

Individual program example(s)

ERDC **Example 1:** Macy calls the office on 4/10 because she has received a notice that her TANF case is closing 4/30. The worker sees that she has been using child care for the last couple months through JOBS support services as she has been working. Though Macy did not ask about child care initially, the worker asks her if she is interested in applying for ERDC. This establishes a date of request.

Example 2: Macy calls the office on 4/10 because she has received a notice that her TANF case is closing 4/30. The worker sees that she has been using child care for the last couple months through JOBS support services as she has been working. Though Macy did not ask about child care initially, the worker asks her if she is interested in applying for ERDC. This establishes a date of request.

After interviewing Macy, the worker is able to narrate her work schedule and get proof of income by calling the employer. The worker reviews the DPCS screen (DPCS,case#) to ensure that there are no unmet copays on Macy's case. The worker reviews all eligibility requirements for ERDC and discovers that Macy is eligible. ERDC is approved by using a Compute 5/1 action.

The April billing form it would be covered by a JOBS Child Care Billing (JCCB) with a $0 copay. The May billing form will be a Child Care Billing (CCB) with the ERDC copay amount based on Macy's household size and income, or $27 if she qualifies for reduced copay when transitioning from TANF.

Filing date

Multi-program example 1

Gena returns page 1 and 2 of the 415F with a DOR of 10/15, requesting SNAP, TANF, and ERDC on 10/20. The application has her name, address, and signature.

SNAP The filing date would be 10/20.

TANF The filing date would be 10/20.

ERDC Filing dates do not apply to the ERDC program. The DOR would be Oct. 15, and ERDC benefits would begin the first of the month of the DOR, Oct. 1.

REF The filing date would be 10/20.

MSP Filing dates do not apply to MSP. The DOR would be Oct. 15.

OSIPM Filing dates do not apply to OSIPM. The DOR would be Oct. 15.

HSD Filing dates do not apply to HSD medical programs. The DOR would be Oct. 15.

Individual program example(s)

SNAP **Example 1:** James applies for SNAP benefits on May 10 for his family. They have already received benefits in another state in May. They are ineligible on the filing date. The effective date is June 1, if they have closed their other SNAP case.

Example 2: Darren provides verification within 30 to 60 days after his filing date and the office did not give him extra time to do this. The effective date is the date he provided the verification, as long as he met all eligibility requirements on that date.

Example 3: The effective date is the first of the month for applications with families including migrant or seasonal farm workers who received SNAP benefits in another state the month before applying for SNAP benefits in Oregon.

TANF **Example 1:** On 4/16, Jamal turns in his TANF application at the local branch.

Front staff add the date stamp for the filing date of 4/16 and schedule an intake.

Example 2 On 4/2 Abby calls her worker and states that her husband Jerald moved back in. The worker explains that though Jerald had been on the case only a few months ago, that eligibility needs to be reviewed. The worker also explains that if she establishes a filing date with a new 415F then once eligibility is cleared, benefits would go back to the filing date. Abby turns in a completed 415F on 4/3. Eligibility is cleared on 4/10. Benefits would begin on the filing date of 4/3.

Example 3 Natalie calls her worker stating that her daughter Janine moved in with her. Natalie is not sure of Janine's SS number and the worker is unable to locate the SS number through IEVS. The worker explains that she would need to provide the SS number to clear eligibility for Janine. Natalie does not turn in a 415F to establish a filing date. Benefits would begin the day eligibility is cleared for Natalie.

REF **Example 1:** Mia requests REF by phone on 7/1; A 415F is sent to her; she turns in the 415F with her name, address and signature section complete on 7/6. Mia's filing date is 7/6. If deemed eligible, cash benefits would begin on 7/6.

Effective date of benefits

Individual program example(s)

SNAP **Example 1:** James applies for SNAP benefits on May 10 for his family. They have already received benefits in another state in May. They are ineligible on the filing date. The effective date is June 1, if they have closed their other SNAP case.

Example 2: Darren provides verification within 30 to 60 days after his filing date and the office did not give him extra time to do this. The effective date is the date he provided the verification, as long as he met all eligibility requirements on that date.

Example 3: The effective date is the first of the month for applications with families including migrant or seasonal farm workers who received SNAP benefits in another state the month before applying for SNAP benefits in Oregon.

TANF

Example 1: On 4/2 Abby calls her worker and states that her husband Jerald moved back in. The worker explains that though Jerald had been on the case only a few months ago, that eligibility needs to be reviewed. The worker also explains that if she establishes a filing date with a new 415F then once eligibility is cleared, benefits would go back to the filing date. Abby turns in a completed 415F on 4/3. Eligibility is cleared on 4/10.

Benefits would begin on the filing date of 4/3.

Example 2: Natalie calls her worker stating that her daughter Janine moved in with her. Natalie is not sure of Janine's SS number and the worker is unable to locate the SS number through IEVS. The worker explains that she would need to provide the SS number to clear eligibility for Janine. Natalie does not turn in a 415F to establish a filing date.

Benefits would not begin until the day eligibility is cleared for Natalie.

ERDC

Example 1: Petri started his new job on March 27. He will only work two days. His cost of child care for March is $28; however; his copay is $98. In this situation, it makes sense to start ERDC effective April 1. Explain to Petri why benefits are starting the first of April and narrate the conversation. Benefits for March do not need to be denied, the parent was eligible, but there is nothing for ODHS to pay on behalf of the parent to the provider.

Example 2: Macy calls the office on 4/10 because she has received a notice that her TANF case is closing 4/30. The worker sees that she has been using child care for the last couple months through JOBS support services as she has been working. Though Macy did not ask about child care initially, the worker asks her if she is interested in applying for ERDC. This establishes a date of request.

After interviewing Macy, the worker is able to narrate her work schedule and get proof of income by calling the employer. The worker reviews the DPCS screen (DPCS,case#) to ensure that there are no unmet copays on Macy's case. The worker reviews all eligibility requirements for ERDC and discovers that Macy is eligible. ERDC is approved by using a Compute 5/1 action.

The April billing form it would be covered by a JOBS Child Care Billing (JCCB) with a $0 copay. The May billing form will be a Child Care Billing (CCB) with the ERDC copay amount based on Macy's household size and income, or $27 if she qualifies for reduced copay when transitioning from TANF.

REF

Example 1: Mia requests REF by phone on 7/1; A 415F is sent to her; she turns in the 415F with her name, address and signature section complete on 7/6. Mia's filing date is 7/6. If deemed eligible, cash benefits would begin on 7/6.

MSP

QMB Example 1: An individual tells us in March they will start receiving Medicare in April. They would not be eligible for QMB until May 1. This is because they don't meet QMB criteria until they begin receiving Medicare. They receive it in April, so they start QMB the month after (May).

SMB/SMF Example 1: An individual has a date of request through ODHS|OHA of January 25. ODHS|OHA receives all verification and determines the individual is eligible on February 10. The individual's eligibility starts on February 1.

Example 2: An individual applies for LIS through SSA on January 25. The LIS application information is received by ODHS|OHA on March 25. ODHS|OHA receives all verification and determines the individual is eligible on May 2. The individual's eligibility starts January 1.

OSIPM

Example 1: An individual applies for and establishes a DOR for OSIPM on 12/10. It is determined that the individual meets all eligibility requirements on the DOR. OSIPM eligibility begins on 12/1.

Example 2: An individual applies for and establishes a DOR for OSIPM on December 10. It is determined that the individual is ineligible on the DOR but meets all eligibility requirements on December 20. OSIPM eligibility begins on December 1.

Example 3: An individual applies for and establishes a DOR for OSIPM on December 10. It is determined that the individual is ineligible on the DOR but meets all eligibility requirements on January 5. OSIPM eligibility begins on January 1.

Example 4: On October 5, Jenny applies for OSIPM. Jenny receives SSI, SSD and Medicare. Jenny has unpaid medical expenses in July, August and September. Jenny is interviewed on October 11 and is found eligible for OSIPM. Jenny asks for help with unpaid medical bills and is found eligible and approved for retroactive medical in each of the three months prior to the DOR. Ongoing eligibility begins October 1.

Example 5: On February 10 an individual applies for their deceased husband. Their spouse passed away on December 15 in Salem Hospital. He had suffered a heart attack and was in the hospital from December 3 until his death. He was an SSI recipient, but had never applied for Medicaid. The individual wants Medicaid to pay for their spouse's hospital costs. Since the husband was Medicaid eligible at the time of hospitalization (receiving SSI), and the date is within 3 months of the Date of Request, we would cover his hospital expenses by approving retroactive OSIPM for December 1-15.

The application process

Multi-program example 1

Gena submits her application with DOR of 10/15; Filing of 10/20. She completes her SNAP, TANF, medical, and ERDC interview on 10/20. She is applying on behalf of herself, her 11yr old daughter and 10yr old son. Her part time job is ending on the 21st; It is determined that she is over income for TANF and is denied Oct benefits. She is pended for additional information for SNAP and ERDC. She requests a new interview for TANF on 11/3. She brings her pended information for SNAP and ERDC to the TANF intake on 11/3. The worker determines that Gena is eligible for SNAP, ERDC, medical and TANF

SNAP Gena completed the application process by establishing a filing date, completed an interview, submitted needed verification for eligibility and cleared eligibility.

TANF Gena can establish a new filing date by resigning her 415F in the month of Nov. Gena's previous interview on 10/20 would have exceeded 10 calendar days from her new filing date on 11/3, therefore she would be scheduled a face-to-face interview to determine eligibility unless she meets the hardship rule for a phone interview.

ERDC Gena completed the application process by establishing a DOR, ERDC does not use a filing date, completed an interview, submitted needed verification for eligibility and cleared eligibility for the month of October.

REF This example does not apply to the REF program.

MSP

QMB Example 1: Gena completed the application process by establishing a DOR, completed an interview, submitted needed verification for eligibility and cleared eligibility. Gena is approved for the month of November.

SMB/SMF Example 1: Gena completed the application process by establishing a DOR, completed an interview, submitted needed verification for eligibility and cleared eligibility. Gena is approved for the month of October. Gena is over income for retroactive benefits.

OSIPM

Example 1: Gena completed the application process by establishing a DOR, completed an interview, submitted needed verification for eligibility and cleared eligibility. Gena is approved for the month of October.

HSD

Example 1: For HSD medical programs, Gena completed the application process by establishing a DOR, Gena is not pended for medical, and eligibility can be determined for Gena and her children beginning in the DOR month of October.

Multi-program example 2

Rukia comes to the office requesting to apply for REF, medical and SNAP on 4/16. A case note shows Rukia established a Date of Request by phone on 4/5. Staff adds the DOR date stamp of 4/5 for medical to the completed application with a date stamp for the filing date of 4/16 for both REF and SNAP. She is then scheduled an intake and submits all verification needed.

SNAP Rukia completed the application process by establishing a filing date, completed an interview, submitted needed verification and cleared eligibility.

TANF This example does not apply to the TANF program.

ERDC This example does not apply to the ERDC program.

REF Rukia completed the application process by establishing a filing date, completed an interview and submitted needed verification for eligibility.

MSP

QMB Example 1: Rukia completed the application process by establishing a date of request, completed an interview and submitted needed verification for eligibility and cleared eligibility. The worker approved QMB for the month of May.

SMB/SMF Example 1: Rukia completed the application process by establishing a DOR, completed an interview, submitted needed verification for eligibility and cleared eligibility. The worker approved Rukia for the month of April. Gena is over income for retroactive benefits.

OSIPM

Example 1: Rukia completed the application process by establishing a DOR, completed an interview, submitted needed verification for eligibility and cleared eligibility. The worker approved Rukia for the month of April.

HSD

Example 1: For HSD medical programs, Rukia completed the application process and eligibility can be determined for medical.

Individual program example(s)

SNAP

Example 1: Clair completes a SNAP interview in the first 20 days from the filing date but calls her worker on day 26 of the application period to say that she is not able to get all of the verification before day 35, because the verification source is out of town. The worker extends the application processing period to day 35 and adds the EAT HH Type code to FSMIS. Clair provides the requested verification on day 35, eligibility is determined and benefits are opened back to the filing date.

Example 2: Meg is receiving SNAP benefits through March 31st. In December, she applies for medical and SNAP benefits. The worker should clarify with Meg that she is already receiving SNAP benefits and there is no need to reapply. Narrate this conversation and no denial notice is needed.

TANF **Example 1:** Jon and Sam turn in an application and have a face-to-face interview for TANF on April 25. They were found to be over-income for the month of April. The worker explained to Jon and Sam how to establish a new filing date. They reapply on May 3.

Since they had a face-to-face interview within 10 calendar days of their filing date, a phone interview is scheduled.

ERDC **Example 1:** Tabatha leaves a note on 12/7 asking for ERDC. The worker notes in TRACS and sends Tabatha a 415F with a DOR of 12/7. Tabatha completes the application and turns it in on 1/10. The worker schedules and completes an interview with Tabatha on 1/12. Tabatha meets all eligibility requirements and is found eligible for ERDC.

The application process is considered complete as the interview and clearing of all eligibility factors was done within 45 days from the DOR.

REF **Example 1:** Tania turns in a completed 415F requesting REF benefits on 5/9. She is scheduled an interview on 05/10, but does not show. She calls back and reschedules her interview for 05/20. She completes the interview and is pended for verification of income, but does not return the verification. A denial is sent. She then calls back on 06/19 stating that she has the verification and would like to continue the process.

Tania will need to restart the application process due to not completing her application process within 30 days from the filing date.

When to use an application

Multi-program example 1

Marvin turns in a paper application with a DOR of 11/19; filing date of Nov. 27. He completes his SNAP, TANF, medical and ERDC interview. It's determined that he had SNAP and TANF benefits in Florida that will not be closed until 12/31. His SNAP and TANF are denied due to concurrent benefits.

SNAP If Marvin comes back and resigns the application in January prior to the 60th day of the Nov. 27 filing date, then the same application can be used.

TANF There is no eligibility in the month of application, nor the next month. Therefore, a new application would be required.

ERDC Marvin does not currently have ERDC in Florida, has established a DOR, and an interview. If Marvin clears all other eligibility requirements he could be considered eligible for ERDC.

REF There is no eligibility in the month of application, nor the next month. Therefore, a new application would be required.

MSP Marvin is not currently receiving medical benefits in Florida, has established a DOR, and an interview. If Marvin clears all other eligibility requirements he could be considered eligible for MSP using the same application.

OSIPM Marvin is not currently receiving medical benefits in Florida, has established a DOR, and an interview. If Marvin clears all other eligibility requirements he could be considered eligible for OSIPM using the same application.

HSD For HSD medical programs, because Marvin is not currently receiving medical benefits in Florida, and has established a DOR, eligibility can be determined beginning in the DOR month.

Individual program example(s)

SNAP

Example 1: Drake applies for SNAP benefits on June 2 for his family. They have already received benefits in another state in June. They are ineligible on the filing date. If they have closed their other SNAP case, you can use the same application for July benefits.

TANF

Example 1: Val receives TANF. Returned mail is received. A basic decision notice is sent and the TANF case is closed effective March 31. Val comes into the office March 25 and reports a new address.

Since Val came in during the same month the case is closing, a new application is not needed.

Example 2: Mary is pregnant and on TANF. She is due May 1. She reports on May 8th that she had her baby May 2.

A new application is not needed.

Example 3: Daryl and his two children are on TANF. Daryl's case is closed Sept. 30 due to being over income. He reports on Oct. 10 that he was laid off due to lack of work. He meets all requirements for TANF, including financial requirements, in October

Since he met eligibility in the month following closure, a new application is not needed.

Example 4: Jane and her son, Michael, are receiving TANF benefits. Jane reports that her new husband, Curtis, has moved into the home. He is requesting to be the head of household.

Curtis will need to review the application and sign the rights and responsibilities page in order to become the head of household.

Example 5: Tangia reports that her husband moved in on 6/8. Tangia does not complete an application.

Once Tangia's husband clears eligibility, his TANF will begin the date he becomes eligible for the program.

Example 6: Oscar turns in an application stating that his wife and son moved in. Oscar's application receives a filing date of 7/5. Due to circumstances, Oscar could not come back for an intake until 7/28.

Once Oscar's family clears eligibility, their TANF will open back to the filing date.

Example 7: Jon and Sam turn in an application and have a face-to-face interview for TANF on April 25. They were found to be over-income for the month of April. The worker explained to Jon and Sam how to establish a new filing date. They reapply on May 3.

Since they had a face-to-face interview within 10 calendar days of their filing date, a phone interview is scheduled.

ERDC

Example 1: Ben calls on Oct. 12; his case was closed Sept. 30, because he did not have a DHS approved provider connected. His provider is now approved. The worker confirms the provider is now approved by checking DPPM and asks Ben what date care started. The worker also asks Ben if he has any changes to his shift work schedule, work hours, rate of pay, household composition or children who need care. Ben has no other changes. The worker will reopen the case, narrate and email an electronic provider connect to DPU to connect Ben and his provider.

Example 2: Alicia is receiving ERDC. Her current certification date is set to end Dec. 31. On July 10, Alicia reports she was permanently laid off from work. Alicia's worker determines that she had good cause for her job loss, and adds the Authorized Work Search (AWS) code to her case. AWS is coded for three months after her job loss, for the months of August, September and October. At the end of October, Alicia's case closes because she did not contact DHS to report new employment. On Nov. 12, Alicia calls and reports she was hired for a new job and starts Nov. 17. Her ERDC may be re-opened effective Nov. 1 as long as she meets the ongoing and exit income limits for ERDC. Her certification dates will remain the same.

Who must sign the application and complete the application process

Multi-program example 1

On May 16th, Shawn inquires how to apply for SNAP, TANF, medical and ERDC for her two godchildren: Levi, age 11, and Angelica, age 17. Shawn reports as it is unsafe for them to live with either of their parents. Shawn provides care, control and supervision of both children. Angelica is pregnant and due June 3.

SNAP Shawn is considered the responsible adult and would sign and complete the application process.

TANF Shawn would not be considered a caretaker relative for TANF as she is not related to either child. Angelica could choose to apply for TANF for herself and her unborn baby.

ERDC ERDC does not require caretakers to be related to children in care. May 16th would establish a date of request and Shawn would need to sign and complete the application process. Note: Angelica is over the age limit for ERDC, so Special Needs Age (SNA) eligibility may need to be addressed if there is a child care need, otherwise the case would be opened for Levi only.

REF This example does not apply to REF.

MSP Shawn is considered the responsible adult and would sign and complete the application process.

OSIPM Shawn is considered the responsible adult and would sign and complete the application process.

HSD For HSD medical programs, Shawn will be able to apply for the children. Angelica should be marked as the head of household on the case and if the children's tax filing information is not available because of the safety issue, the tax filing status of non-filer should be selected for each child. Eligibility can be determined for the children beginning in the DOR month.

Multi-program example 2

Mia, age 40, and her pregnant daughter Jana, age 17, are refugees inquiring about SNAP, TANF, medical and REF on Dec. 2. Jana is not currently enrolled in school and will turn 18 on Jan. 16. Jana is due to give birth Jan. 10.

SNAP Mia is considered the responsible adult on the case. She would sign and complete the application process.

TANF Mia is the caretaker of Jana. She would sign and complete the application process. Once Jana turns 18 and the baby is born, she could apply for TANF on her own. Jana would then sign and complete the application process.

ERDC This example does not apply to ERDC.

REF Once Mia is no longer eligible for TANF, she would sign and complete the application process for REF.

MSP Mia is considered the responsible adult on the case. Mia would sign and complete the application process.

OSIPM Mia is considered the responsible adult on the case. Mia would sign and complete the application process

HSD Mia completed the application process and eligibility can be determined for medical for Mia and her daughter.

Interviews

Multi-program example 1

Erica mailed in an application and requests to be scheduled for a phone interview for TANF, SNAP, ERDC, medical and REF.

SNAP A phone interview is scheduled for SNAP eligibility.

TANF A face-to-face interview is required unless Erica meets a hardship.

ERDC A phone interview is scheduled for ERDC eligibility.

REF A face-to-face interview is required unless Erica meets a hardship.

MSP A phone interview is scheduled for MSP eligibility.

OSIPM A phone interview is scheduled for OSIPM eligibility.

HSD For HSD medical programs, an interview is not required.

Individual program example(s)

SNAP

TANF Devin turned in his CAPI application requesting TANF. Staff call to inform him that TANF requires a face-to-face interview. Devin explains that his child has been going through a rough patch with his autism. He worries that going into the office with him would trigger his sensory issues and cannot find care for him.

Since Devin is the only caretaker relative in the home, he would be granted the hardship for a phone interview.

ERDC Darren requests ERDC by phone, turns in a completed application with a note to please call him for a phone interview.

The eligibility worker would schedule and complete a phone interview.

REF Anila turned in her application requesting REF. Staff call to inform her that REF requires a face-to- face interview. Anila explains that she lives more than two hours away from her local branch and her friend who usually gives her rides isn't able to due to a dead battery. There isn't a bus for her to ride, but even if there had been one, she doesn't have enough money to pay for the transportation.

Anila would be given an intake by phone based on living over two hours from her nearest branch, transportation difficulties due to no transportation and/or financial hardships. The worker would narrate carefully on TRACS the reason for the phone interview.

Head of household

Multi-program example 1

Chetan, age 46, and daughter Asha, age 20, and Asha's son Ashwin, age 2, would like to apply for SNAP, TANF, ERDC, medical and REF benefits.

SNAP Chetan or Asha could be considered the primary adult who could serve as the head of household.

TANF Asha would be the head of household, as Chetan would not be in the filing group.

ERDC Asha would be the head of household, as Chetan would not be in the filing group.

REF Chetan would be the head of household, as Chetan would be the only person in the filing group.

MSP Chetan or Asha could be considered the primary adult who could serve as the head of household.

OSIPM Chetan or Asha could be considered the primary adult who could serve as the head of household.

HSD For HSD medical programs, Chetan or Asha can be selected as the head of household.

Authorized representative

Multi-program example 1

Josh's mom Janie comes to the office and asks to become Josh's authorized representative. Janie does not have power of attorney. Josh is 25 and currently receiving SSI. Janie further explains that he needs help with his budgeting and understanding how to work with ODHS|OHA. Josh has not completed a form to designate Janie as his authorized representative.

SNAP Janie cannot assign herself as an Authorized Representative. However, the agency can look at allowing the request if it seems that Josh is not capable of handling his own affairs.

TANF Janie cannot assign herself as an Authorized Representative. However, the agency can look at allowing the request if it seems that Josh is not capable of handling his own affairs.

ERDC Janie cannot assign herself as an authorized representative. However, the agency can look at allowing the request if it seems that Josh is not capable of handling his own affairs.

REF Janie cannot assign herself as an Authorized Representative. However, the agency can look at allowing the request if it seems that Josh is not capable of handling his own affairs.

MSP Janie cannot assign herself as an Authorized Representative without Power of Attorney (POA) or legal guardianship. However, the agency can look at allowing the request if Josh is not capable of handling his own affairs and Janie is able to act responsibly on Josh's behalf. ODHS|OHA may not appoint an AR on someone's behalf if they cannot apply for themselves.

OSIPM Janie cannot assign herself as an Authorized Representative without Power of Attorney (POA) or legal guardianship. However, the agency can look at allowing the request if Josh is not capable of handling his own affairs and Janie is able to act responsibly on Josh's behalf. ODHS|OHA may not appoint an AR on someone's behalf if they cannot apply for themselves.

HSD For HSD medical programs, Janie cannot assign herself as an Authorized Representative without Power of Attorney (POA) or legal guardianship. Josh can appoint Janie by submitting a signed MSC0231. ODHS|OHA may not appoint an AR on someone's behalf if they cannot apply for themselves.

Multi-program example 2

Janie returns to the office with Josh and they complete the MSC0231.

SNAP The form is accepted and given to a worker to process.

TANF The form is accepted and given to a worker to process.

ERDC The form is accepted and given to a worker to process.

REF The form is accepted and given to a worker to process.

MSP The form is accepted and assigned to a worker to process.

OSIPM The form is accepted and assigned to a worker to process.

HSD The form is accepted and assigned to a worker to process.

Multi-program example 3

The worker looks up Janie's information and notices that Janie has an IPV and that Josh's father Danny is already an authorized representative for Josh's SSI.

SNAP The request to become an authorized representative is denied due to having an IPV, and it appears that another authorized representative is available.

TANF The request to become an authorized representative is denied due to having an IPV, and it appears that another authorized representative is available.

ERDC The request to become an authorized representative is denied due to having an IPV, and it appears that another authorized representative is available.

REF The request to become an authorized representative is denied due to having an IPV, and it appears that another authorized representative is available.

MSP The request to become an authorized representative is denied due to having an IPV, and it appears that another authorized representative is available.

OSIPM The request to become an authorized representative is denied due to having an IPV, and it appears that another authorized representative is available.

HSD The request to become an authorized representative is denied due to having an IPV, and it appears another authorized representative is available.

Alternate payee

Multi-program example 1

Darby has a medical condition that is limiting her ability to shop for herself. She requests that her friend Christy be her alternate payee. She completes the MSC0231. The worker reviews the form and notices that Christy is potentially Darby's landlord.

SNAP The worker would inquire about the relationship between Darby and Christy to determine if this is considered a conflict of interest prior to approving the request. The worker can make exceptions based on Darby's limiting condition, relationship and no other viable options.

TANF The worker would inquire about the relationship between Darby and Christy to determine if this is considered a conflict of interest prior to approving the request. The worker can make exceptions based on Darby's limiting condition, relationship and no other viable options.

ERDC The worker would inquire about the relationship between Darby and Christy to determine if this is considered a conflict of interest prior to approving the request. The worker can make exceptions based on Darby's limiting condition, relationship and no other viable options.

REF The worker would inquire about the relationship between Darby and Christy to determine if this is considered a conflict of interest prior to approving the request. The worker can make exceptions based on Darby's limiting condition, relationship and no other viable options.

MSP The worker would inquire about the relationship between Darby and Christy to determine if this is considered a conflict of interest prior to approving the request. The worker can make exceptions based on Darby's limiting condition, relationship and there are no other viable options.

OSIPM The worker would inquire about the relationship between Darby and Christy to determine if this is considered a conflict of interest prior to approving the request. The worker can make exceptions based on Darby's limiting condition, relationship and there are no other viable options.

HSD Alternate Payees do not apply to HSD medical programs.

Assistance with applications

Multi-program example 1

Debbie is receiving SSDI, she is legally blind and struggles to apply for services.

SNAP If Debbie did not have someone to help her complete the application, a staff member would assist her in completing the application. All further written correspondence would be provided in Braille.

TANF If Debbie did not have someone to help her complete the application, a staff member would assist her in completing the application. All further written correspondence would be provided in Braille.

ERDC If Debbie did not have someone to help her complete the application, a staff member would assist her in completing the application. All further written correspondence would be provided in Braille.

REF If Debbie did not have someone to help her complete the application, a staff member would assist her in completing the application. All further written correspondence would be provided in Braille.

MSP If Debbie did not have someone to help her complete the application, a staff member would assist her in completing the application. All further written correspondence would be provided in Braille.

OSIPM If Debbie did not have someone to help her complete the application, a staff member would assist her in completing the application. All further written correspondence would be provided in Braille.

HSD If Debbie did not have someone to help her complete the application, a staff member would assist her in completing the application. All further written correspondence would be provided in Braille.

Expedited service and priority processing

Individual program example(s)

SNAP

Example 1: Jarrell, a non-citizen, has $100 a month in income, and no resources. He has a non-citizen status that makes him ineligible for SNAP benefits. Jerrell meets the expedited service criteria but is denied because he does not meet all other SNAP eligibility requirements.

Example 2: Nala, a non-citizen, has $100 a month in income, and no resources. She also has a non-citizen status that appears SNAP eligible but SAVE indicates to implement secondary verification. Nala is approved for SNAP benefits, because she appears to meet all eligibility requirements and the eligibility decision cannot be delayed beyond the seven-day processing time-frame while waiting for the secondary verification from SAVE.

Example 3: Brie applied for SNAP benefits on Aug. 18 and met the expedited criteria. She comes into the office for an interview on Aug. 25. This is the seventh calendar day following the filing date. Identification is viewed. She is mandatory and an ABAWD living in a time-limit area. She previously received CT1, CT2, and CT3. Brie lost benefits for exceeding the SNAP time limit. She has not worked since her benefits ended and does not meet an ABAWD exemption. She is not eligible for expedited service or SNAP until they regain eligibility.

Example 4: Malorie applied for SNAP benefits on Feb. 4 and meets the expedited criteria. The interview is completed on Feb. 4. Malorie is an ABAWD and lives in a time-limit area. She does not meet an ABAWD exemption and previously received CT1, CT2, and CT3, resulting in case closure at the end of October. She states that she worked 100 hours in December. Malorie is eligible for expedited services if the agency is able to verify the hours right away. If not, they are given a pending notice (DHS 210ABW) requesting proof of their work hours in December and case is opened when that verification is received.

Example 5: Jacob is an ABAWD. He does not meet any of the exemptions and is therefore mandatory. He lives in a time limit area and is subject to the SNAP time limits. Jacob received CT3 and his benefits closed two months ago. He meets the criteria for expedited service. However, he is ineligible due to being over the SNAP time limit. When questioned, he has not worked since his benefits closed two months ago. He has not regained eligibility and therefore remains ineligible for SNAP until he does regain. As he cannot complete 80 hours of work activities in the expedited period, he is ineligible for expedited service. Proceed using the regular application processing time frames.

TANF This does not apply to the TANF program.

ERDC **Example 1:** Shaniyah submits an ERDC application on Oct. 30. Shaniyah indicates that she and her children are homeless and she does not have access to their pay stubs, and the worker is unable to reach the employer by phone. The worker lets Shaniyah know that she may be eligible for ERDC through priority processing, but that she would still need to provide verification or her case will close.

Shaniyah indicates that she is currently working Monday through Friday between 32 and 36 hours a week at $11.00 per hour. This is what she expects to continue working. The worker documents the work schedule.

The worker takes the following actions:

ERDC is certified for 10/01/15 – 09/30/16
Authorized work hours are 36 x 4.3 = 154.80 (155)
EML is 32 + 36 = 68 / 2 = 34
34 x $11 x 4.3 = $1608.20
The DHS 210 is completed:

- Priority child care processing: Your child care benefits are open from 10/01/15 to 12/31/15 while we wait for the above listed things. If we get these things by 12/14/15, we will decide if you qualify for child care benefits to continue. If you do not return these things, you will not receive a separate notice when your case closes on 12/31/15. OAR 461-170-0150(2) & 461-175-0300(5)(c)

Shaniyah turns in pay verification on Dec. 12. The new verification shows that Shaniyah is actually working only 20-25 hours a week.

UCMS is updated:
Compute 01/01/17
Authorized hours reduced to 25 x 4.3 = 107.5 (rounded up to 108)
EML reduced to 20 + 25 = 45/2 = 22.5
22.5 x $11 x 4.3 - $1064.25

No reduction notice is needed even though the child care hours are decreasing. Child care hours are not the child care benefit; the copay has gone down meaning the family is receiving an increase in benefits.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Chapter 2, section 2: Eligibility groups

Household group

Individual program example(s)

SNAP

Example 1: Art, age 20, in a self-contained camp trailer on his parents' property. He has a bathroom, microwave oven and a small stove in the trailer. Art states that he purchases and prepares his own food, and he is applying for SNAP benefits for himself only.

Forming the group: Art does not need to apply for SNAP benefits with his parents, because he is in a separate dwelling where he prepares his own meals. He is living in a household separate from his parents and is therefore eligible to apply for SNAP benefits for himself only.

Example 2: Dustin, age 18, lives in a camp trailer on his parents' property with his girlfriend Aspen. They state that they purchase and prepare their meals together. However, the camp trailer is not equipped for cooking, they cook and eat at his parents' house.

Forming the group: Dustin and Aspen cannot form their own filing group separate from his parents, because they do not have the facility or equipment to prepare their own meals.

Example 3: Winnie and her two children live with her husband, Jack, who is a long-haul truck driver. Jack is on the road three weeks out of every month. He buys his meals on the road. Winnie and the children want to apply for SNAP benefits separate from Jack.

Forming the group: Winnie and the children are separate from the Jack. Jack is not included in the household, because he eats over 51 percent of his meals elsewhere. However, the portion of Jack's pay that he gives to his family counts as unearned income (support).

TANF

Individuals living in multiple household groups in one month

Example 1: Jenny and her daughter Geonna are applying for TANF. Geonna's father, Tony, does not live in the home, but sleeps there three nights a week. Since Tony is sleeping in Geonna's home more than 30 percent of the time (or at least nine nights), he is considered part of the household group.

Example 2: Jenny and her daughter Geonna are applying for TANF. Geonna's father, Tony, does not live in the home, but sleeps there three nights a week. Since Tony is sleeping in Geonna's home more than 30 percent of the time (or at least nine nights), he is considered part of the household group.

Example 3: Kevin lives with his grandmother and grandfather, who currently receive a NNCR grant. Kevin's biological mother, Tiffany, moves in along with her other son Justin. Tiffany is currently receiving a TANF grant for herself and Justin. Tiffany does not have care, control, and supervision of Kevin. The family will need to determine which grant will be most beneficial. The family is deciding whether Kevin's grandparents keep the NNCR grant or Tiffany keeps her grant with Justin.

Example 4: Carrie and her daughter Tatiana are applying for TANF. Dad does not live in the home, but sleeps there three times a week. Since dad is sleeping in the child's home more than 30 percent of the time, he is considered part of the household group.

TANF Individuals gone for 30 days or more

Example 1: John is applying for TANF. His son, Jordan, is in foster care, but documentation from his child welfare worker shows that Jordan will be returned in two weeks. Since Jordan is expected to be returned within 30 days, he is part of the household group. (Jordan will not be added to the benefit group until his foster care payments end and he is returned to his dad.)

Example 2: Jessica is applying for TANF for herself and her child, Angel. She is recently divorced. The divorce settlement states Angel has 50 percent visitation with both parents. A divorce settlement, child custody order or other parenting agreement cannot solely be used to determine where a child is residing. A conversation with Jessica about the actual visitation taking place with Angel, as well as who has primary care, control and supervision would need to take place. After the conversation, it is determined that the child lives 50 percent of the time in the home of each parent; the child is not considered part of the TANF household group.

Example 3: Edgar provides documentation indicating that he will be in treatment an additional 45 days: DHS would approve the individual for a 60-day extension since the first 30-day extension would expire. Additional documentation would not be necessary under this circumstance. This could include other in-patient addiction services as well, for example, gambling addiction or eating disorder treatment.

Example 4: Andy and Mary apply for TANF for themselves and their child, Molly. The family is homeless. Mary and Molly are living in a homeless shelter. Due to the facility's policies, Andy is not allowed to stay in the shelter. For up to 60 days, we would consider the family a two-parent household.

Example 5: In the previous example, Mary and Molly are still living in the shelter after 60 days. On a case-by-case basis, we could consider a 30-day extension to keep Andy in the household.

Example 6: Kevin lives with his grandmother and grandfather, who currently receive a NNCR grant. Kevin's biological mother, Tiffany, moves in along with her other son Justin. Tiffany is currently receiving a TANF grant for herself and Justin. Tiffany does not have care, control, and supervision of Kevin. The family will need to determine which grant will be most beneficial. The family is deciding whether Kevin's grandparents keep the NNCR grant or Tiffany keeps her grant with Justin.

The NNCR grant: Because Tiffany is in the home she would be included in the filing group with her child Kevin, and Kevin's brother, Justin. Tiffany is included in the financial group and her income would also count against the NNCR grant.

Tiffany's TANF grant: Because Kevin is Tiffany's biological son and Justin's brother, he is included in the filing group. Any income he receives would be counted. He would not be in the benefit group because Tiffany is not considered to be the caretaker for Kevin.

TANF

No-adult

Example 1: Grandma Betty is applying for a non-needy caretaker relative grant for her grandson, Christopher. Betty also lives with her husband, Ralph and foster child Gary. Gary is not included in the adjusted household group for the benefit calculation.

ERDC

Example 1: Cora is applying for ERDC benefits. She reports that her husband, Paul, is currently working in California. They are still together, though he does not know when he will be able to transfer to Oregon.

Paul is included in the ERDC household. He will be counted in the # ERDC field on UCMS and his income will be counted in calculating the copay. As a two-parent household, only overlapping work hours will be authorized.

Example 2: Clarissa is applying for ERDC benefits. She is working full time and her husband, Sam, has been staying home with the children. Sam left to help his grandmother while she is selling her home and moving to an assisted- living facility. They do not know how long it will take for Sam to return home. Sam is not receiving any payment or reimbursement for his time. The family is not eligible for ERDC, because Sam is still part of the household and considered available to provide care.

Example 3: Hans is a new applicant for ERDC. He is working while the children's mother, Esther, had been staying home with the children. Esther left the country to take care of her mother during an illness, and is expected to return within 90 days. The family is not eligible for ERDC, because Esther is still part of the household and considered available to provide care.

Four months later, Hans contacts the office asking to apply for ERDC. Esther has tried to return home, but her VISA has expired. She has been unable to come back to the United States. Since Esther is no longer gone due to her mother's illness and is not able to return home, the family can now be considered for ERDC benefits. Hans does not know how long it will take for Esther to re-enter the country. Esther is no longer absent to care for the emergent need caused by her mother's illness and she is not reasonably anticipated to return within 90 days.

Example 4: DDori has applied for ERDC on the fifth of the month. She has no children in the home at this time. She provided information from Child Welfare stating that her children are returning home on the 28th of the month. Though Dori has visitation this month, she does not have a child care need until the end of the month.

ERDC can be approved since the children are reasonably anticipated to return with 90 days.

The worker will need to compare the August copay against the family's child care need for August. The copay may be higher than the cost of care for the family. If so, August benefits would be denied and the case can be approved Sept. 1.

Example 5: Ann calls the office to report that 17-year-old Sonja had to fly back east for her grandmother's funeral. She will be returning in the next two to three months.

Though Sonja is going to a funeral, she is not caring for the emergent needs related to her grandmother's death. She is "reasonably anticipated to return with 90 days." The worker will not remove Sonja from the # ERDC field on UCMS.

If Ann reported that Sonja would be gone for three to four months, the worker would need to remove Sonja from the # ERDC field on UCMS. A 10- day notice would be required if the action caused an increased copay.

REF **Example 1:** A refugee family of six – Lakshaki and her husband Adeel and their 4 children ages 13, 15, 17 and 21, Maanika – applies for benefits.

Forming groups: Lakshaki, Adeel and their three teenagers will form one TANF filing group. Their 21-year-old, Maanika, would form her own REF filing group. If Maanika meets REF eligibility standards, she would have eight months total REF eligibility.

Example 2: A refugee family of five consists of two grandparents, Rada and Radford ages 68 and 72, Gabby her husband Hagan and their 22-year-old daughter, Hania.

Forming groups: Rada and Radford will be referred to APD for assistance. Gabby and Hagan will be in one REF filing group and Hania would form her own REF group.

Example 3: An Asylee family of 3- Ali, his wife Asha, and their 18-year-old daughter who is enrolled and attending high school.

Forming groups: This would not be a REF cash case as the 18-year-old is still in high school. It would be a TANF case.

MSP

Standard living arrangement

Example 1: **Couple:** One person eligible for QMB

Sam and Martha are married and live at home with no services. Sam is 65, receives Social Security and Medicare. Martha is 60 and has a small pension but no Social Security or Medicare.

Forming groups: Both Sam and Martha are in the household group. Count both Martha and Sam's income (both in Financial group) and use the two-person need standard (both are in the Need group). Sam is the only one in the benefit group because he is the only one who receives Medicare (a non-financial requirement).

Non-standard living arrangement

Example 2: **Couple:** One person receiving in-home services and the other receives no services

Joe and Kelly are married and live at home. Joe is 65, receives Social Security and Medicare. Kelly is 60 and has a small pension but no Social Security or Medicare. Joe starts receiving in-home waivered services. Their income level is 117% FPL for a couple.

Forming groups: Both Joe and Kelly are in the household group. You will count both Kelly and Joe's income (both in Financial group) and use the two-person need standard (both in Need group). Joe is the only one in Benefit group because he is the only one who receives Medicare (a non-financial requirement).

Non-standard living arrangement

Example 3: **Couple:** Both in a community-based care facility, both receiving Medicare

John and Sally are married and live in the ACME Foster Home. John is 65, receives Social Security and Medicare. Sally is 60 and has Medicare and Social Security. They both have service needs which meet the service need rule. Their combined income is 119% FPL for a couple.

Forming groups: Both John and Sally are in the household group.

Note: For MSPs even though they are in a non-standard living situation their income and resources are considered together if they are under the same roof.

Standard living arrangement

Example 4: **Children under 21 in the household**

Claudia lives with her two minor children, Max and Sarah. She receives a retirement pension and Medicare. Her pension is higher than the one-person QMB standard, but below the three-person standard.

Forming groups: All groups (except Benefit) will include Claudia and her children, because she chooses to include them in order to be eligible.

Non-standard living arrangement

Example 5: **Couple:** One member in community based care and the other at home, both receiving Medicare and Medicaid.

Greg and Sarah are married. Greg lives in the ACME Foster Home while Sarah lives in their home. Greg is 65, receives Social Security and Medicare. Sarah is 60 and has a small pension, Social Security and Medicare. Sarah has no OSIPM eligibility. Greg's income is 140% FPL and Sarah's is 130% FPL.

Forming groups: There are two sets of groups with Greg and Sarah each having individual household; filing; financial; need and benefit groups for each program.

OSIPM

Standard living arrangement

Example 1: **Couple:** Adam and Bessie are married and live at home with no services. Both received an SSB increase and are over income for SSI. Both are financially eligible as an individual and adjusted combined income is below the two person OSIPM income standard.

Forming groups: Both Adam and Bessie are in the household group. Count both Adam and Bessie's income (both in Financial group) and use the two-person need standard (both are in the Need group). Both are in the benefit group.

Waivered services

Example 2:

Couple: Adam and Bessie Smith are married. Bessie needs waivered services to remain in her home.

Situation A

Forming groups: Bessie is the only one counted in the household and filing groups. Both are counted in the financial group for resources in the initial month, but only Bessie's income is counted for initial and ongoing months. Bessie is the only one in the need and benefit groups.

Situation B:

Couple: Adam and Bessie Smith are married. Both need waivered services to remain in her home.

Forming groups: Adam and Bessie would each have their own separate household, filing, financial, need and benefit groups.

Situation C

Couple: Adam and Bessie Smith are married. Both are moved into a nonrelative adult foster care home and need waivered services to remain there.

Forming groups: Adam and Bessie would each have their own separate household, filing, financial, need and benefit groups.

Nursing homes

Example 3:

Couple: Adam and Bessie Smith are married. Bessie goes into a nursing home. Adam remains in their home.

Situation A

Forming groups: Bessie is the only one counted in the household and filing groups. Both are counted in the financial group for resources in the initial month, but only Bessie's income is counted for initial and ongoing months. Bessie is the only one in the need and benefit groups.

Situation B:

Couple: Adam and Bessie Smith are married. Adam's health gets worse and he enters the same nursing home as Bessie.

Forming groups: Adam and Bessie would each have their own separate household, filing, financial, need and benefit groups.

Filing group

Individual program example(s)

SNAP

Example 1: Lisa is pregnant and living with Daniel, the father of their unborn. They state that they purchase and prepare food separately. Lisa wants to apply for SNAP benefits separate from Daniel.

Forming the group: Lisa and Daniel can be separate for SNAP. When the baby is born, however, the baby must get SNAP with both parents. Therefore, at that time, the three of them will become one group, even if they continue to purchase and prepare food separately.

Example 2: Martha is 19 years old and currently pregnant. She lives with her parents and her brother Mark, age 12. She states she purchases and prepares food separately from the rest of the family and wants to apply for SNAP separately.

Forming the group: Martha must be part of the SNAP group that lives together. She is under age 22 and lives in her parents' residence. Therefore, Martha is part of their filing group. Even when the baby is born, she and her baby cannot form a separate group from her parents until she turns 22.

Example 3: Micky is 18 years old and lives in a camp trailer on his friend Nick's property. He states he purchases and prepares his own meals. He cooks and eats his meals at his friend's house, because the trailer is not equipped for cooking.

Forming the group: Even though Micky is in his friend's household group, he does not need to apply for SNAP with Nick, because he purchases and prepares his own meals. Mick can form his own filing group even though he cooks at Nick's house, because his friend is not his parent.

Example 4: Heidi, 19, her friend Shane, 24, and their common child live with Heidi's parents. Heidi states that she and her child purchase and prepare food separately from the rest of the household and want to apply for separate SNAP benefits.

Forming the group: Heidi, Shane and their common child must be part of the same SNAP filing group, because the child draws in both parents. Heidi is under age 22 and she is living with her parents. Therefore, they must all be part of the same filing group. (If Heidi and Shane were living with the Shane's parents, they could be in a separate filing group from his parents.)

Example 5: Trish, 26, moved in with her parents. Two of her children, Maizy and Joey, also live with her parents. Trish's parents have guardianship over Maizy and Joey.

Forming the group: : Trish cannot be a separate filing group from her two children, because they are under the age of 22. The children cannot be a separate filing group from the grandparents because they have parental control, care and supervision. Therefore, the filing group consists of Trish, her parents, Maizy and Joey.

Example 6: Natalia, age 12, is on SNAP benefits with her mother, Denise. On March 16th, Natalia moves in with her father, Jeffrey, who applies for benefits for both of them. Although Jeff may be eligible in March, Natalia cannot receive SNAP benefits with him and is excluded from the filing group. Send 10-day notice to Denise to remove her daughter from that case before adding her to her father's filing group.

Example 7: Jess and Russ purchase and prepare food together and want to apply for SNAP benefits together. Russ is an ineligible student.

Forming the group: This is one household group, but since Russ is an ineligible student, he is excluded from the filing and other groups. Therefore, only Jess can get SNAP benefits, and none of Russ' income or resources count.

Example 8: Tammy moves in with Tommy, and they are purchasing and preparing their meals together. Tommy wants to apply for SNAP benefits, but Tammy received benefits with her mother this month in Washington. Forming the group: Since Tammy was not the head of the household on her mother's case, Tommy can receive benefits this month without Tammy.

SNAP Special living arrangements

Example 1: **Elderly person –** Anita and her spouse, Stan, live with their daughter Sarah, 21, and her husband, Brett. The couple has disabilities that prevent them from purchasing and preparing their own meals. The couple may form a separate filing group from Sarah and Brett even though Sarah is under age 22, as long as the daughter and her spouse meet the SNAP income limits.

Example 2: **Elderly person –** Mary, 72, lives with her daughter Luanne. Mary has temporary disabilities due to a car accident and is unable to purchase and prepare her own meals. Mary may not form a separate filing group from because she does not meet the criteria of a severe and permanent disability.

Example 3: **Foster care –** Leland is in adult foster care. His daughter Jill (age 26), her spouse Kelly and their two children, Hannah and Carol are applying together. Jill and Kelly may apply for SNAP benefits with or without her Leland. They are all purchasing and preparing meals together, but ter may exclude her father from the filing group simply because he is getting AFC.

Example 4: **Foster care –** Ester and Charlie are elderly and living with their 27-year-old daughter Kristie. Kristie provides foster care for Charlie. Kristie purchases and prepares food for everyone in the household and wants to apply for SNAP benefits for herself and her mother, Ester only.

Forming the group: Kristie can choose to exclude Charlie because he is in foster care and his spouse, Ester along with children under 22 from the group. Kristie can only apply for her Ester if she includes her AFC father, Charlie. Kristie can be a separate SNAP group. Charlie and Ester, however, cannot be in a separate group because he is in foster care and is ineligible if he applies for himself and Ester.

Example 5: **Foster care –** Deborah is a foster care provider for teenager, Misty and her newborn baby, Jeremiah.

Forming the group: Deborah must choose to include or exclude her foster child, Misty and Jeremiah from the filing group. Jeremiah cannot receive SNAP benefits without his mother Misty. Misty can only receive SNAP benefits if the provider applies and includes the teen in their filing group.

Example 6: **Live-in attendant –** Aria's household group consists of a person with disabilities, Devin, that keeps her from doing housekeeping or personal services. Aria has hired Mia to live in their home to provide these services.

Forming the group:

- Each may apply for SNAP as separate filing groups, as long as they are not required to apply together due to relationship.
- If the person receiving care, Devin, provides the majority of the attendant, Mia's, meals, the attendant cannot apply for SNAP as a separate filing group.
- If Devin provides the majority of Mia's meals and she is not in the filing group, Devin may also get a medical deduction for the cost of the meals up to a one-person SNAP payment standard.

Example 7: **DV –** Ingrid and her two children fled their home to her friend, Linda's home to be safe. Ingrid may not get a second SNAP issuance in the month, because she did not flee to a DV shelter and is not in a dwelling that meets the definition of a safe home.

Example 8: Tyson and his wife Tammy are living with Gertrude's 52-year-old mother Sherry. Tammy does all the grocery shopping, using Sherry's money to pay for her mother's own food. Tammy also does all the cooking, preparing separate meals each day for her mother.

Forming the group: There are two filing groups in this household – The married couple, Tyson and Tammy are one; Sherry, the mother is separate. Even though the daughter does all the shopping and cooking, the food is purchased and prepared separately for the two groups.

TANF

Example 1: Mary has three children. Two of the children are from a previous marriage, but the third is by her current boyfriend, Roland, who does not live with her. Mary wants to apply for TANF for herself and her oldest children, but not for the youngest child, because she does not want to pursue the boyfriend for child support. All three children must be included in the filing group with the mother, because they are blood-related siblings.

Example 2: Devin and Daphne apply for TANF. Daphne has two children by a previous relationship, but they have a child in common. They must all be in the filing group together for TANF, because the blood-related siblings cannot be separated from one another and the parents cannot be separated from the children.

Example 3: Gina, age 17, is applying for TANF for herself and her 2-month-old son, Charles. They currently live with her dad, Jonas.

Option 1: If Jonas has care, control, and supervision of both Gina and Charles, Jonas will be included in their filing group.

Option 2: If Gina is considered the caretaker relative, having sole care, control, and supervision of Charles, she can apply for herself and her child without her father Jonas. Income from Jonas would be deemed and applied to the grant.

TANF

Pregnant women

Example 1: Jillian is due on April 8. The calendar month prior to the due date would be March. We would look at the first of the month, which in this case would be March 1.

Example 2: Sarah is pregnant and applying for TANF for herself and her two children. The father of the unborn child, Mikey, resides in the home with her. Sarah, her children and Mikey must be in the filing group together.

TANF

Caretaker relatives and children on duplicate TANF cases

Example 1: Sheila applies for TANF, establishing her filing date on May 15 for her two children. She clears all other eligibility as of May 17. The children are currently receiving TANF on their father John's case. Sheila's worker does not find this questionable as John has already reported that the children have left his household. John's worker sends a 10-day notice to close his TANF case May 31. Sheila may receive TANF for herself starting May 15. Her children are added to the case effective June 1.

Example 2: On May 25, Marcus applies for TANF for himself and his daughter, Bethany, who is receiving TANF on a non-needy caretaker relative grant with her grandmother. This report is considered questionable, as Marcus had previously reported having his daughter in his care when he did not. The worker pends for verification that Bethany lives with Marcus. This is received May 31. The grandmother's worker sends a 10-day notice removing Bethany from the TANF case, effective June 30. Marcus receives TANF for himself only for May 31 through June 30. Bethany is added July 1.

Example 3: Tracy applies for TANF for her son Brody on May 16. It is not questionable as it is confirmed by Tracy's Child Welfare worker. Brody is currently receiving TANF on his aunt's case. Brody also receives $150 per month in SSB benefits. A 10-day notice is sent removing Brody from his aunt's case effective May 31. The SSB counts against Tracy's TANF grant which is opened effective May 16.

Example 4: On Aug. 2, Jonas applies for TANF for himself and his two children. It is not questionable that the children are in Jonas' care as he has primary custody and provides care, control and supervision during the school year. His two children are currently receiving TANF on their mother's case in California. The worker in California is closing TANF for the children Aug. 30. Jonas may receive TANF through the end of August on his own. His children will be added to his case effective Sept. 1.

Example 5: Nadia and her 2 children are receiving a Social Security check each month. Part of the check is SSB but the other part is SSI. The mother's SSB would not count toward the children's TANF grant because, due to the SSI, she is not in the financial group and none of her income is counted for TANF.

Example 6: Albert receives TANF for himself and his child Charles, but his daughter Cynthia is on SSI. The children have different mothers. Cynthia, of whom receives SSI, also received child support from her mother. The child support does not count toward the TANF grant of the father and the other child.

ERDC **Example 1:** Bryan and Elaine live together, they are not married. Bryan has a child from a previous relationship and Elaine also has a child from a previous relationship. They have no common children. Together Bryan and Elaine do not meet the requirements of an ERDC filing group. They do meet the requirements as two separate filing groups in the same household. Bryan and his child are on one case and Elaine and her child on another.

Three months later, Elaine calls to report she is pregnant with Bryan's child. When Elaine calls to report the unborn, the cases are combined as one case because the common child (unborn) now ties Elaine and her other child to Bryan and his child. Any changes due to combining households and income that increase the copay must be given a 10-day notice.

Example 2: Molly has legal custody of her two grandchildren. The children's biological mother, Liza, is also living in the home. In this situation, because Molly is the legal guardian, she, both children and Liza are all in the ERDC filing group. Any income Liza has is counted toward the ERDC income.

If Liza is not working, the ERDC case would be denied. This is because a parent is in the home and can care for their children. However, if the grandma, Molly, has court documentation or child welfare determination stating that Liza cannot be left home alone with her children, then the case can be reviewed for eligibility. Any income from Liza is counted.

Example 3: Samantha lives in the home with her two children and grandchild, Kara (17), Tyler (10) and Kara's son Mason (18 months). Samantha is working 40 hours during the week. Kara is working 20 hours a week after school and on weekends. What are the family's options and whose income would count?

Option 1: Samantha states that she watches Mason on the weekends and she needs child care for both Tyler and Mason while she is at work. She can apply as the caretaker for Kara, Tyler and Mason. Samantha's income would count and her work hours would be used in determining how many child care hours to authorize. Kara's earned income is excluded. Only Samantha's work hours and commute time can be covered with the ERDC hours. Even when Kara is working on the weekend, Samantha is Mason's caretaker and she cannot use ERDC to cover child care when she is not working.

There are four in the ERDC group. Both Tyler and Mason would show on the billing form.

Option 2: Samantha states that Kara is fully responsible for the care of Mason and the child care need is during Kara's work hours only. Kara can apply as the caretaker for Mason. She would have her own ERDC case. Her earned income is now counted and the authorized child care hours are for the time she is working and commuting to and from work. The ERDC case is based on two in the ERDC group.

REF **Example 1:** Serena and Anthony are an unmarried refugee couple who just arrived in the U.S. last week. Serena is 3 months pregnant by Anthony.

Forming the group: Serena and Anthony if not married can each have their own filing group for REF cash until the pregnancy reaches the month before the due date. At that time they will need to apply for TANF together.

Example 2: Husband Mohamud arrived in the US three months ago and is working full time. His wife Selena recently arrived in the U.S. last week and is now in the home with him.

Forming the group: Mohamud and Selena are married and will be on the same REF cash case regardless whether Selena came later and Mohamud's income and resources will be used to determine eligibility.

Financial group

Individual program example(s)

TANF **Example 1:** Aisha and her two children are receiving a Social Security check each month. Part of the check is SSB, but the other part is SSI. Aisha's SSB would not count toward the children's TANF grant because, due to the SSI, she is not in the financial group and none of her income is counted for TANF.

Example 2: Van receives TANF for himself and one of his children, Avery, but his other child Kalen is on SSI. The children have different mothers. Kalen, who receives SSI also received child support from his mother. The child support does not count toward the TANF grant of the father and the other child, Avery.

Example 3: Jana receives TANF for herself and her two children, Kody and Kyle. Kyle's father, Russel, stays with the family on Friday, Saturday and Sunday of each week. Russel is in the household group. He is also required to be in the filing and financial groups. His income is counted against the TANF grant for the entire family.

Example 4: Anita is applying for TANF for her two grandchildren, Annabelle and Stephanie, as a non-needy caretaker relative. Anita and her husband, Rusty, along with their two minor children also live in the household.

Anita, Rusty, their two children, Annabelle and Stephanie must pass the first income test. The combined countable income of all individuals in the filing group must be less than the NNCR countable income limit standard for six. If not, the entire caretaker relative filing group is ineligible. If the income is less than the standard, the dependent relative children (Annabelle and Stephanie) must also have income below the "no-adult countable income limit" for the need group to be eligible.

Example 5: Gina, age 17, is applying for TANF for herself and her 2-month-old son, Charles. They currently live with her dad, Jonas.

Option 1: If Jonas has care, control and supervision of both Gina and Charles, they will all be in the filing and financial groups, and income for all three will be considered when determining eligibility for TANF.

Option 2: If Gina is considered the caretaker relative, having sole care, control, and supervision of Charles, she can apply for herself and her child without her father Jonas. Gina and Charles are in the financial group, but income is deemed from Jonas and applied against the TANF grant as Gina is a minor parent.

REF **Example 1:** Aisha and her husband Cam are in the home together. Cam is receiving SSI and that income would not count towards the REF grant as he is not in the financial group.

Need group

Individual program example(s)

SNAP **Example 1:** Tabatha, her husband John, along with their two children purchase and prepare food together and want to apply for SNAP together. Tabatha is an ineligible non-citizen.

Forming the group: This is one filing group. Tabatha is excluded from the need and benefit group, because she does not meet the nonfinancial requirement for citizenship. Because she is in the financial group, a prorated share of her income and deductions count.

TANF **Example 1:** Missy and her two children are applying for TANF. She does not want to get TANF for one child as she does not want to pursue child support. The mother can choose not to apply for TANF for the child. The child is required to be in the household, filing, financial and need group, but would not be in the benefit group. She would not be required to cooperate with DCS, but if she was receiving support for that child, it would be used in determining eligibility and benefit amount.

REF **Example 1:** Maria arrived in the US as a refugee 12 months ago and her husband Manuel arrived in the U.S. yesterday. Maria is currently not working.

Forming the group: Maria is excluded from the need and benefit group, because she has been in the U.S. more than 8 months. She is in the financial group so her income and deductions count towards the REF case.

Benefit group

Individual program example(s)

TANF **Example 1:** Belinda receives a non-needy caretaker relative TANF grant for her grandchild, Starla. Starla's mother, Janine, is not allowed to have care, control or supervision of the child by order of Child Welfare. As part of Janine's rehabilitation, she is ordered by the court to live with her mother, Belinda. Starla's mother would be in the household group, filing group, financial group (income she is receiving would count against the child's grant) and need group. The child's mother would not be in the benefit group, because she does not meet all nonfinancial eligibility factors (she is not a caretaker relative). Therefore, the grandmother could potentially continue to receive benefits for the grandchild.

TANF **Unborn child**

Example 1: Lacey is in her ninth month of pregnancy and is living with Liam, the father of the unborn child. Neither have any other dependent children.

- Household – Lacey, Liam, and unborn;
- Filing – Lacey, Liam, and unborn;
- Financial – Lacey, Liam, and unborn;
- Need – Lacey and Liam;
- Benefit – Lacey and Liam.

Lacey and Liam are living together. Both claim that the alleged father is, in fact, Liam (no other man has been identified as the father). Because, both of these individuals are a parent of the unborn child, both must be included in the filing group. Since the pregnancy has reached the calendar month before the due date month, both parents are in the benefit group and receive TANF.

Example 2: Jemma is in her third month of pregnancy and is living with Charlie, the father of the unborn. She also has a child, Ashley, from a previous relationship.

- Household – Jemma, Ashley, Charlie and unborn;
- Filing – Jemma, Ashley, Charlie and unborn;
- Financial – Jemma, Ashley, Charlie and unborn;
- Need – Jemma, Ashley, Charlie and unborn;
- Benefit – Jemma, Ashley, Charlie and unborn;

Because of the relationship of the individuals in the household (Jemma is a parent to her child and a parent to the unborn, Charlie is a parent to the unborn), all are included in the filing group. Although Jemma's pregnancy has not reached the ninth month, because there is another dependent child in the filing group, Charlie is included in the benefit group along with Jemma and her child, regardless of the month of pregnancy.

Example 3: Kellie is in her ninth month of pregnancy. She does not live with the father of the unborn, but they are a "couple" and see each other every day. Once the baby is born, the father plans to be very involved in the child's life.

- Household – Kellie, unborn;
- Filing – Kellie, unborn;
- Financial - Kellie, unborn;
- Need – Kellie;
- Benefit – Kellie.

Because Kellie and the father of the unborn do not live together and have no other eligible dependent children, the father is not considered in the household.

TANF Blended family

Example 1: Cassie, her child Logan, boyfriend Steven and their common child Destiny are applying for TANF. The boyfriend voluntarily quit a full-time job without good cause 1 month ago. They are all applying for TANF together.

- Household – Cassie, Steven, Logan and Destiny
- Filing – Cassie, Steven, Logan and Destiny
- Financial – Cassie, Steven, Logan and Destiny
- Need – No eligible persons;
- Benefit – No eligible persons.

Because of relationship of the individuals (Cassie is a parent to Logan; Logan is a half-sibling to the common child Destiny; Steven is Destiny's parent), all are included in the filing group. Since Steven (who is in the need group) quit a full-time job without good cause, this family is ineligible for TANF.

Example 2: Jolene, spouse Frank, Jolene's daughter Jasmine, and common child, Zoie. Frank is working full time. Jolene is applying for TANF for herself and Jasmine.

- Household – Jolene, Frank, Jasmine and Zoie;
- Filing – Jolene, Frank, Jasmine and Zoie;
- Financial – Jolene, Frank, Jasmine and Zoie;
- Need – Jolene, Frank, Jasmine and Zoie;
- Benefit – No eligible person.

Because of relationship of the individuals (Jolene is a parent to Jasmine; Jasmine is a half-sibling to Zoie; Frank is a parent to Zoie and step-parent to Jasmine), all are included in the filing group. Because Frank is working full-time, this family is over the income limit to receive TANF.

TANF Child Welfare/child in foster care

Example 1: Becca, her child, Mackenzie and along with two unrelated foster children, David and Donny are in her care.

- Household – Becca, Mackenzie, David and Donny;
- Filing – Becca and Mackenzie;
- Financial – Becca and Mackenzie;
- Need – Becca and Mackenzie;
- Benefit – Becca and Mackenzie;

Since David and Donny are in foster care and are unrelated, they are not part of the filing group. Becca and Mackenzie would be in the need and benefit group as they meet all eligibility requirements.

Example 2: Melanie, her only child, Jeannette, who is in foster care, but will return to the household within the next 30 days.

- Household – Melanie and Jeannette;
- Filing – Melanie and Jeannette;
- Financial – Melanie and Jeanette;
- Need – Melanie;
- Benefit – Melanie;

Because the Jeannette is will be returned to the home in the next 30 days, she is considered part of the household. Jeannette also remains in the filing and financial groups. She is not in the need group as she is in foster care. Melanie is eligible for TANF as her only child, Jeannette, is in foster care but expected to return in the next 30 days.

TANF Adopted children

Example 1: Neva, her biological child, Tiffany and adopted child Celina (not receiving adoption assistance).

- Household – Neva, Tiffany and Celina;
- Filing – Neva, Tiffany and Celina;
- Financial – Neva, Tiffany and Celina;
- Need – Neva, Tiffany and Celina;
- Benefit – Neva, Tiffany and Celina;

Because the adopted child, Celina, is NOT receiving adoption assistance, she remains in the filing group. Everyone meets all eligibility requirements and are in the need and benefit groups.

Example 2: Fen, her two adopted children, Lynsi and Geegee (both receiving adoption assistance).

- Household – Fen, Lynsi and Geegee;
- Filing – No eligible person;
- Financial – No eligible person;
- Need – No eligible person;
- Benefit – No eligible person.

Because the children are receiving adoption assistance, they are not considered part of the filing group. In order for the Fen to be eligible for TANF, she must have an eligible dependent child or unborn in her filing group. Since the children are not in the filing group, Fen is ineligible for TANF.

Example 3: Dana, and her two adopted children, Emily and Cindy (both receiving adoption assistance)

- Household – Dana, Emily and Cindy
- Filing – No eligible person;
- Financial – No eligible person;
- Need – No eligible person;
- Benefit – No eligible person.

Because the children are receiving adoption assistance, they are not considered part of the filing group. In order for Dana to be eligible for TANF, she must have an eligible dependent child or unborn in her filing group. Since the children are not in the filing group, the mom is ineligible for TANF.

TANF Non-needy caretaker relative

Example 1: Aunt Nellie, uncle Thom, their minor child Amber and niece Violet. Only requesting benefits for niece Violet.

- Household – Nellie, Thom, Amber and Violet;
- Filing – Nellie, Thom, Amber and Violet;
- Financial – Violet;
- Need – Violet;
- Benefit – Violet.

Because Nellie, Thom and Amber are not requesting benefits and have income less than 185 percent of the non-needy caretaker relative countable income limit, they are not in the financial group. The niece, Violet, remains in the need and benefit group as she meets all eligibility requirements.

Example 2: Grandma Bahati, grandson James, granddaughter Candace (cousin to James). She is only requesting TANF for grandson James.

- Household – Bahati, James and Candace;
- Filing – Bahati, James and Candace;
- Financial – James
- Need – James
- Benefit – James

Since Bahati is not requesting benefits for the Candace and Candice is not a sibling to James, Candice is not in the filing group. Also, because Bahati is not requesting benefits for herself and has income less than the non-needy caretaker relative countable income limit, she is not in the financial group. James remains in the need and benefit group as he meets all eligibility requirements.

Example 3: Great-grandma Dorthea, great-grandson Jimmy, great-granddaughter Arlene (second cousin to Jimmy). Dorthea is only requesting TANF for great-grandson Jimmy.

- Household – Great-grandma, great-grandson, great-granddaughter;
- Filing – Great-grandma, great-grandson;
- Financial – Great-grandson;
- Need – Great-grandson;
- Benefit – Great-grandson.

Since great-grandma is not requesting benefits for the great-granddaughter and the great-granddaughter is not a sibling to the great-grandson, the great-granddaughter is not in the filing group. Also, because great-grandma is not requesting benefits for herself and has income less than the non-needy caretaker relative countable income limit, she is not in the financial group. The great-grandson remains in the need and benefit group as she meets all eligibility requirements.

TANF SSI recipient

Example 1: Olivia of whom receives SSI and her child.

- Household – Mom and child;
- Filing – Mom and child;
- Financial – Child;
- Need – Child;
- Benefit – Child.

Because the mom receives SSI, she is not in the financial group. The child remains in the in the need and benefit group because they meet all eligibility requirements.

Example 2: David, his wife, Jaden, and their child of whom receives SSI.

- Household – Mom, dad and child;
- Filing – Mom, dad and child;
- Financial – Mom and dad;
- Need – Mom and dad;
- Benefit – Mom and dad.

Because the child receives SSI, they are not in the financial group. The mom and dad remain in the financial need and benefit group as they meet all eligibility requirements.

Example 3: Allison of whom receives SSI and SSDI, and her child.

- Household – Mom and child;
- Filing – Mom and child
- Financial – Child;
- Need – Child;
- Benefit – Child.

Because the mom receives SSI, she is not part of the financial group. Since she is not part of the financial group, none of her income, including her SSDI, counts. The child remains in the financial, need and benefit groups as they meet all eligibility requirements.

TANF TANF-non-citizen

Example 1: Martina, who is an ineligible non-citizen, Emilio and their child.

- Household – Mom, dad, child;
- Filing – Mom, dad, child;
- Financial – Mom, dad, child;
- Need – Mom, dad, child;
- Benefit – Dad, child.

Because of their relationship, mom, dad and child are in the filing, financial and need group. Mom falls out at the benefit group as she does not meet the citizenship and non-citizen requirements, and therefore, does not meet all nonfinancial requirements.

Example 2: Victoria, who is an ineligible non-citizen, at risk of harm due to domestic violence and pregnant in the fourth month.

- Household – Mom, unborn;
- Filing – Mom, unborn;
- Financial – Mom, unborn;
- Need – Mom;
- Benefit – Mom.

Since mom is at risk of harm due to domestic violence, the requirement to meet citizenship requirements and to be in the month prior to her due date can be waived. Since she meets all other requirements, she would be TANF eligible.

TANF Minor parent

Example 1: Major mom, Paula, minor parent, minor parent's child, sibling of minor parent. Major mom is requesting TANF for everyone, and has care, control and supervision of the minor parent's child.

- Household – Major mom, minor parent, minor parent's child, sibling of minor parent;
- Filing – Major mom, minor parent, minor parent's child, sibling of minor parent;
- Financial – Major mom, minor parent, minor parent's child, sibling of minor parent;
- Need – Major mom, minor parent, minor parent's child, sibling of minor parent;
- Benefit – Major mom, minor parent, minor parent's child, sibling of minor parent.

Since major mom is requesting TANF for the minor parent, the minor parent cannot be a separate filing group than major mom.

Example 2: Major mom, minor parent, minor parent's child, sibling of minor parent. Major mom does not want TANF and does not have care, control and supervision of the minor parent's child.

- Household – Major mom, minor parent, minor parent's child, sibling of minor parent;
- Filing – Minor parent, minor parent's child;
- Financial – Minor parent, minor parent's child;
- Need – Minor parent, minor parent's child;
- Benefit – Minor parent, minor parent's child.

Since Major mom is not requesting TANF for the minor parent, the minor parent is therefore not considered a dependent child, the minor parent and their child can be in a separate filing group. Major mom's income will still need to be deemed to determine eligibility.

Example 3: Gina, age 17, is applying for TANF for herself and her 2-month-old son, Charles. They currently live with her dad, Jonas.

Option 1: If Jonas has care, control and supervision of both Gina and Charles, they will all be in the filing group. Household – Jonas, Gina, Charles; Filing – Jonas, Gina and Charles; Financial – Jonas, Gina and Charles; Need – Jonas, Gina and Charles; Benefit – Jonas, Gina and Charles.

Option 2: If Gina is considered the caretaker relative, having sole care, control and supervision of Charles, she can apply for herself and her child without her father Jonas. Income from Jonas would be deemed and applied to the grant. Household – Jonas, Gina, Charles; Filing – Gina and Charles; Financial – Gina and Charles (income deemed from Jonas); Need – Gina and Charles; Benefit – Gina and Charles

REF **Example 1:** Olga and Husband Sergey arrived in the U.S. three months ago. Olga just started receiving SSI this month.

Sergey would need to be removed from the benefit group as he is receiving SSI. Olga can continue to receive REF cash as SSI is excluded income for REF.

Chapter 2, section 5: Financial eligibility

Categorical eligibility

Individual program example(s)

SNAP

Example 1: Malaki, his wife Jemma and their 20-year-old son Curtis are applying for SNAP together. They have income below 185 percent of FPL. They receive the TANF information and referral pamphlet Resource Guide for Low-Income Households (ODHS 3400). This family is categorically eligible the length of the certification period unless the family income exceeds 185 percent of FPL.

Example 2: Ben is getting SSI and living in a Group Care home. He is categorically eligible for SNAP. The CAT EL field should have a "Y" and the CATEG field must be "PA." SSI income must be coded. The CMS case number for medical and person letter should be coded with the person.

Example 3: Dani is receiving SSI. Her two children are receiving TANF (Program 2). They are categorically eligible for SNAP. The CAT EL field should have a "Y" and the CATEG field must be "PA" and each person has a CMS case and person letter listed.

Example 4: Misha and her three children are receiving ERDC. They are categorically eligible for SNAP. The CAT EL field should have a "C" and the CATEG field should be "NA" and each person should have a CMS case and person letter listed.

Example 5: Cynthia, and ineligible non-citizen, is receiving TANF (Program 2) for a child. Cynthia's income and resources were used to determine eligibility for TANF and she is ineligible for TANF solely due to citizenship/non-citizen status. This family is categorically eligible for SNAP. This means that even though the non-citizen is not eligible for SNAP, their resources are not considered when determining SNAP eligibility for the rest of the household. It also means that the computer will not look at the countable or adjusted income limits. The CAT EL field should have a "C" and the CATEG field should be "NA" and each person should have a CMS case and person letter listed.

Example 6: Julie 20yrs old and her James are receiving TANF. They live with the participant's mother Betty. Betty is not receiving any program benefits. Julie is under the age of 22; therefore, she is required to apply for SNAP with her mother Betty. The combined household income exceeds 185 percent of FPL. Julie and James are categorically eligible but the mother is not categorically eligible. The SNAP filing group is not categorically eligible for SNAP. Code the CAT EL field with an "N" and the CATEG field must be "NA." If the FCAS message is over income, close or deny the case.

Example 7: Dorthea is a 52-year-old grandmother receiving TANF (Program 2) for her two grandchildren. Dorthea is not receiving any program benefits for herself. She is not categorically eligible for SNAP because her income in combination with the children's exceeds 185 percent of FPL. Close or deny the case and code the CAT EL field with an "N" and the CATEG field must be "NA."

Example 8: Amy and her 14yr old son Patrick have been receiving SNAP. Their household income is below 185 percent of FPL. Amy quit her job without good cause and is disqualified due to noncooperation with OFSET. They are not categorically eligible for SNAP because of the OFSET disqualification. To be categorically eligible she must meet the OFSET work requirements and have her needs restored to the SNAP case. The CAT EL field should have an "N" and the CATEG field must be "NA."

Income limits

Individual program example(s)

TANF

Example 1: Dorothy and Toto are in the office applying for TANF for themselves and their daughter Glenda. Toto is working and has a steady income of $10.00 an hour and works 20 hours per week:

$10*20hrs*4.3=$860.00. Comparing the monthly earnings to the Countable Income Limit for a family of three ($616), the Oz family is OVI for TANF.

Example 2: Fred Farmer, his wife Bessie, and their daughter Banjette are applying for TANF. Bessie is working at the local dairy market and she is bringing home $400.00 a month. Comparing the monthly earnings to the Countable Income Limit for a family of three ($616), the Farmer family is under the Countable Income Limit and worker will need to review the Adjusted Income Limit.

TANF

Adjusted income

Example 1: Chrissy is in the office applying for TANF with her two children John and Janet. Chrissy states that she is working for a food demo company. Per statement from Food Yum, Chrissy earns $10.00 an hour and works a total of 30hrs per month. After calculating her monthly income ($10*30hrs=$300.00 pr month), Chrissy's gross of $300.00 is less than the Countable Income Limit for a family of three ($616). To determine the Adjusted Income, the worker will take the earned income of $300/2(50%)=$150.00 and compare to the Adjusted Income Limit ($485). $150.00 is less than the Adjusted Income limit. Therefore based on financial eligibility, the worker can continue to look at eligibility factors for the Roper family.

NOTE: A 50% earned income deduction is applied to the $300 earned income.

Example 2: Since Fred and Bessie's monthly income is only $400.00 and is under the Countable Income Limit. We need to determine if the income is less than the Adjustable Income Limit of $485. At the Adjusted level, any earned income must be given the 50 percent earned income deduction. We will take $400.00 and with the 50 percent deduction, compare the new amount of $200.00 to the Adjusted Income of $485.00. The Farmer family is under the Adjusted Income.

TANF

Exit limit increase (ELI)

Example 1: Jason and his two children are TANF recipients of $506 a month. He reports he has started working at Coco Nuts. He turned in employer statement saying that Jason is working 20 hours per week at $10.00 an hour and earns a total of $860.00 a month. Since Jason is part of the TANF benefit group and has earned income, the worker will need to check the new Exit Limit Increase Countable chart and determine if his earnings are less than $1,012. Jason's income is less than the ELI. Once the 50 percent deduction is allowed and the computer counts $430.00, he will remain eligible for TANF with a new GNT amount of $76.00.

Example 2: Shane and his child are TANF recipients of $432 a month. Shane reports that he started working at the Walking Factory and reports the "Big 3." He will earn $9.75 an hour at 40 hours per week and his first pay check is the 10th of the following month. The worker calculates that Shane's monthly gross income will be $1677 and he is over the Exit Limit Increase of $864.00. Since he reported the "Big 3" and his first pay date is the 10th of next month, the worker will close TANF the end of next month.

Example 3: Jason and his two children receive TANF. In April, he calls to report he is no longer employed. The following month he calls to report his wife Amy has moved into the home and she is working. The agency verifies Amy earns $900 per month. Since Amy was not part of the original TANF benefit group, the worker will use the countable income limit to determine eligibility. Based on the countable income limit of $795 for a family of four, the household is over income. The household is not eligible for the Exit Limit Increase since wife was not part of the benefit group. Timely notice would be sent to close the TANF case.

TANF Coding exit limit increase (ELI) and non adult standard exit limit increase (NAS)

Example 1: Brian is applying for TANF with his son. He works at Target earning $300.00 per month. The worker will need to determine if Brian's income meets the countable and adjusted limit for a family size of 2 on the Adult Standard Chart or TANF Calculator. The worker determines that the countable income for 2 is $499 and Brian's earnings of $300 is less, so the worker can now look at the adjusted limit of $416. The worker will use 50% of Brian's earned income which is $150. Brian is under the adjusted as well and since he met all other TANF eligibility the worker will code UCMS with: Brian as an 'AD' in grant code with c/d ELI and n/r EML C 300.00.

Example 2: Amber is applying for TANF with her two children. She is employed at Target and earning $300 per month. Amber has received TANF more than 60 months and does not meet any reasons for an extension. The worker will need to determine if Amber's income meets the countable and adjusted limit for a family size of three on the No Adult Standard Chart or TANF Calculator. The worker determines that the countable income for three is $410 and Amber's earnings of $300 is less, so the worker can now look at the adjusted limit of $334. The worker will use 50 percent of Amber's earned income which is $150. Amber is under the adjusted as well and since she met all other TANF eligibility the worker will code UCMS with: Amber as a 'NO' in grant code with c/d NAS and n/r EML C 300.00.

Example 3: Ambian is applying for TANF with her five daughters. She is self employed as a massage therapist. She turns in her tax documents and states that her income is consistent. Ambian's taxes shows that she grosses $10,000 a year. The worker determines Ambian's monthly gross is $833.33. Per the One or More Adult Standard Chart, Ambian's monthly gross is less than the countable income limit of $1060. The worker will use 50% of Ambian's self- employment which is $416.66. Ambian is under the adjusted as well and since she meets all other TANF eligibility the worker will code UCMS with: Ambian as an 'AD' in grant code with c/d ELI and n/r SLF C 833.33

Resource limits

Individual program example(s)

SNAP **Example 1:** An individual's resource limit is $2,500 and they have $1,500 countable resources. They give a countable resource with a fair market value of $4,000 to a relative prior to applying for SNAP benefits, so that they will be found eligible. $4,000 (transferred) + $1,500 (other resources) = $5,500 - $2,500 (allowable resources) = $3,000 uncompensated value. For this example, due to the uncompensated value falling between $3,000 and $4,999, the disqualification is 9 months. The worker will need to notify the applicant that they are denied for SNAP benefits. The forms are either the DHS 0456 (Notice of Decision and Action Taken) or SDS 0540 (Notification of Planned Action).

TANF **Example 1:** Jane is on TANF with her children. Both of her children are in school. She has had a JOBS case plan in the past but failed to cooperate with the activities in the plan. She is currently serving a disqualification. She is at a DQ1 and will be moving to a DQ2 next month. The family's TANF resource limit is $2,500 because Jane has a current JOBS disqualification.

Example 2: Bristol is receiving TANF for herself and her child. She is needed to care for her child who has a disability. Currently she is JOBS-exempt from JOBS participation. Bristol is a parent in the need group; she is not a new applicant for TANF; she does not have a case plan and is not serving a disqualification. The TANF resource limit for the family is $10,000.

Example 3: Harvey and his three children are receiving TANF. Harvey does not have a case plan. All three of Harvey's children require childcare and one child special needs care. The district does not have the resources to cover the care. Harvey is not a new applicant for TANF; he does not have a case plan or current disqualification; and he is a parent in the need group. The TANF resource limit for the family is $10,000.

Example 4: Maria is on SSI. She is receiving TANF for her two children. The TANF resource limit for the family is $2,500 because there are no caretaker relatives or parents receiving TANF.

Example 5: James is applying for TANF benefits and states that he has a 2015 Honda Accord Civic Sedan LX with 45,000 miles on it and owes $15,735.00 on the vehicle. He states that he does not own any additional vehicles.

Per KBB at time of intake the vehicle is worth $9,196 FMV (Average Trade-in Value)

Is this vehicle counted as a resource? If so, how much?

$ 9,196 FMV (Good Condition)
- 15,735 amt owed on vehicle
$ - 6,539

This vehicle is not counted as a resource as he owes more than it's worth.

Example 6: Lara and Monica are applying for TANF benefits and states that they have a 2017 Toyota Sienna SE with 35,000 miles on it and owes $6,052.00 on the vehicle. He states that he does not own any additional vehicles.

Per NADA at the time of intake the vehicle is worth $23,424 FMV (Average Trade-in Value)

Is this vehicle counted as a resource? If so, how much?

$ 23,424 FMV
- 6,052 amt owed on vehicle
$ 17,372 *Equity Value
- 10,000 Excluded Equity Value
$ 7,372 **Amount counted towards resources

Example 7: Larry and his mom Sheryl own a 2014 Nissan Titan 4X4. Sheryl will not allow Larry to sell the truck, therefore it is not considered an accessible resource for Larry. We would not count this as a resource.

ERDC **Example 1:** Brad has submitted an Employment Related Day Care (ERDC) Re- Application and Supplemental Nutrition Assistance Program (SNAP) Application (DHS 7476) to the local branch office. He is applying for child care assistance for his son, Maddox. On the application, Brad marks question #9, indicating the family assets exceed one million dollars. Since the family's assets exceed the asset limit for the ERDC program, Brad will be denied child care assistance. A decision notice of ineligibility will need to be sent.

OSIPM

Resource deeming from an ineligible parent to an applying child who is not assumed eligible

Example 1: John and Mary Smith, neither of whom are eligible for SSI or TANF have a total of $4,000 in countable resources. Their 9 year old son, Sam, is applying for OSIPM and has $500 in a savings account.

$4,000 ineligible parents' countable resources
$3,000 couple OSIPM resource limit
$1,000 in resources to be deemed to Sam

$1,000 in deemed resources
+ 500 from Sam's savings
$1,500 in total resources

Sam is under the resource limit since the OSIPM resource limit is $2,000 for an individual.

Example 2: Bill and Jane Jones, who are both ineligible, have 3 children: Alpha, Beta and Zoey. Alpha and Beta are applying for OSIPM while Zoey is not. The parents have savings and cash totaling $7,000 and Zoey has a saving's account worth $1,000. Alpha and Beta both have saving's accounts worth $350 each. Since Zoey is a non-applying child, her savings account isn't considered, and the parents' excess resources are only split between Alpha and Beta.

$7,000 ineligible parents' countable resources
$3,000 couple OSIPM Resource Limit
$4,000 in resources to be deemed to Alpha and Beta

For each child we have:

$2,000 deemed from the parents ($4,000/2)
+ 350 from the saving's account
$2,350

So, both children are over resources and not eligible for OSIPM.

Example 3: Fred and Frieda Jones, who are both ineligible, have three children: Huey, Louie and Dewey. Huey and Louie are applying for OSIPM while Dewey is not. The parents have savings and cash totaling $6,000. Louie and Dewey have saving's accounts worth $1,000 each. Huey has a saving's account worth $350. Since Dewey is a non-applying child, his savings account isn't considered, and the parents' excess resources are only split between/deemed to Huey and Louie. We still have to reevaluate if one of the applying children end up being ineligible for OSIPM.

$6,000 ineligible parents' countable resources
$3,000 couple OSIPM Resource Limit
$3,000 in resources to be deemed to Huey and Louie

For Huey we have:

$1,500 deemed from the parents ($3,000/2)
+ 350 from their saving's account
$1,850 - So, at the moment, he looks to be eligible.

For Louie, we have:

$1,500 deemed from the parents ($3,000/2)
+1,000 from their saving's account
$2,500 – so he is not eligible

Now, here is the problem for Huey. Since Louie is not eligible, no resources can be deemed to him, so all of the resources have to be deemed to Huey.

So now for Huey we have:

$3,000 deemed from the parents
+ 350 from his saving's account
$3,350 – so he is not eligible either. No, it doesn't seem logical or fair, but that's the way the policy is applied by the SSA.

Availability of assets

Individual program example(s)

SNAP

Example 1: Neil and his son, JJ's, their TANF benefits are closing at the end of the month because of failure to engage in a plan. On the SNAP case, count the full TANF grant of $432 as DQI (the benefit amount they could be getting). The DQI income on the SNAP case will be coded for one year unless the TANF penalty is lifted, the family no longer meets other TANF eligibility criteria, or the if the TANF cash case has been closed for at least 12 month. Neil begins getting $200 child support for JJ. Code ($432 - $200 SUP) = $232 DQI, change GNT to 200.00, and add the MNL HH Type on the front page of FSUP and change Cat EI. Coding to an N.

Example 2: Nellie and her daughter Aubrey's TANF benefit of $432 closed because of failure to engage in a plan. Count $432 DQI on the companion SNAP case. The participant begins working and will earn $700/month. This earned income exceeds the TANF countable income limit, so the participant no longer qualifies for TANF. Remove the DQI income, GNT and MNL HH Type from the companion SNAP case due to this change.

Example 3: Masha and her daughter Sari's TANF benefit of $432 closed because of failure to engage in a plan. Count $432 DQI on the companion SNAP case for up to one year, unless they become ineligible for TANF due to other reasons. Remember to review to see if any employment program disqualification needs to be applied for SNAP.

Example 4: Rose refused to engage in a JOBS plan. Following re-engagement, a notice of disqualification was sent to her. After receipt of the notice, she contacted the branch and asked that her family's TANF benefits end. The current DQI of $506.00 (the full grant amount) is coded on FSMIS. End the DQI after one year if she has not otherwise become ineligible for TANF before that date.

Example 5: An individual with two children has a $150 participant-caused TANF overpayment. The TANF grant is reduced by $20 a month to repay the overpayment. The COP of $20 is coded on FCAS with an expected end date noted in the comment field. The COP is re-evaluated at each recertification and continues either until the overpayment is repaid or the TANF grant closes.

Benefits from the GA program is available unearned income, including ongoing monthly payments, housing allowances paid to the landlord, utility allowances, accommodation allowances, and the personal incidentals payment.

Lump-sum income is a treated as a resource unless rule requires a different treatment.

TANF

Example 1: Terry, a noncustodial parent has been ordered by a court to pay child support his daughter Tabatha's mother, Abigail but chooses to make a payment to a landlord for shelter expenses for Tabatha (rather than making the payment directly to the DOJ Division of Child Support or directly to Abigail). A noncustodial parent's payments to a third party for the benefit of the financial group are considered child support and are countable, unearned income.

Example 2: Daryl is in the office needing to apply for TANF. Daryl states that his grandchildren, Beth, Mika, and Lizzie are all living with him. During the interview, Daryl reports that the grandchildren are not his biological grandkids. Daryl was dating their grandmother, but she left to Costa Rica. With this revelation, Daryl is not eligible for TANF.

Example 3: Uncle Rick needs to apply for TANF for his nephew Carl, but he is employed and wonders if his earnings will be looked at. The worker informs Rick that they will look at his monthly income and determine if his monthly gross is less than the NNCR countable income of $2,686 for a filing group of two.

ERDC

Non-citizen

Example 1: Michonne is in the office needing to apply for TANF for herself and her two kids. Michonne states that she is working at a bakery and her youngest daughter Judith is a U.S. citizen. The worker will need to take her pay verification of $250.00 a month and determine eligibility using the countable and adjusted income test for the need group.

OSIPM

Resources

Example 1: Gertrude put her daughter Mary on her checking account so that Mary can write out the checks for Gertrude's bills. All of the money in the account is Gertrude's, so the entire account is considered available to Gertrude.

Example 2: Gertrude opened a savings account for her daughter Mary when Mary was a teenager. The account is still open, in both Gertrude's and Mary's name, and has $5,000 balance. Mary directly deposits $200 from each paycheck to the account each month. They both claim all the money belongs to Mary, and the bank statements support their statements. The account is considered unavailable to Gertrude.

Example 3: Gertrude has a joint savings account with her significant other, George. They both make automatic transfers of $100 from their checking accounts when they receive their Social Security checks and have done that for several years. The balance is $5,000 and they state they each own half. Of the $5,000, $2,500 is considered available to Gertrude.

OSIPM

Income

Example 1: Joe applies for medical benefits for the very first time in June 2014. His income includes $780 gross SSDI; however, SSA is withholding $100 per month from his SSDI to repay an overpayment dating back to 2010 (apparently they miscalculated his benefits when he was first approved by SSA). He only receives $680 in actual SSDI benefits due to the repayment. He was receiving $900 per month when he was first approved in 2010, but after SSA discovered the error, his benefit decreased and is now $780. He was not receiving any type of APD medical benefit in 2010 when he was overpaid by SSA and receiving $900 per month; therefore, the garnished amount is considered available and we will be counting $780 rather than $680 when determining his countable income.

Example 2: Joe is approved for SMB on 1/1/14. His income at the time included UC benefits and SSB. In March 2014, EDD discovers that they overpaid him $500 between November 2013 and February 2014 and starts garnishing his current UC benefit effective April 2014. After investigating, the worker finds that $300 of the total $500 overpayment occurred in January and February; therefore, we will consider the withheld amount unavailable (i.e. we will count the net amount after garnishment but before taxes) until we have "ignored" $300 of withholding. He will have $200 more in withholding before his overpayment is paid back, but we will start counting the gross UC benefit until it's paid off regardless.

Prospective eligibility and budgeting

Individual program example(s)

SNAP

Example 1: An individual has received child support payments of differing amounts only twice in the past six months. None was received so far in the month of application. It is not known what amount will be received next or when the individual will receive it again. Therefore, the child support should not be counted as anticipated income for the certification period. Be sure the individual understands the need to report changes and that the decision and the reason to not use this income are carefully documented.

Example 2: An individual reports on the last day of the month that someone joined their household earlier that month. The new person's needs and income would be added for the following month's benefits after receiving required verification. However, if they report the person will be joining the home next month, do not add that person's needs until the month following the month they actually move in.

Example 3: In SRS: Filing date is 4/12. The applicant was just laid off work. As of the date of the interview on 4/13, he received one weekly pay check on 4/6 and expects to receive one more paycheck today. He has applied for UC and is currently serving the waiting week. This month's income is not expected to continue. Issue April benefits using actual anticipated earned income for April, then zero out his EML for future months. Do not count any UC because the waiting week is not a guarantee of benefits. Explain reporting requirements.

Example 4: In TBA: A SNAP case can never be certified or recertified using the TBA report system. Therefore, TBA will never be the report method for a first month of SNAP benefits.

Example 5: The ERDC certification period runs from April through June and the SNAP redetermination period runs from May through July. The worker can do a four-month certification (July – October) for ERDC and a three-month SNAP redetermination (August – October) so both end in October. Or the ERDC certification period could run three months from July through September and the SNAP redetermination five months from August through December. The SNAP redetermination would then end at the same time as the October through December certification period for ERDC. Once the end dates are aligned, a 12-month certification of both, with the SNAP case in SRS, is strongly encouraged.

Example 6: CRS to TBA. Max and his child, Margaret, were receiving TANF (Program 2). On March 21, they report he went to work on March 12 and will get his first pay on March 31. This change was reported within 10 days of the start of the job and therefore timely reported. Pend the participant for TANF benefits only for their first pay stub. This will be due April 10, 10 days after the first pay stub was received. When the pay stub was received, it was determined that the family is prospectively ineligible for TANF. As there is time for 10-day notice, notice is given to end TANF effective April 30. On CM, the TANF case is closed effective April 30 and the case is converted to EXT, effective April 1. On SNAP, the case is converted to TBA, effective May 1. For TBA, the GNT is changed to zero and any other income that was used to issue the April benefits continues unchanged. If the only income used for April benefits was the GNT, no income is used for TBA.

Example 7: Erika and her child Donald receive TANF (Program 2). She reports on October 28 that she went to work October 15. The change was reported outside of the 10 days required from the first day of work for TANF. The family is not eligible for TBA. Make any changes to SNAP benefits as appropriate for the CRS or SRS reporting system.

Example 8: Current TBA case: Participant reports that someone joined their SNAP group. Participant is informed they may re-apply for SNAP using the new situation. If participant re-applies and benefits will increase, recertify the SNAP case under SRS or CRS. Make no changes to TBA if the new benefit amount is equal to or lesser than the amount under TBA.

Example 9: Children are removed from the household by child welfare and placed in foster care. SNAP is placed into TBA. These children remain coded as members of the TBA group for the five-month period. They are only removed from the group if their foster care provider begins to get SNAP for the children.

Example 10: Sarah was receiving TANF for herself and her 6-year-old son Adam. In March she started working and reported this information to the agency. Her TANF case ended April 30 based on income verification provided Her SNAP case was converted to TBA effective May 1. On July 10, Sarah reapplies for TANF. She is placed in the Pre-TANF Program. Sarah continues to be TBA-eligible until her TANF cash case is opened.

Example 11: Current SNAP certification ends March 31 and TANF is closing at the end of March based on participant's verified earnings from a new job. SNAP case can be placed in TBA April 1 by extending the certification end date. A recertification action does not have to be done in this situation.

Example 12: Children are removed from the household by child welfare and placed with their grandparents. SNAP is placed into TBA. The following week, grandma comes to the SNAP office to apply for SNAP benefits for herself and the children. The children are removed from their parents SNAP TBA case so they may receive benefits with their grandparents. The parent becomes an ABAWD and unless otherwise exempt, the parent must comply with the work requirements. If they fail to do the 20 hours a week or 80 hours over the month in work-related activities, they receive a counting month. If they exceed the SNAP time limit before the end of the five-month TBA period, they will become ineligible for exceeding the SNAP time limit.

ERDC

Example 1: For a 12-month certification period, add the total anticipated income for 12 months including the initial month, and divide by 12.The income calculation may not match SNAP income. Ending and starting a new job in the date of request (DOR) month.

Example 2: Applicant turns in an application with pay stubs attached from a job that ended but pay was received in the DOR month. Also attached is a pay stub from the new job received in the DOR month and a letter from the employer with the ongoing income, hours and work schedule.

Last pay from previous job is $785, the income verification from the new job includes pay check for $574 and ongoing on the letter states $10.25 per hour at 30 hours per week.

Calculations: month 1 = $785 + $574 = $1,359, ongoing months

$1.25 x 30hrs x 4.3 = $1,322.25

Ongoing months $1,322.25 x 11 = $14,544.75 + $1,359 = $15,903.75 Final calculation: $15,903.75/12 = $1,325.31

OSIPM

Example 1: Thomas applies for medical on Oct 12. During the interview Thomas reports that he receives $800 SSB and an annual payment of $2,400 in income from mineral rights. Thomas receives these payments each January. The countable income would be calculated as follows;

SSB $800 + mineral rights $190 ($2,400 divided by 12 months minus $10 monthly earned income exclusion) = $990 countable income

Frequency of income

Individual program example(s)

SNAP **Example 1:** Leonard owns the "Science Is Fun" store. His sales have really gone down in the last year. His income currently is not what it used to be. When you talk to him you find that the last three months are pretty representative of the future. Use the last three months to anticipate ongoing. We would want to re-look at this income at ICR.

OSIPM

Periodic income

Example 1: Maude applies for medical and services on 7/12/18. During the interview Maude reports that she receives $800 SSB and an annual payment of $1,200 in royalties from a cookbook published 10 years ago. Maude receives these payments each January. Calculate the countable income as follows beginning July:

$800 SSB + $90 royalties ($1,200 ÷ 12 - $10 monthly earned income exclusion) = $890

Example 2: Harold requests OSIPM and service benefits on 8/20/18. During the interview, Harold reports that has $1,500 SSB. Harold also reports that his uncle died and left him some money from a family trust that he can use without restrictions. Per the terms of the trust, Harold will receive $600 each quarter beginning in October 2018. The countable income is calculated as follows:

- August: $1,500 SSB
- September: $1,500 SSB
- October and ongoing: $1,500 SSB + $180 trust income ($600 ÷ 3 - $20 monthly exclusion) = $1,680

Example 3: Harold requests OSIPM and service benefits on 7/19/18. During the interview, Harold reports that has $1,500 SSB. Harold also reports that his uncle died and left him some money from a family trust that he can use without restrictions. Per the terms of the trust, Harold will receive $600 each quarter and that he received his first payment earlier that month. The countable income is calculated as follows:

- July and ongoing: $1,500 SSB + $180 trust income ($600 ÷ 3 - $20 monthly exclusion) = $1,680

Example 4: Burt applies for Medicare Savings Program benefits on 9/20/18 and requests retroactive benefits. During the interview, Burt reports receiving $1,100 SSB and has been receiving $600 each quarter (Jan, April, July, Oct) since 2003 from a third-party trust with no restrictions. Burt provides all necessary information on 9/24/18. The countable income is calculated as follows:

- June – August: $1,100 SSB + $180 trust income ($600 ÷ 3 - $20 monthly exclusion) = $1,280
- September and ongoing: $1,100 SSB + $180 trust income ($600 ÷ 3 - $20 monthly exclusion) = $1,280

Example 5: Burt applies for Medicare Savings Program benefits on 9/20/18 and requests retroactive benefits. During the interview, Burt reports receiving $1,100 SSB and will start receiving $600 each quarter (Jan, April, July, Oct) from a third-party trust with no restrictions starting in July 2018. Burt provides all necessary information on 9/24/18. Countable income is calculated as follows:

- June: $1,100 SSB
- July – August: $1,100 SSB + $180 trust income ($600 ÷ 3 - $20 monthly exclusion) = $1,280
- September and ongoing: $1,100 SSB + $180 trust income ($600 ÷ 3 - $20 monthly exclusion) = $1,280

OSIPM

Countable periodic income when calculating service liability

Example 1: Maude applies for OSIPM and services in August 2018. During the interview Maude reports receiving $1,800 SSB and an annual payment of $1,200 in royalties from a cookbook she published 10 years ago. Maude receives these payments each January. The countable income is calculated as follows:

- For eligibility purposes:
  - August and ongoing: $1,800 SSB + $90 trust income ($1,200 ÷ 12 - $10 monthly exclusion) = $1,890
- Countable income used in liability calculation:
  - August - December: $1,800 SSB
  - January and ongoing: $1,800 SSB + $100 ($1,200 ÷ 12) = $1,900 (SSA COLA not included)

Example 2: Harold applies for OSIPM and services in August 2018. During the interview Harold reports receiving $1,800 SSB and quarterly, third-party trust distributions of $600. Harold receives these payments in Jan, April, July, and Oct. The countable income is calculated as follows:

- For eligibility purposes:
  - August and ongoing: $1,800 SSB + $180 trust income ($600 ÷ 3 - $20 monthly exclusion) = $1,980
- Countable income used in liability calculation:
  - August - September: $1,800 SSB
  - October and ongoing: $1,800 SSB + $200 ($600 ÷ 3) = $2,000 (SSA COLA not included)

Example 3: Burt applies for OSIPM and services in July 2018. Burt reports $1,500 SSB and ongoing quarterly trust income of $600, received each Jan, April, July, and Oct. The countable income is calculated as follows:

- For eligibility purposes:
  - July and ongoing: $1,500 SSB + $180 trust income ($600 ÷ 3 - $20 monthly exclusion) = $1,680
- Countable income used in liability calculation:
  - July - Sept: $1,500 SSB
  - October and ongoing: $1,500 SSB + $200 ($600 ÷ 3) = $1,700

If periodic income is received regularly but the amount varies, the individual will have to provide you verification of the last several payments so you can come up with an average amount, after which you will average over the period the payment covers.

Example 4: Paul applies in June 2018. Paul reports receiving quarterly periodic mineral rights payments that vary from quarter to quarter. The worker pends the case for a minimum of the last 12 months worth of payments. Paul provides the following information:

- $567 received 1/5/17
- $702 received 4/5/17
- $398 received 7/5/17
- $498 received 10/5/17
- $632 received 1/1/18
- $546 received 4/1/18

First calculate an average quarterly amount, then calculate the average amount received each month:

- $567 + $702 + $398 + $498 + $632 + $546 = $3,343 / 6 = $557 average quarterly payment
- $557 / 3 = $186 monthly

For eligibility, countable income would be $166 ($186 - $20 unearned income exclusion)

For liability, countable income would be $186

OSIPM

Use of rounding when calculating countable income

Example 1: Molly works 10-15 hours per week at the Coffee Hut for $12.25 per hour and is paid weekly on Friday. Molly provides paystubs for an entire month, so the earned income must be first averaged to determine an average amount per pay-period, and then that amount must be converted to a stable monthly amount using the weekly pay-period multiplier. See below for how rounding should be used:

- $122.50 received 6/5/20 (round to $123)
- $159.25 received 6/12/20 (round to $159)
- $134.75 received 6/19/20 (round to $135)
- $140.88 received 6/26/50 (round to $141)

Calculate the countable earned income as follows:

$123 + $159 + $135 + $141 = $558.00/4 pay periods = $139.50 average pay rounded to $140, then $140 x 4.3 = $602.00 total countable income (no rounding needed here, but if the result was $602.45, it would be rounded to $602 and if it was $602.75, it would be rounded to $603).

Example 2: Ruby receives quarterly periodic retirement income payments of $1,015.25. Ruby's monthly countable income would be calculated as follows:

- $1015.25 is rounded to $1015.00. That amount is averaged over (or divided by) 3 months and the result is rounded to the nearest dollar: $1015/3 = $338.33 rounded to $338 countable income per month.

Example 3: Mitch reports $1,000.50 in gross self-employment income, and a total of $300.25 in allowable costs. The $1,000.50 is rounded to $1,001.00, costs are rounded to $300.00. Total countable income after excluding costs is $701.00.

Self-employment income

Individual program example(s)

Amy Jefferson applies for cash, medical, day care and food benefits for herself and Billy, her three-year-old son. Amy is a hairstylist. She pays $460 per month for a space at The Hair Biz. Her rental pays for her share of utilities, exclusive use of her chair, access to a sink, a supply of towels, her share of the receptionist's salary and use of the laundry facilities. Amy sets her own hours, usually putting in 30-35 hours per week. She determines which services to offer, sets her own prices and is solely responsible for collecting the income from her work. Amy is determined to be self-employed.

She provides a copy of the bookkeeping log that she is keeping for tax purposes. Amy's budget month income of

$1,800 is the same as her ongoing average of $1,800 per month. Her allowable costs for space rental and supplies total $670.

Note: Amy's tips are considered and coded as part of her self-employment income.

SNAP Amy has allowable costs, so she is given the 50 percent self-employment income deduction. Because Amy was not self-employed last year, the worker anticipates her income at $1,800 per month, codes it as SEC and the computer deducts 50 percent.

TANF Amy's budget month income of $1,750 is over the countable income limit. She is over income for TANF. The 50 percent earned income deduction can be applied only after the applicant passes the countable income test.

ERDC Amy has allowable costs of at least $1, and chooses to use her deductions for a lower copay. Amy's gross self-employment income of $1,800-50 percent = $900. Amy's child care hours are determined in ONE by selecting .5 costs in the ERDC Self Employment Deduction screen after running eligibility which divides her income after costs of $900 by the current minimum wage for the business location. $900 / $14 (minimum wage in Portland in 2021) = 64.3 hours rounded up to 65.

Note: Compare the gross SLF amount to the ERDC income chart. The use of costs deductions are up to the individual. If more hours are needed, they may prefer to not use cost deductions. If a lower copay is needed, they may want to use the deductions.

MSP Amy's countable self-employment income is $1800 - $670 in costs = $1130. This amount is used when calculating the adjusted income for MSP eligibility.

OSIPM Amy's countable self-employment income is $1800 - $670 in costs = $1130. This amount is used when calculating the adjusted income for OSIPM eligibility and liability.

Individual program example(s)

SNAP **Example 1:** Joe owns "Joe to Go Coffee Kart." He started his business eight months ago and income, while low, has been consistent. We would use the last eight months to anticipate ongoing income. We would want to re-look at the income at ICR.

Example 2: $35,000 annual rental income (not self-employment) is computed as follows:

- Annual rental income $ 35,000
- less repairs (rentals only, not home) - 3,059
- licenses, fees, advertising, and office supplies - 5,371
- utilities (rentals only, not home) - 7,276
- sanitary services - 2,500
- mortgage - 6,000
- property taxes and insurance - 2,570
- management fees (not paid to HH member) - 7,200
- balance $ 1,024

In this example, the countable income from income-producing property is $85.33 a month ($1,024 ÷ 12). This income is coded as PTY on FCAS.

If this income is considered self-employment, the income of $2,916.66 ($35,000 ÷ 12) would be coded as SEC on FCAS.

Example 3: A farmer has $99,000 from the sale of livestock, produce, grains, etc. (look at Part 1 of Schedule F.) Some of the incomes listed on this form are excluded for SNAP. If income is received from an excluded source, subtract the amount before arriving at the gross figure. Deduct excluded incomes from line 9:

- Line 5: Commodity credit corporation bans. If a loan, treat like a loan. If a commodity payment to not plant a crop, the proceeds are counted as self-employment.
- Line 6: Disaster assistance is excluded. However, payments made for crop failure that is not connected to a presidentially declared disaster are counted as self-employment income.
- Line 6: Crop insurance payments are a nonrecurring lump-sum income and counted as a resource.
- Line 8: Federal and state gasoline tax credit or refund is excluded.

Example 4: $99,171 annual farm income from line 9 after deducting any amounts from lines 5, 6 and 8, which are not considered income (see above). The computations based on tax forms are:

- Countable Farm Income: $ 99,171
- Subtract allowable expenses from Schedule F, Part 2
- Fertilizers and lime - 6,769
- Lease on machinery - 2,000
- Repairs/maintenance - 3,646
- Gas, fuel, and oil - 2,327 insurance (farm only and not home) - 5,488
- Mortgage (farm only and not home) - 22,461 supplies - 274
- Utilities (farm only and not on home) - 1,500 sanitary services (farm only, not on home) - 1,497
- Telephone (farm only, not on home) - 2,823
- Office costs (not wages paid to HH member) - 375
- Registration and permits (farm only) - 784 legal/professional fees - 547
- Other costs – 661
- Labor (excluding wages paid to the SNAP group) - 41,911
- Balance $ (3,892)

OSIPM Applying self-employment losses to other earned income

Example 1: Faith earns $650 a month working part-time at a local cafe, but she also has a small business on the side baking custom cakes. Another cake lady moved in her neighborhood, so her cake business hasn't been doing so well lately. Last year she showed a net loss of $1,000 and doesn't expect things to change until she can move to the other side of town. Her net loss for the prior year is divided by 12, and then that amount is excluded from her monthly income from working at the café.

$1,000 / 12 = $83.33

$650 gross wages - $83.33 self-employment losses = **$566.67 countable earned income**

Example 2: Benjamin and his wife Jessica are both self-employed and are applying for a Medicare Savings Program. Benjamin is making money doing payroll for several small businesses, but Jessica's organic produce business is operating at a loss because her neighbor uses a lot of pesticides on his orchard, they have been blowing over into her garden, and she's struggling to stay certified. Last year, Benjamin earned $3,000 in gross receipts, had $1,000 in costs, and Jessica showed a net loss of $800. Her losses can be excluded from Benjamin's gross receipts before his costs are excluded.

$3,000 gross income for Benjamin - $800 loss for Jessica - $1,000 costs = $1,200 / 12 months - **$100 countable monthly self-employment income for the financial group**.

Expenses and deductions

Individual program example(s)

SNAP **Example 1:** A participant reports in January that they will be moving at the end of the month and their rent for February will go up. The change would be made to the rent amount on the case for the month following the month the change actually occurs. In this case the change would be made for March.

Example 2: Clarice is allowed a deduction for $300 per month rent. She reports that she failed to pay her rent for two months because of a family emergency, and now she is being billed $400 per month until the back rent is paid in full. Do not allow a deduction for the extra $100 per month that the participant is now being billed, because it was already allowed during previous months when she failed to pay her rent.

Example 3: Bob reports renting his home and he has a roommate. They do not purchase and prepare meals together and each pays half the rent and half the utilities. This is a share-shelter situation. Allow half the rent, as owed by Bob for the shelter deduction and the appropriate utility standard.

Example 4: Jean is buying a home and the mortgage payment of $600 a month. She has a roommate who pays half the mortgage ($300) plus half of the utilities. They are separate filing groups. Allow Jean a shelter deduction of half the mortgage ($300) plus taxes and insurance and the appropriate utility allowance. If the roommate applies for SNAP benefits, they will receive a deduction for $300 rent plus the appropriate utility allowance.

Example 5: Alma is renting a house for $500 a month. She is sharing the house with three other individuals who are paying her a flat $150 a month toward the rent and utilities. They are each separate filing groups. The full rent is $500 less $150 less $150 less $150 = $50 as her share of the rent. Code $50 rent for the participant and the appropriate utility allowance.

Example 6: Kristina is renting a house for $500 a month plus heating costs. She is sharing the house with three individuals who are paying her a flat $200 each toward the rent and another $50 for the utilities. The full rent is $500 less $200 less $200 less $200 = $0 as her share of the rent. Code zero rent for the participant and allow the FUA because she pays the heating costs. In addition, she has income of $100 from the excess rental income. Code the $100 income as PTY.

Example 7: Tony is buying a home with a $500 mortgage payment plus $50 a month taxes and $25 a month insurance. He is sharing the home with two other persons who are paying him $400 a month rent, which includes the utilities. The full shelter cost is $575 less $400 less $400 = $0 as her share of the mortgage, taxes and insurance. Code zero shelter and allow the FUA because he pays the heating costs. In addition, he has income of $225 from the excess rental income. Code the $225 income as PTY.

Example 8: The Jones family receives a year's worth of mortgage payments thru a MAP. If they sell their home within 5 years, they must repay that year of payments. If they stay in their home and do not default for five years, they do not have to repay the year of payments. As there are conditions on the year of payments, a shelter deduction is allowed.

Example 9: The Mendoza family receives a year's worth of mortgage payments thru a MAP. They never, under any circumstances, have to repay that year of MAP payments. As there are no conditions for repayment, no shelter deduction is allowed. The family may report when they resume making their own mortgage payments.

Example 10: Jana is homeless, living in a shelter. She has $500 earned income each month from a part time job. Jana pays $100 per month in shelter costs. She also has a phone bill of $79 per month. Her Excess Shelter Deduction would be $58. Because the Homeless Shelter Deduction of $159.73 is higher, ONE will use the Homeless Shelter Deduction. ONE will take the homeless shelter deduction off her adjusted income before determining her SNAP benefit amount.

SNAP Reverse mortgage

Example 1: Alexander owns his home. He has a reverse mortgage on this home. Alexander provides his most recent reverse mortgage monthly statement. Alexander is charged $200 per month in interest, $50 in mortgage insurance, and $20 in recurring service fees. Alexander receives $500 per month from the reverse mortgage.

The allowable shelter deduction is $270 (this includes the interest, mortgage insurance and service fee).

The $500 Alexander receives from the reverse mortgage is treated as loan income, which is excluded.

Example 2: Simone owns her home but is still paying on her original mortgage. She also has a reverse mortgage on this home. Simone pays $400 on her original mortgage. She provides a recent reverse mortgage statement. Simone is charged $350 in interest, $75 in mortgage insurance and $50 in recurring fees. Simone draws off the reverse mortgage payments when she needs to. On the reverse mortgage statement she provided, she withdrew $5,000. She states she used this to go on a cross-country trip.

The allowable shelter deduction is $875. This includes her original mortgage, the reverse mortgage accrued interest, mortgage insurance and recurring fees.

The $5000 Simone withdrew from the reverse mortgage is treated as loan income, which is excluded.

SNAP Medical expenses

Example 1: Sidney is eligible for medical deductions and she reports she was in the hospital for a few days, and she now has a $3,000 unanticipated medical bill. Sidney does not have a repayment plan with the provider, the worker will average the bill over the remainder of the months in the certification period. When Sidney reapplies, she states she is still paying this bill at the rate of $150 per month. Do not allow a deduction for this $150 per month cost, because the entire bill was already allowed during the previous certification period.

Example 2: John turns in and verifies $50 worth of medical expenses, yet he reports that his monthly expenses are $120. Since $50 is greater than $35 and the reported amount of $120 is less than $205, the work should code $120 on FSMIS.

Example 3: John turns in and verifies $25 in medical deductions, but states that his monthly medical expenses are $120. Since John has not turned in verification of more than $35, the worker would code $25 on FSMIS.

Example 4: John turns in and verifies $50 worth of medical expenses, yet he reports that his monthly medical expenses are $300. Since the reported medical expenses are above $205, the worker should code $50 on FSMIS and explain to John that if he wishes to have a higher deduction than the SMD, he should turn in all verifications. John turns in and verifies $300 worth of medical expenses. The worker should code $300 on FSMIS.

Example 5: Dorothy currently has $55 coded as her medical deduction on FSMIS and she reports that her current medical expenses are $75. The worker would update FSMIS to $75 without requiring further verification.

Example 6: Dorothy currently has $55 coded as her medical deduction on FSMIS and she reports that her current medical expenses are now $225 a month. The worker should leave $55 codded on FSMIS and explain to Dorothy that is she wishes to have a higher deduction than the SMD of $4205, she should turn in all verifications.

Example 7: Dorothy currently has $25 coded on her medical deduction on FSMIS and she reports that her current medical expenses are now $45 a month. The worker should leave $25 coded on FSMIS and explain to Dorothy that she will need to turn in verifications.

Follow-up: Dorothy turns in $35.01 worth of verifications. The worker would then code the reported amount of $45 in FSMIS.

SNAP

Verifying medical deductions for elderly/individuals with disabilities

Example 1: A 67-year-old participant, Gertrude, who has been prescribed two medications has costs that amount to $55 a month. She also has a medical insurance premium of $100 per month that he pays. Gertrude meets the definition of elderly for the SNAP program so she is eligible for medical deductions. Code $155 on FSMIS as a MED deduction.

Example 2: Toni, 29-year-old mother of two pays for medical insurance for herself and her son, Jake, who receive SSI. The total insurance cost is $249 a month. The portion she pays for herself is $145. Since the mother does not meet the SNAP definition of an elderly or person with disabilities, she is not eligible for a deduction. However, her son, Jake, receives SSI and is eligible for a medical deduction. Code $104, the portion of the insurance that is for her son, on a line under her son, in FSMIS as an MED deduction.

Example 3: A 58-year-old man, Bob, with a disability is told by his mental health counselor that he should be taking Melatonin to help him sleep and improve his mood. The cost of the melatonin is $13 at the local store for a month's supply. He also pays $27 a month in prescription copays. Code $40 on FSMIS as a MED deduction.

Example 4: Denise is participating in the EPD (Employed Persons with Disabilities) Program must pay a $100 participant fee in order to receive medical coverage. To qualify for this program, the participant must receive SSDI or meet the Social Security definition of disabled. Because of this, the participation fee is allowed as a medical deduction for SNAP.

OSIPM

Example 1: Susan owns a home and has a reverse mortgage. Susan provides the most recent reverse mortgage monthly statement. Susan is charged $160 per month in interest, $50 in mortgage insurance, and $20 in recurring service fees. Susan receives $470 per month from the reverse mortgage.

The $470 Susan receives from the reverse mortgage is treated as a bona fide loan, which is excluded as income, but is counted as a resource if retained in the month following the month of receipt.

Example 2: Richard owns a home and has a reverse mortgage Richard provides a recent reverse mortgage statement. Richard is charged $170 in interest, $55 in mortgage insurance and $30 in recurring fees. Richard occasionally draws off the reverse mortgage payments. On the reverse mortgage statement provided, Richard withdrew $5,000. Richard states it was used to go on a cross-country trip.

The $5000 Richard withdrew from the reverse mortgage is treated as loan income, which is excluded. It is not counted as a resource in the month following the withdrawal because it has already been spent and was not used to purchase an asset.

OSIPM

Deeming income when an adult applies

Example 1: Mary Smith is applying for OSIPM, has $600 in SSD and is not in need of services. Mary's husband works and earns $1600 per month. They have 3 children who have no income of their own.

Step 1: Individual Eligibility

Mary's unearned income	$600	
Unearned income exclusion	- $20	
Mary's adjusted income		$580

Since $580 is less than the OSIPM standard, go to the next step.

Step 2: Allocation calculation

Husband has no unearned income, so the allocation comes from his earned income.	$1,600		
Each child is allocated $420 x 3	- $1,260		
Remaining Earned Income		$340	
Since $424 is more than $420, go to the next step.			
Step 3: Deeming			
Unearned income	$600		
Unearned Income Exclusion	- $20		
Remaining Unearned Income			**$580**
Remaining Earned Income (from step 2 allocation)		$340	
Earned Income Exclusion		-$65	
Subtotal		$275	
½ Remaining Earned Income			**+ $134.50**
Deemed Income			**$717.50**

$717.50 is less than the 2 person OSIPM standard, so Mary is eligible.

Example 2: Susan Jones has $900 in SSD and is not in need of services. Susan's husband works and earns $800/mo. They have 2 ineligible children.

Compare Susan's adjusted income $880 ($900 - $20) to the OSIPM individual income standard. The adjusted income is over the standard, so Susan is ineligible for OSIPM. There is no need to look at allocating income from the ineligible spouse to the ineligible children since Susan is not eligible as an individual.

Example 3: Luisa Lopez has no income, is married and has 3 children. Each child has $150 in income per month. Luisa's husband has $850 in SSB and earns $900.

Step 1: Allocation calculation		
Husband's unearned income	$850	
Each child is allocated $270 ($420 - $150) x 3	- $810	
Since $850 is more than $810, all of the allocation comes from his unearned income leaving $40.	$40	
Earned Income	+ $900	
Total income	**$940**	
Since $940 is more than $420, go to the next step.		
Step 1: Deeming		
Remaining Unearned Income	$40	
Unearned Income Exclusion	- $20	
Subtotal		**$20**
Earned income	$900	
Earned Income deduction	- $65	

	$835
½ Remaining Earned Income	**+$417.50**
Deemed Income	**$437.50**

$437.50 is less than the 2-person income standard for a couple for OSIPM, so Luisa is eligible.

Use the DE3510 OSIPM Income Allocation and Deeming worksheet to calculate the allocation and/or deeming amounts and determine who is in the financial group.

OSIPM Deeming income when a child applies

Example 1: Parents have only earned income

Bill Sanders is a child applying for OSIPM who lives with both parents and a brother and sister, neither of whom is applying for OSIPM. Bill's parents earn $5,367.00 per month.

Parents' Earned Income	$5,367.00
Allocation for 2 non-OSIPM Applicant Children (2 X $420)	- $840
Remaining Earned Income	$4,527.00
General Income Exclusion plus Earned Income Exclusion	- $85
Remaining Earned Income	$4,442.00
½ Remaining Earned Income	$2,221.00
Parental Living Allowance	- $1,261
Deemed income	**$960.00**

Bill will deem income of $960. Less the $20 deduction, the adjusted income is $940 and is not eligible for OSIPM.

Example 2: Parents have only unearned income

Nancy Weaver is a child applying for OSIPM who lives with both parents and a 10-year-old brother who is not applying for OSIPM. One parent receives a pension of $1,000 per month and the other parent receives a pension of $686 per month. Nancy's brother receives $100 per month in unearned income.

Parents' Unearned Income	$1,686.00
Allocation for 1 non-OSIPM Applicant Children [$420 - $100 (amount of the child's own income)]	- $320.00
Remaining Unearned Income	$1,366.00
Unearned Income Exclusion	- $20.00
Remaining Unearned Income	$1,346.00
Parental Living Allowance	- $1,261.00

Deemed income	**$85.00**

Nancy's income is $85. Less the $20 deduction, the adjusted income is $65 and is eligible for OSIPM.

Example 3: Multiple children applying

Note: When multiple children apply, the deemed income is divided evenly between them. If the deemed income puts one of the children over income, only deem that amount to them that equals the one-person SSI amount. Any excess is split between the other children applying. In order to be considered an applying child at application or redetermination, a child must meet all OSIPM eligibility requirements except for excess income.

James and Janet Johnson are children applying for OSIPM. James receives $480 per month of unearned income. They live with their mother who receives $1,642 in unemployment compensation.

Parents' Unearned Income	$1,642.00
Unearned Income Exclusion	- $20.00
Remaining Unearned Income	$1,622.00
Parental Living Allowance	- $841.00
Deemed income	**$781.00**

$390.50 is deemed to each child ($781/2).

James' income is $480 + $390.50 for a total of $870.50. Less the $20 deduction= $850.50. This is greater than the one-person OSIPM standard, so James is not eligible for OSIPM. James' income exceeds the one-person income standard by $9.50 ($850.50 - $841), so this amount is added to the income that is deemed to Janet.

Janet has no previous income and has deemed income of $390.50 + $9.50 for a total of $400. Less the $20 deduction = $380 and is eligible for OSIPM.

Use the DE3511 OSIPM Income Allocation and Deeming worksheet to calculate the allocation and/or deeming amounts and determine who is in the financial group.

Concurrent and other benefits

Concurrent ERDC/TANF benefits

TANF **Example 1:** Isabel is on SSI and receives TANF for her 2 children, Natalie and Josiah. Isabel reports that she found a part time job and has had her youngest child Josiah in childcare since she started on 9/08. The Family Coach explains to Isabel that although she is not eligible for JOBS Support Services, she could potentially be eligible for an ERDC (M5) case. If Isabel clears all eligibility requirements, the Family Coach would set up a separate M5 case. Since Isabel receives SSI, her new income is not applied against the TANF grant, but her SSI and EML income is countable for the M5 case. Therefore, Isabel will have a co-pay and will need to understand the requirement to pay her co-pay.

ERDC **Example 1:** Marybeth has a non-needy caretaker relative grant open with her grandson Timothy. Marybeth has a job and needs help with daycare. Marybeth is encouraged to apply for Employment Related Daycare. If she clears all eligibility requirements, the worker would create a separate M5 case from the TANF case. Marybeth would have a co-pay and must comply with all ERDC requirements.

Concurrent ERDC/TANF benefits

OSIPM **Example 1:** Samuel moved to Oregon from Texas on November 3 and applies for OSIPM. It has been verified Samuel is currently receiving Medicaid in Texas that will end December 31. Samuel is seeking medical treatment in Oregon, but reports the provider refuses to submit a bill to the Medicaid agency in Texas. ODHSIOHA accepts Samuel's statement and determines he is not able to receive medical treatment in Oregon with his current Medicaid benefits. Samuel is approved for OSIPM effective November 1 in order to receive access to medical treatment in Oregon.

Treatment of specific assets

Individual program example(s)

Burial arrangements and burial funds

OSIPM **Example 1:** Mr. Jones completes an irrevocable assignment of a life insurance policy (FV = $15,000, CSV = $8,500) to fund a burial arrangement for goods and services that total $6,000. Since the cost of the arrangement is less than the FV of the life insurance policy the transfer of the policy is a potentially disqualifying transfer. To determine the amount of the disqualifying transfer subtract the cost of the contract from the CSV of the life insurance policy. In this example the disqualifying transfer amount is $8,500 (CSV of the life insurance policy) - $6,000 (the cost of the goods and services provided for in the contract) = $2,500.

Example 2: Mr. Smith pays $7,000 for an irrevocable burial arrangement, but the contracted goods and services only total $4,000. The difference between the prepayment and the contract that it funds ($3,000) is potentially disqualifying. Note: When an individual purchases a burial arrangement the individual must be the owner of the policy, not a family member or other individual.

Child support and cash medical support

OSIPM **Example 1:** Sarah, a single mother of two applies for OSIPM and services. Sarah receives SSD and child support from her ex-husband. Per 461-110-0410(1)(a), the children are not in the financial group and therefore, the child support would not be considered income for the mother.

Corporations and other business entities

OSIPM **Corporations**

Example 1: Bill and Ted started a landscaping business together and decided to incorporate. On the articles of incorporation, both are listed as officers and they are the only two stockholders. The business prospered, and eventually they were able to hire a site supervisor, a staff of 10, and an accountant. The business continued to grow and inevitably Bill and Ted asked themselves why they were breaking their backs when they could play golf and collect the profits. Because they no longer work for the corporation, their stock in the business (i.e. their ownership interest) is a countable resource under OAR 461-145-0520. The profits they receive are countable as unearned income.

Example 2: Bernie owns stock in Wal-Mart, Apple, and Starbucks; he has an ownership interest in these corporations (albeit small) but doesn't work for any of them. Bernie's stock is a countable resource and any dividends or profits received are countable as unearned income.

Example 3: Bill, the retired landscaper from example 1, is given one of the corporation-owned vehicles when his truck breaks down. The truck is considered unearned in-kind income (OAR 461-145-0280), but again, that rule specifies that items such as cars are evaluated according to the asset's specific rule. If we evaluate the truck under the motor vehicle rule (OAR 461-145-0360), it is counted as a resource.

OSIPM **Other business entities**

Example 1: Bob and Tom are brothers and trained mechanics. Bob wants to go into business for himself and open an auto shop but doesn't have enough money, so Bob asks Tom to be his partner. Tom is an excellent mechanic but has no business sense whatsoever. Tom agrees to invest in the business but wants nothing to do with the daily operations and makes no business decisions; Tom just works there as the shop's lead diesel mechanic. Tom doesn't have to be Bob's partner in order to work there, Bob would always have a place for his brother in the shop. They agree that Tom will be paid a salary of $25 per hour and also have a 50% share of the profits. The $25 per hour is counted as earned income and the profits are unearned income. Tom's interest in the business is a countable resource because Bob could buy him out and Tom could still work there. Note: Bob is considered self-employed, so his income and resources have to be evaluated under the rules governing self-employment.

Example 2: Let's say that Tom decides he wants to be bought out, but Bob can't quite raise the money to do it (he has expensive tastes and his debt-to-income ratio is a bit too high). Bob hits up his younger brother, Stuart, who is an aspiring golf pro. Stuart can get a loan and help Bob buy out Tom, but rather than giving him the money outright, he wants to be Bob's new business partner because he knows how profitable it is (plus the bank needs collateral). Stuart is trying to work his way into the pro tour and has neither the time nor the desire to be involved in the business; therefore, they decide that he will be a silent partner. The equity value of Stuart's ownership interest in the business would be a countable resource, and any profits he receives from the business would be countable as unearned income. The business also pays Stuart's golf match entry fees, so those are counted as unearned income as well.

Income-producing property

OSIPM

Example 1: Harry's godfather passes away in November and leaves his family home to Harry in his will. Harry is away at school and decides to rent out the house for $500 per month. The $500 is unearned income because Harry is not managing the property at least 20 hours per week. Property taxes and insurance average $80 per month and Harry sends a check for $20 to a local kid to mow the weeds every month, so the countable unearned income is $400 ($500 rent - $20 yard maintenance fees - $80 taxes/ insurance).

Example 2: Harry's home from school for the next 3 months and can now do some work on the home and yard. Harry spends about 40 hours per week in June, July, and August painting, making repairs, and cleaning up the yard. Harry's still only asking $500 per month, but it will be counted as earned income in June – August because he's spending more than 20 hours a week managing the property. When Harry returns to school in September, it will be once again counted as unearned income.

Example 3: Harry's home (from above) has an equity value of $75,000. 6% of $75,000 is $4,500. Harry receives $4,800 ($400 x 12) in countable income each year from renting out the house. Since the countable income ($4,800) is more than 6% of the equity value of the house ($4,500), $6,000 of the equity value can be excluded. This means that $69,000 ($75,000 - $6,000) is counted as a resource.

Lodger income

OSIPM

Individual is sole owner of home and pays utilities. One room is rented.

Example 1: Frank owns his own home and pays $1000 each month towards mortgage and other fees. Of this $1000, $700 goes to principal, $50 to interest, $150 to property taxes and $100 to real estate insurance. The interest, property taxes, and real estate insurance are allowable expenses; the principal is not allowable. Frank also provided verification that utilities on the home are $350 a month. This brings Frank's total allowable expenses to $650. Frank rents a single room in the home to Carl for $400 a month. The home has 3 bedrooms, 1 bathroom, 1 living room and 1 kitchen. That makes 5 rooms in total (the bathroom is excluded). Prorate this by dividing the allowable monthly expense of $650 by the number of livable rooms, 5. This gives you the prorated lodger expense of $130. Subtract this prorated expense of $130 from the monthly lodger rental income of $400 to get the reduced lodger income of $270. This is the countable lodger income amount.

Calculation: Monthly mortgage payment is $1000.

$700 principal, $50 interest, $150 property taxes, $100 real estate insurance. Owner pays all utilities, verified to be $350. The utilities, taxes and insurance are allowable expenses; the principal is not allowable. This brings the total allowable housing expense to $650 ($350 + $50 + $150 + $100 = $650)

Home: 3 bed, 1 bath, 1 living room and 1 kitchen. The garage is not a livable space. There are 5 total rooms (3 bedrooms + 1 living room + 1 kitchen) (bathroom and garage excluded) and 1 room is being rented for $400.

$650/5 = $130.00
Allowable housing expense divided by number of livable rooms = prorated Lodger reduction

$400 - $130.00 = $270.00
Lodger income minus prorated Lodger reduction = Adjusted Lodger income

Example 2: **Individual is sole owner of home and pays utilities. Two rooms are rented.**

Sally owns her own home and pays $2000 each month towards mortgage and other fees. Of this $2000, $1600 goes to principal, $100 to interest, $150 to property taxes and $150 to real estate insurance. The interest, property taxes, and real estate insurance are allowable expenses; the principal is not allowable. Sally pays the utilities on the home and verified they are $475 a month. This brings Sally's total allowable expenses to $875. Sally rents two rooms to two couples; each of the couples pays Sally $400 a month for their room. Sally is receiving $800 a month from the couples in total. The home has 3 bedrooms, 2 bathrooms, 1 living room and 1 kitchen. The basement has been converted into a family room. That makes 6 rooms in total as the bathrooms are excluded and the converted basement is included. Prorate this by dividing the allowable monthly expense of $875 by the number of livable rooms, 6. This gives you the single prorated lodger expense of $145.83. Multiply this amount by the number of rooms being rented, 2; note that the number of tenants does not matter. This amount is the total lodger expense of $291.66. Subtract this prorated expense of $291.66 from the monthly lodger rental income of $800 to get the reduced lodger income of $508.34. This is the countable lodger income amount.

Note: The calculation is based on number of rooms being rented, not tenants, if one or two people rent a single room the calculation does not change.

Calculation: Monthly Mortgage is $2000

$1600 principal, $100 interest, $150 property taxes, $150 real estate insurance. Owner pays all utilities, verified to be $475. The utilities, taxes and insurance are allowable expenses; the principal is excluded. This brings the total allowable housing expense to $875 ($475 + $100 + $150 + $150 = $875)

Home: 3 bed, 2 bath, 1 living room, 1 kitchen. The basement has been converted into a family room. There are 6 total rooms (3 bedrooms + 1 living room + 1 kitchen + 1 converted basement) (bathrooms are excluded)

2 separate bedrooms are being rented to two couples (4 people in total). Rent is $400 for each of the two rooms. ($800 total)

$875/6 = $145.83
Allowable housing expense divided by number of livable rooms = prorated Lodger reduction for one room

$145.83 x 2 = $291.66
Lodger reduction for one room multiplied by the number of rooms being rented = total prorated Lodger reduction

$800 - $291.66 = $508.34
Lodger income minus total prorated Lodger reduction = Adjusted Lodger income

Example 3: **Individual rents an apartment and is solely named on lease. Individual pays utilities. Lodger rents one room.**

James rents an apartment; his rent is $850 a month. James is the only person on the rental agreement. James pays the utilities and has provided documentation to show they are $220 total. James's rent payment as well as the utilities are allowable expenses. This brings James's total allowable expenses to $1070. James rents a single room to Tony for $425 a month. The apartment has 2 bedrooms, 1 bathroom, 1 living room and 1 kitchen. That's 4 rooms in total as the bathroom is excluded. Prorate this by dividing the allowable monthly expense of $1070 by the number of livable rooms, 4. This gives you the prorated lodger expense of $267.50. Subtract this prorated expense of $267.50 from the monthly lodger rental income of $425 to get the reduced lodger income of $157.50. This is the countable lodger income amount.

Calculation: Monthly rent $850 and all utilities, verified to be $220.

The rent and utilities are allowable expenses. This brings the total allowable housing expense to $1070 ($850 + $220 = $1070)

Apartment: 2 bed, 1 bath, 1 living room and 1 kitchen.

There are 4 total rooms (2 bedrooms + 1 living room + 1 kitchen) (bathroom is excluded) and 1 room is being rented to a friend for $425.

$1070/4 = $267.50
Allowable housing expense divided by number of livable rooms = prorated Lodger reduction

$425 - $267.50 = 157.50
Lodger income minus prorated Lodger reduction = Adjusted Lodger income

Sale of a resource

OSIPM **Proceeds from the sale of the home of the financial group**

Example 1: Sam sells his home and receives a lump sum payment of $100,000. One month after Sam received the proceeds from the sale of the home, he purchased a new home for $95,000.

At the same time, Sam entered into a contract with a roofing company to repair the roof on the new home. The contract terms state that Sam will pay the contractor $5000 once the roof is repaired and the work is completed. The contractor has stated that it will be 5 months before the work is completed.

Even though Sam has not "spent" the $5000 within 3 months of receiving the funds from the sale of the home, this amount is still excluded. Because Sam entered into the roofing contract and became obligated to pay $5000 upon completion of the work, the funds are considered to have been reinvested in the purchase of another home, and are therefore excluded. In this instance, Sam reinvested the entirety of the proceeds of the sale of the home in another home. The entire proceeds are excluded.

Chapter 2, section 6: Non-financial eligibility

Caring for an incapacitated individual

Multi-program example 1

James' father Dean is struggling with a medical condition that requires James' to help Dean out with most of his daily living needs. Dean refuses to move in with James, so he drives to Dean's house and spends most days caring for him.

SNAP If James' statement is questionable, Jason would need to provide verification of the need of care from Dean's physician. Otherwise, consider James exempt for caring for his father.

TANF James's father is not a disabled person in the HH in need of care. Therefore, we would not be able to exempt James.

ERDC Does not apply to this program.

REF James's father is not a disabled person in the HH in need of care. Therefore, we would not be able to exempt James.

Individual program example(s)

SNAP **Example 1:** Steven was working for a department store. He has a son named Donny, with several disability. Recently his son's conditions worsened; causing Steven to leave work on a regular basis. The employer was unable or unwilling to accommodate absences. Steven was fired. Steven presented his worker documentation from Donny's Physician. The documentation includes a diagnosis, prognosis of which states that Donny is requiring a calmer and cleaner environment while balancing new medication. This will require consistency and time. The worker determines that Steven is needed to care for his child's disability. Steven can be considered exempt from the JOBS program at this time.

Example 2: Tia's child Natalie was born with Clubfeet and qualified for SSI. Though Natalie has had multiple surgeries throughout her life, she attends school regularly. Tia is not needed in the home to care for an incapacitated individual and would not be exempt just because Natalie receives SSI. Her daughter's condition does not prevent her from engaging in JOBS activities.

Example 3: Lori's mother Daliah with stage 4 Cancer, has moved in with Lori, as no one else is able to care for her at this time. Lori is trying to get Hospice set up, but the process is not going as quickly as hoped. Daliah's doctor writes a note confirming the diagnosis and need for 24hr care. Lori would be considered exempt to care for her mother.

REF **Example 1:** Jason and Jackie apply for REF. Jason has several documented disabilities and needs assistance from Jackie. DHS sends the DHS 7785 to Jason's doctor, who returns to form to ODHSIOHA. According to the form, Jackie is needed to care for Jason. Jackie is now exempt.

Fleeing felons; probation and parole violators

Multi-program example 1

DDillon is in the office applying for services. Dillon marks the application that there is a warrant out for his arrest. He explains that he moved because his PO out of Clackamas County went to his mom's residence looking for him. The PO informed Dillon's mother that there is a warrant out for Dillon for not following through with his probation requirements. In the conversation with Dillon's worker he informs the worker that his original charges were for a felony assault crime committed in Portland, Oregon. He knows that he needs to make contact with his probation officer, but doesn't want to be arrested, as he will go back to jail for 30 days this time for a probation violation.

SNAP If the worker does not see that the participant has mental or physical issues preventing cooperation, a basic denial notice would be sent. The worker would let Dillon know that he would need to make substantial effort to resolve the matter for future eligibility and narrate the conversation.

TANF Dillon would be considered disqualified from benefits and removed from the benefit group until he is able to provide verification from the corrections agency or court that he is no longer in violation. Dillon's income and resources would still count, but the other individuals in the benefit group may remain eligible for benefits. The worker would let Dillon know that he would need to make substantial effort to resolve the matter for future eligibility and narrate the conversation.

ERDC This does not apply to the ERDC program.

REF Dillon would be considered disqualified from benefits and removed from the need group until he is able to provide verification from the corrections agency or court that he is no longer in violation. Dillon's income and resources would still count, but the other individuals in the benefit group may remain eligible for benefits. The worker would let Dillon know that he would need to make substantial effort to resolve the matter for future eligibility and narrate the conversation.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD This does not apply to HSD medical programs.

Pursuit of assets

Penalties for not pursuing assets

Multi-program example 1

Janelle comes in for an intake and states that she was injured on an escalator and is waiting for a settlement. The worker explains that she would need to complete the Non-Vehicle Related Personal Injury (MSC 0451 NV) form. She refuses to fill out the form.

SNAP This does not apply to the SNAP program.

TANF The worker would deny the application.

ERDC This does not apply to the ERDC program.

REF The worker would deny the application.

MSP The worker would deny the application.

OSIPM The worker would deny the application.

HSD The application would be denied.

Multi-program example 2

Jeff calls his worker to let them know that he cannot make it to his JOBS activity because he was rear-ended. The worker offers to assist Jeff in completing the online form, but Jeff doesn't have all of the information with him. The worker pends Jeff on a DHS 210A or RFI for a completed Vehicle Related Personal Injury Form. Jeff does not contact his worker to confirm that this is completed.

SNAP This does not apply to the SNAP program.

TANF The worker would close the TANF case benefits with a timely decision notice.

ERDC This does not apply to the ERDC program.

REF The worker would close the REF case benefits with a timely decision notice.

MSP The worker would close the MSP case benefits with a timely decision notice.

OSIPM The worker would close the OSIPM case benefits with a timely decision notice.

HSD Benefits would close for this individual with a timely decision notice.

Good cause for not pursuing assets

Multi-program example 1

Anna explains to her worker that she jointly owns a newer BMW with her grandfather's. Though, she has access to this car when she needs it, he is unwilling to sell the vehicle.

SNAP This does not apply to the SNAP program.

TANF Anna has good cause for not pursuing this asset as she does not have the ability to sell it.

ERDC This does not apply to the ERDC program.

REF Anna has good cause for not pursuing this asset as she does not have the ability to sell it.

MSP Anna has good cause for not pursuing this asset as she does not have the ability to sell it.

OSIPM Anna has good cause for not pursuing this asset as she does not have the ability to sell it.

HSD This does not apply to HSD medical programs.

Specific assets

Multi-program example 1

Kris was laid off from the local mill that she has worked at for quite a long time. She is in applying for any program that may help her through this financial burden.

SNAP This does not apply to the SNAP program.

TANF Kris is pended on a DHS210 to apply for UC. Kris contacts the worker a few hours later and states that she completed the application process for UC. The worker accepts Kris' statement and does not ask for documentation of the confirmation number.

ERDC This does not apply to the ERDC program.

REF Kris is pended on a DHS210 to apply for UC. Kris contacts the worker a few hours later and states that she completed the application process for UC. The worker accepts Kris' statement and does not ask for documentation of the confirmation number.

MSP Kris is pended to apply for UC. Kris contacts the worker a few hours later and states that she completed the application process for UC. The worker views ECLM and verifies that Kris did apply.

OSIPM Kris is pended to apply for UC. Kris contacts the worker a few hours later and states that she completed the application process for UC. The worker views ECLM and verifies that Kris did apply.

HSD When verification of the individual's application for unemployment compensation is received, their application for HSD medical can be processed.

Individual program example(s)

TANF

Example 1: Nala's husband and the father of her son Nathan passed away. She is applying for TANF.

The worker would ask if she has applied for Survivor Benefits through the SSA for both herself and her son. If Nala states that she has applied, then the worker would accept her statement and remind her of her reporting requirements. If Nala states that she has not, then a DHS210 would need to be given and benefits would not be opened until this is complete.

Example 2: Joshua is applying for TANF program benefits for himself and child. During the intake appointment, the case worker finds out that Joshua was injured in an auto accident and is trying to get the other insurance company to pay for damages. The worker offers to assist Joshua in completing the online form or the paper format in the office or will pend on a DHS 210 for completion of the Vehicle Related Personal Injury form and submission to the Personal Injury Lien Unit if Joshua is not able or willing to do it in the office.

Example 3: Peter is in the office applying for TANF for himself and his three children. Peter informs the worker that Lois, his wife and the mother to his children, passed away six months ago due to a boating accident. The worker will need to pend on a DHS210 for Peter to apply for survivor benefits before TANF can be approved.

Cooperation with the Division of Child Support (DCS)

Refer to Child Support Program examples.

Requirement to live with a caretaker or caretaker relative

Multi-program example 1

Dan's best friend Manny is the God-father for Dan's son Justin. Shortly after Dan's divorce he was diagnosed with a terminal illness. He moved himself and his son in with Manny, so that Justin could have a stable caretaker. Dan has since passed, leaving Justin in Manny's care. Manny continues to be Justin's caretaker, but would appreciate any help available.

SNAP This does not apply to the SNAP program.

TANF Manny is not considered a caretaker relative and cannot receive TANF on his behalf.

ERDC Though Manny is not a caretaker relative, he is the caretaker of Justin. Therefore, he can receive ERDC if the remaining eligibility requirements are met.

REF This does not apply to the REF program.

MSP This does not apply to MSP.

OSIPM This does not apply to OSIPM.

HSD Manny can apply for HSD medical benefits for himself and Justin. Both individuals can receive medical benefits if all eligibility requirements are met.

Individual program example(s)

SNAP **Example 1:** Julie is applying for TANF with her great grandson Eli. Due to their relationship, Julie is eligible since she is one generation removed from Eli, she is a blood relative in a preceding generation.

Example 2: Elisa and Brad are in the office applying for TANF. Elisa is pregnant and due next month. Both Elisa and Brad state that he is the father of the unborn child. Since both adults state that Brad is the father, he is considered the father. Elisa and Brad would apply together, and if eligible, they would both receive TANF benefits.

ERDC **Example 1:** A single mom with two kids, ages 7 and 8, asks her neighbor to provide care for her children while she is away on active duty. Mom still has custody, even though she is out of the home for more than 30 days. In this case, you can authorize up to 172 hours of child care. Do not authorize more than full time hours. The provider should not bill for the time children are in school.

Immunization requirements

Individual program example(s)

ERDC **Example 1:** Audrey marks on the application her child is not up to date on the immunizations. In the interview, she states they will take their child to receive the needed immunization. The application is pended for proof that the series of immunizations has started. Proof can be a copy or written statement of upcoming doctor's appointment or immunization record.

Example 2: Arya marks on the application that her child is up to date on the immunizations. In the interview, it is unclear whether the immunizations are up to date. Since it is unclear that the immunizations are up to date, the ODHS worker can pend the application to show proof that the immunization series has started by marking "I don't know" to the question "Are the immunizations up-to-date?". Make a case note to explain what was unclear and caused the application to be pended.

The conversation continues and Arya states she does not believe in immunizations for her child. A copy of a medical or nonmedical exemption form is needed to continue to process the application. The worker gives the parent the website address to the Oregon Health Authority. https://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/Pages/ index.aspx for more information on the exemption process of immunizations and the documentations required.

Employability screening tool and JOBS Program overview

Individual program example(s)

TANF

Example 1: Gretchen and Paul are applying for TANF with their three children. Gretchen attends the TANF intake without Paul who is watching the children. Gretchen completes the Employability Screening Tool (DHS 415A) and listens to the JOBS overview. Before TANF can open, Paul will need to complete the DHS 415A or the worker could ask the questions over the phone and complete the form with their answers and upload a copy of the form to the ONE electronic case file.

Example 2: Bernadette is a non-citizen authorized to work in the U.S. and is applying for TANF for herself and twin daughters. Since Bernadette is in the need group, she is required to complete the DHS 415A.

Example 3: Danika and her child are receiving TANF. Her new husband, Joe, moves into her home. Joe must complete the DHS 415A to meet eligibility requirements.

Child care need

Individual program example(s)

ERDC

Requirement to be employed or in self-sufficiency activities

Example 1: Ann is an assistant teacher at a certified child care center. She is required to be certified in First Aid and CPR. She is not paid for the time it takes for her to complete her certifications, but the class time can be covered as a retention activity by her authorized child care hours for ERDC.

Example 2: Thorson is an EMT. He is required to take six hours of Airway Management/Ventilation classes in order to be eligible to renew his certification. His employer does not pay him during class time. He is allowed to use his ERDC child care to cover the time he is required to be in these classes. He calls his worker because he needs more child care hours for this month to cover the training. The worker emails DPU to cancel and replace the current month billing form, including the additional six hours.

(adding hours for ongoing)

Student hours for career advancement: Additional child care hours may be authorized for working students. The caretaker must be able to show that the coursework will lead to a certificate, degree or job- related knowledge and skills. The caretaker must request student hours either on the application (DHS 415F or DHS 7476) or using the ERDC change report (DHS 862). Caretakers approved for additional authorized student hours will be coded with the STU case descriptor.

Child care hours

Individual program example(s)

ERDC Caretaker work/school schedule

Example 1: Paige is school aged and her sister is in preschool. The child care provider transports Paige to school at 8:20 a.m. and picks her up at 3:00 p.m. The provider cannot bill for the hours that Paige is at school.

Example 2: Katheryn is going into kindergarten this fall. Her preschool offers kindergarten classes and charges $700.00 per month for the kindergarten class which includes before and after school care (from 7 a.m. – 5:30 p.m. DHS cannot pay for the kindergarten tuition. Since before and after school care is included in the cost of tuition, there is no remaining cost that ODHS can cover.

Example 3: Morgan is applying for child care. She works during the day and reports homeschooling her child in the evenings and weekends. She is asking for full-time child care for her school-aged child. The worker explains to Morgan that ODHS cannot pay for child care during hour when free care is available. This includes school hours for a school- aged child.

The worker will authorize Morgan's work hours. The hours are not reduced based on the only child being school aged. This allows Morgan to have child care during school breaks, closures and when the child is unable to attend school (example: illness).

It is important for Morgan to understand the appropriate use of child care. When full-time hours are billed for a school-aged child, the case is flagged in a School Age Report and the payment is reviewed. If Morgan signs a billing form authorizing payment for school hours, she is liable for the overpayment.

ERDC Determining child care work hours for one-parent families

Example 1: The parent's verification shows they are working 30 to 35 hours per week, you would enter the actual verification in the Income Details screen. If paystubs are entered, the highest verified hours will be pulled from the paystubs. If another form of verification is entered, the maximum hours field will be used for ONE's child care hours calculation.

ERDC Determining child care work hours with split physical custody

Example 1: Sophie is applying for ERDC for her two children. She has a 50/50 custody arrangement where she has the children every other week. Sophie works 40 hours every week. Her authorized child care hours would be 40 x 4.3 = 172. Even though Sophie states she has a 50/50 custody arrangement, her highest verified work hours are allowed as custody arrangements can vary. It is important to let her know that her child care provider should only bill when the children are in Sophie's care and control. The worker will need to enter the shared custody information in the Household Questions screen in ONE. Otherwise, ONE will not allow child care eligibility if both parents apply.

Example 2: Rosie is applying for ERDC. She has split custody with her child's father. She states that he has the child every week from Friday until Sunday. Rosie's work schedule varies and she can be called in to work on the weekend. She states that sometimes she has the child on a Saturday or Sunday if the child's father isn't available or when she has special plans. Rosie's authorized hours would not be lowered due to the split custody arrangement and it would be the provider's responsibility to bill for the time the child is in Rosie's care. The worker will need to enter the shared custody information in the Household Questions screen in ONE. Otherwise, ONE will not allow child care eligibility if both parents apply.

ERDC Student hours

Example 1: Rich is eligible for ERDC. He is working 25-30 hours a week and is attending GED classes at the community college five hours a week. He supplied verification of his registration and enrollment and is approved for 35 hours a week (30 for employment and five for student hours).

Example 2: **Student hours higher than employment hours**

Brenda is working 10 hours a week and is attending class full time (14 hours a week) at SOU. Brenda is primarily a student, her work hours are less than her school hours. After the worker enters Brenda's pay verification and student schedule in ONE, she is authorized for 20 child care hours per week, 10 for work hours and 10 for student hours. This does not meet all of Brenda's child care need, but the allowable student hours are based off the work hours.

Example 3: **Working full time**

Robert is eligible for ERDC and is working 40 hours a week. He is taking additional classes at an online university and is requesting an additional 10 hours a week for student hours. Robert is not eligible for additional student hours because he is already authorized full time child care, 172 hours per month. The worker does not need to ask for verification of registration or class schedules. The worker should explain to Robert in the ERDC interview that additional hours cannot be given for his class time. The worker does not need to send a notice when student hours are not authorized.

Example 4: **Student hour verification not received**

Marie is applying for ERDC while she is working and attending school. She has supplied all of the required verification except for a copy of her current class schedule. Marie states that she will have her class schedule within the next week. The case is pended for the verification and the worker explains that we cannot open the child care case until we have proof of Marie's class schedule. The worker should explain that Marie should contact the office as soon as possible if she decides not to pursue student hours. If Marie does not return the pended item the case will be denied.

Example 5: **Schooling completed**

Jordan is eligible for ERDC. She was working 20 hours a week and attending school nine hours a week. She reports that she has completed her schooling and is asking about her child care hours. Her children are both enrolled in full-time spots at a local center. The center does not have any part-time spots available and Jordan is concerned that she will lose her child care if they cannot continue to attend full-time.

The worker explains that the authorized hours will not be reduced for this certification period. Jordan can continue to take the children to the site full-time, at least 136 hours per month, in order to maintain their current enrollment. At her next re-certification the worker will determine Jordan's authorized child care hours based on her work hours at that time. Jordan understands that her certification ends in three months and that she will need to increase her work hours if she wants her children to continue attending the center full-time.

ERDC Requesting student hours during the certification period

Example 1: Cornelius is currently receiving child care benefits for his two children. He was working 25 hours a week at his initial certification. He reports that he is taking 10 hours of coursework a week to become a CNA. He also reports that his work hours have decreased. No verification is provided. The worker should Report a Change to add the school enrollment information, and to request student hours. The worker can select Needs Verification, which will pend for verification. If Cornelius needs a lower copay, the worker can add an income record with the decreased hours and select Needs Verification to pend for verification of the new income.

All verification is received. Cornelius' work hours have decreased to 20 hours a week. Based on the decreased work hours and the additional school hours, the new authorized hours are 30 hours a week. His copay is decreased based on the new proof of income received.

Example 2: Jean is currently authorized 20 child care hours per week due to employment. She reports reducing her work hours and returning to school full-time to complete her accounting degree. Her current class schedule shows that she is taking 18 hours of classes per week. Her new income verification shows that she is working eight hours a week. The worker should enter the new income verification as well as work and school schedule in ONE.

No change will be made to her authorized hours but her copay may decrease. It is explained to Jean that she is approved for student hours, but that her student hours are limited by her work hours. Her authorized hours will not be increased or decreased at this time. If her work hours have not increased by her recertification date her authorized hours will be reduced to 16 per week .

Example 3: **No overlapping work hours 2 parent household**
Vonda and Ellis are applying for ERDC for employment and student hours. Vonda works M-F 6 a.m. – 2:30 p.m. and Ellis works Th –Sun 4 p.m. – 8 p.m. Vonda also attends classes every Saturday from 5 p.m. – 7:30 p.m. Vonda and Ellis do not have any overlapping work hours. Since no hours can be authorized for employment, they are not eligible for student hours. They are not eligible for ERDC.

ERDC Authorizing a higher limit for extra hours

Example 1: **Sleep Hours and Graveyard Shift**

Denny works 40 hours a week from 11 PM to 9 AM Saturday through Tuesday. He is requesting sleep time. You can authorize up to five hours of sleep time per work day. The work schedule would be entered in ONE using two work records:

11 p.m. – 12 a.m. Saturday – Tuesday
12 a.m. – 9 a.m. Sunday – Wednesday

The sleep time will be entered in ONE by selecting Sleep Hours as the Schedule type. For example:

9 a.m. – 2 p.m. Sunday – Wednesday

Denny's total child care hours will be:

40 x 4.3 = 172 work hours
172 x 1.25 = 215 work plus travel time
5 x 4 days a week x 4.3 = 86 sleep hours 215 + 86 = 301 work, sleep and travel time

Example 2: **Commute Hours**

Misty is working 40 hours a week and commuting from Salem to Eugene for employment five days a week. They report that their commute time is one hour and 15 minutes to get to work and one hour and 45 min to return (due to traffic). Misty has a half hour unpaid lunch break.

The worker will enter Misty's work schedule in ONE, and add a record for her commute hours. The family's child care need is calculated in ONE as:

8 hours for work, .5 for the meal break and 3 hours for travel time
= 11.5 hours per day
11.5 x 5 = 57.5
57.5 x 4.3 = 247.25 (248)

The usual 1.25 calculation is not used since travel time is already added.

Example 3: Jessie rides the bus to work five days a week and has to transfer several times. It takes her three hours a day to travel from the provider's house to work and back again. She works eight hours a day and is required to take a one-hour lunch break, so she needs 12 hours of care per day. The worker will enter Jessie's work schedule and add a record for her commute time.

The system calculates: 12 x 5 x 4.3 = 258 work and travel time

Child care copays

Individual program example(s)

ERDC **Requirement for caretaker to pay ERDC copay**

Example 1: Julie reapplies for ERDC on Aug. 15 but has an unmet copay from the prior certification period. On Sept. 5, the worker receives verification that the copay was met on Aug. 25. If all other eligibility factors are met for August, the case would be reopened effective Aug. 1.

Example 2: Dan's case closed Sept. 30 because he did not pay the August copay. Dan paid the August copay on Dec. 10 and reapplies. If all other eligibility factors are met, the case would be reopened effective Dec. 1. There is no eligibility for October or November because the copay was not paid in those months.

Child care provider requirements

Individual program example(s)

ERDC **Example 1:** On 12/27, the computer system tries to send a billing form out on the parent's case. When no provider is found, a closure notice is sent to the parent that day stating that their case will close 2/28. A second notice is sent to the parent at the end of February stating that their case has been closed for not using an ODHS listed provider.

Example 2: A provider failed in December completes the Orientation on Feb. 15. If participant and provider are otherwise eligible, provider can be paid for the month of February – effective Feb. 15 – (and forward). Billing forms will not be issued for January while the provider was in failed status. A provider is failed in February because they did not meet the requirement to attend the orientation. Billing forms issued for February will be paid (if participant and provider are otherwise eligible). If the child care provider completes the orientation in March, billing forms will be issued for March and can be paid effective from the date the provider completed the orientation (and is in approved status).

Child care payment process

Individual program example(s)

ERDC **Example 1:** **Administrative errors:** ODHS|OHA received pay stubs on Aug. 24 showing an increase in hours and income, but the action in ONE to increase the authorized child care hours was not taken timely. The September billing form can be canceled and reissued with higher authorized hours due to the administrative error.

Example 2: **Job loss:** Meg lost her job on May 4, her copay is $120. She will receive a check in May for $100. With no other income, the family is not able to meet the copay amount of $120 for May. The worker can contact DPU and have the CCB for May canceled and reissued. Based on her new income of $100, the copay would be $0; this is more than a $25 change in the copay amount. This CCB can be canceled and reissued.

Example 3: **Reduction in income:** John's hours were cut from full time to 15 hours a week on June 5. His income dropped from $400 a week to $150. His gross income for June is verified as $720:

June 6 - $270

June 13 - $150 ongoing income is anticipated to be $150 a week.

He will not have enough income to pay his $100 copay, the copay would be $0; this is more than a $25 change in the copay amount. This CCB can be canceled and reissued.

Example 4: **Increased hours:** Georgia submits and employer letter on May 5 reporting her hours are increasing from 20 to 30 hours a week. She cannot afford to pay her child care provider the difference between the part-time monthly and full-time monthly rate. This CCB can be canceled and reissued.

Example 5: **Increased hours:** Paulette submits a pay stub on Sept. 22 showing her weekly hours have increased from 37 to 40 hours. She is requesting more child care hours. Paulette's September CCB was issued with 200 child care hours (including travel time); this is a sufficient number of hours to cover her full child care need for September. The September CCB will not be canceled and reissued. Paulette's authorized hours will be increased on the system for October 1.

Example 6: **Reported after CMS cutoff:** Ringo reported on Jan. 29 that he lost his job. The worker reviews the situation and determines good cause. AWS is approved for February through April. The February billing form was already issued out with a $60 copay. The worker emails DPU to request the February CCB be canceled and reissued with a waived, $0 copay.

Example 7: **When reported timely in the beginning of the month:** Nonie went into labor on Feb. 27. She contacted the ODHS branch office on March 2, to report the birth of the baby and her maternity leave. Nonie also states she will have less income for March. The March billing form can be adjusted. Verification of actual March income and her expected income during her maternity leave is needed. An RFI is sent through ONE. Once verification is received, the March billing form can be canceled and reissued with the lower copay. Nonie will be approved for AML through May.

Example 8: **When reported timely in the beginning of the next month:** Sam lost his job on Dec. 30. He had a new job lined up to start on Dec. 31. He reported the job change to ODHS on Jan. 4. At his new job, he is working more hours but is paid at a lower rate causing his monthly income to be less. Because Sam reported timely, his case can be updated effective January and the January CCB can be canceled and reissued with the higher hours and lower copay.

Child care contracts

Individual program example(s)

ERDC **Example 1:** Deborah works Thursday through Sunday at Walmart and in need of childcare. A parent who works Thursday through Sunday would not be a good fit for a contracted site that is open Monday through Friday.

TANF time limits

Individual program example(s)

TANF **What is the Oregon TANF time limit?**

Example 1: Al has lived in Oregon his entire life and applies for TANF. His time limit records indicate 60 months federal and 24 months Oregon. Since eligibility in this situation is based on the Oregon Time Limit, Al may receive TANF if he meets all other eligibility requirements.

Example 2: Erica and her children move to Oregon from Colorado. In Colorado, Erica received TANF from 09/1997-08/2002 and then her TANF closed as she reached 60 months. Since Oregon does not count time prior to 07/2003, this time does not count towards the Oregon Time Limit and Erica may receive TANF in Oregon as long as she meets all other requirements.

Example 3: Nancy and her children move to Oregon from Florida. In Florida, Nancy received TANF intermittently between 2004 and 2016. TANF was closed in Florida because Nancy received 60 months of federally funded TANF. She does not qualify for a hardship extension in Oregon, so only the children will receive TANF in Oregon; Nancy will not be eligible for TANF, but remains JOBS-eligible.

TANF **What is Indian Country?**

Example 1: Trevor is on TANF, is an enrolled member of the Klamath tribe and lives in Lincoln County. Effective October 1, 2015: Lincoln County is determined to meet the definition of Indian Country. As of October 1, 2015, Trevor has accrued 57 months of TANF. Because he lives in an Indian Country county and is an enrolled Klamath tribal member, none of the months from October 1, 2015, until Lincoln County's Indian Country designation changes will be counted.

TANF What is an exemption?

Example 1: Lisa has been on TANF. She was a victim of domestic violence in 2015 and was not able to obtain or maintain work due to safety issues. Since she was unable to obtain work, she was coded with a TLD N/R and this time was not counted towards the time limit.

Example 2: Michelle has been on TANF. She has a mental health condition. This condition has always been managed with medication and does not prevent her from looking for or accepting work. Since it does not limit her ability to work, she would not have been eligible for an exemption and each month would have counted towards her time limit.

TANF What is a time limit hardship criteria extension?

Example 1: Julie is on TANF. During her 60th month, she is a victim of domestic violence and cannot obtain work right now due to safety issues. Since she is unable to obtain or maintain employment, she is coded as an "AD" with a TRH C/D and TLD N/R for three months. When the TLD N/R date approaches, the case should be reviewed for any other hardship extension criteria; if none are identified, Julie is removed from the benefit group and timely notice is sent.

Example 2: Jodie is on TANF. She has accrued 60 months toward the time limit and has been removed from the grant for several months. She tells her worker that she is now in treatment for substance abuse. Jodie turns in documentation from her treatment provider that she is unable to work from July to October. The worker should code the case with a TRH C/D and TLA N/R through October and code Jodie as an "AD" on the case. When the TLA N/R date approaches, the case should be reviewed for any other hardship extension criteria; if none are identified, Jodie is removed from the benefit group and timely notice is sent.

TANF Temporary continuation of benefits

Example 1: Kris is on TANF and received her 60th month of benefits on Feb. 1. On Feb. 7, Kris calls and reports that she had a house fire and is now homeless. Her worker staffs this situation with a TANF policy analyst, and it is determined that Kris meets the Family Crisis Temporary Continuation of Benefits criteria. She is coded as an "AD" with a TRH C/D and a TLF N/R for 90 days. Once the 90 days TLF extension is over, Kris' situation is reviewed for any other hardship; if none are identified, Kris is removed from the benefit group and timely notice is sent.

Example 2: Cecilia is on TANF and has been showing significant progress in her JOBS Plan. Her goal is to be placed in a JOBS Plus activity. In September, during her 59th TANF month, an appropriate site is identified, and Cecilia begins her JOBS Plus agreement in her 60th month. Her worker staffs with a TANF policy analyst and determines that Cecilia meets the criteria for a JOBS Plus Completion (TLP) temporary continuation of benefits. She is coded as an "AD" with a TRH C/D and a TLP N/R with an end date that matches the JOBS Plus agreement of 03/YY. When the TLP N/R date approaches, the case should still be reviewed for any other hardship extension criteria; if none are identified, Cecilia is removed from the benefit group and timely notice is sent.

TANF JOBS participation after reaching 60 months

Example 1: Lisa and her child have received TANF for 60 months. DHS has documentation of Lisa's learning disability, which has impacted her ability to obtain and maintain employment. Lisa and her child would be eligible to receive TANF beyond 60 months, as long as Lisa continued to engage with her case plan, and they continued to meet all other eligibility factors.

Example 2: Karen and her two children have received TANF for 60 months. Karen has provided documentation from her child's pediatrician that she is needed in the home to care for her child due to his disabilities. Karen and her children would be eligible to receive TANF beyond 60 months, as long as they continued to meet all other eligibility factors. Karen is not able to engage in a case plan, because she is JOBS-exempt as she is caring for a disabled child.

Example 3: Juan and Maria just moved to Oregon with their children. They had both received TANF in WA for 60 months. The family meets all financial and nonfinancial eligibility requirements except for time limits. Juan has been looking for work, but Maria has been staying at home with their child who has chronic asthma and needs round the clock care. Maria has provided documentation from the child's doctor that she is needed in the home. Juan meets no time limit hardship extension criteria, so he will not be able to receive cash, but Maria and the children will continue to be eligible. Juan is JOBS- eligible and must engage with his case plan for the family to continue to receive cash.

Example 4: Lisa received TANF in a state where the time limit was 48 months. She moved to Oregon after having timed out in the state she came from. She fits all TANF eligibility requirements. Because Oregon has a 60-month time limit, Lisa is eligible for an additional 12 months of assistance.

Example 5: Mary is a single parent with one child applying for TANF. She has received TANF out of state for 60 months. She has no identified barriers and does not meet a time limit hardship extension criteria. Mary will not be able to receive cash, but her child may receive TANF as long as Mary engages with her case plan.

Example 6: John is a single parent with two children who has received TANF in excess of 60 months. John does not meet any of the time limit hardship extension criteria but has been receiving TANF for his children. John has stopped engaging in activities listed in his case plan. Even though John's needs have already been removed from the grant, John is entitled to have the opportunity to participate in the re-engagement process and look at good cause. If no good cause is found, John is subject to disqualification.

Example 7: Fred and his wife Genevieve came to Oregon after having received 60 months of TANF in Washington. The family meets all financial and nonfinancial eligibility criteria, except for time limits. Neither Fred nor Genevieve meet any Oregon hardship extension criteria. The TANF case would open just for the children. Both Fred and Genevieve would be considered JOBS-eligible and would need to engage with their case plan for the family to remain eligible for TANF.

Out-of-state benefits

Individual program example(s)

SNAP **Example 1:** **ABAWD and SNAP time limits:** Lisa is an ABAWD and she applied for SNAP benefits on March 3, 2019. She is not exempt and is subject to the SNAP time limit. She must comply with the work requirements. She reports receiving benefits from the state of Washington from 10/1/2018 – 2/28/2019. She does not know if she was an ABAWD in Washington. You call the former state, and the Washington worker tells you that Lisa was an ABAWD subject to the SNAP time limits and she used three counting months in Washington for the months of 12/2018, 1/2019 and 2/2019.

Oregon's clock began on 1/1/2019, two of the counting months in Washington were received 1/2019 or later. Therefore, two of the three-counting months count as CT months in Oregon. The worker should note 1/2019 and 2/2019 as countable months. The counting month received from the state of Washington for 12/2018 does not count in Oregon because it was applied before Oregon's clock began.

Example 2: **ABAWD and SNAP time limits:** Fred is an ABAWD and is applying for SNAP benefits on Dec. 28, 2020. He is not exempt and is subject to the SNAP time limit. You explain that he must comply with the work requirements. He presents an out-of-state I.D. from California during your intake and you ask if he received benefits from that state. Fred tells you that he received SNAP benefits there, but they closed his benefits because he did not keep doing his job classes.

You call the former state, and the California worker tells you that Fred was an ABAWD subject to the SNAP time limits and he used three counting months in California for the months of 9/2020, 10/2020 and 11/2020. All three-counting months count as CT months in Oregon because they were received after Oregon's clock began.

TANF Verifying time on TANF from another state

Example 1: Antonina moved to Oregon from Washington. At intake she said she had about four years on assistance in Washington. The worker called Washington but was unable to make a connection with anyone. Since all other eligibility factors were met, the worker opened TANF for the children only and pended Antonina for proof of time on TANF in Washington. The worker emailed Washington. Two weeks later, she received an email from Washington verifying she had received TANF for 48 months, none of which were prior to July 2003 or in Indian Country. The worker was able to supplement TANF back to the filing date.

Example 2: Eryk and his children moved to Oregon from Washington, D.C. Eryk said he had received 60 months of TANF in DC and so the family had timed out. Eryk did not meet a hardship extension criteria. The worker tried to call D.C., but the office was already closed because of the difference in time zones. Since the family met all other eligibility requirements, the worker opened benefits for the children only and pended Eryk for proof of time on TANF in D.C. The worker then faxed a request to D.C. to verify time on TANF for Eryk. The verification was received two days later. Because Eryk had received TANF for 60 months, none of which were prior to July 2003 or in Indian Country, the worker sent a notice to Eryk denying him TANF and updated the Out-of-State Time Limit screens. TANF remained open for the children.

Other parent available to provide care

Individual program example(s)

ERDC **Example 1:** Sam and Diane are applying for ERDC. Sam is working full time and Diane is receiving SSI. Receipt of SSI alone does not mean Diane cannot provide adequate care for their children. Diane provides medical documentation stating that she cannot lift more than

10 lbs. She has a 15-month-old child and a 5 year old. ERDC is approved because the worker can determine that the 15 month old requires a caregiver to lift them and the child weighs more than 10 lbs.

Job separation and voluntary reduction of hours

Individual program example(s)

SNAP **Example 1: Reduction in work hours without good cause; disqualification notice sent:**

Certification period: October through March
Household composition: Jerod (age 24)
Work Registration Status: Mandatory
OFSET status: Exempt.

Situation: He was working 26 hours a week at $8.95 an hour, which equates to more than 30 hours a week at federal minimum wage.) On 11/2, he reported he was now working 16 hours a week. The employer verified that Jerod asked to work fewer hours. This is treated the same as job quit. Jerod told his worker that he asked for fewer hours because he works at night and he wants to spend more time with friends. This is not good cause.

Notices: The FS00CON (conciliation) and FSC1FJQ (disqualification) notices were sent. The disqualification also told him that ways to comply and one way to comply with the work requirements was to ask his employer to restore his work hours.

Disqualification effective: 12/1

Situation 1: On 11/26, Jerod reports his employer agreed to restore his hours. He is again OFSET exempt because he is working the equivalent of 30 hours a week. As Jerod became exempt from OFSET in November, the LV cannot be imposed for December. Undo the 12/1 close action on FSMIS. Remove the LV1, LV2 or LV3.

Situation 2: On 1/5, Jerod reapplied for SNAP. He is still working 16 hours a week. His supervisor stated that the busy season is over and he cannot increase Jerod's hours. A DHS 210 is given to Jerod asking him to do six job search contacts in two weeks. He did not turn in the required work activities in the 30-day application period and the benefits were denied 2/4. Jerod arrived in the office on 2/8 with a completed Job Search Verification (DHS 475) showing he had completed the requested job search activity. The disqualification can be lifted 2/8, the date he submitted proof he completed the required work activity, and the case is recertified using 2/8 as a new filing date.

Example 2: **Ending the disqualification due to a change in status:**

Certification period: October through March
Household composition: Harry (age 32) and Ginny (age 30)
Work Registration Status: Harry is mandatory. Ginny is mandatory.
OFSET status: Harry is Mandatory. Ginny is pregnant with no complications affecting her ability work. (They live in a time-limit-exempt county.)

ABAWD status: Harry is mandatory ABAWD in a time-limit-exempt area; Ginny is an exempt ABAWD.

Situation: Harry quit a productive job in November. He did not have good cause.

Notices: The FS00CON (conciliation) and FSC1FJQ notices were sent to Harry in late November.

Disqualification effective: 1/1.

Situation 1: Harry comes into the branch on 12/22 to report and verify he is now working 25 hours a week at $9.50 an hour. He is now OFSET and ABAWD exempt. Lift the disqualification and process SNAP benefits for January with Harry included. Remove the LV1 coding because his status changed to exempt prior to the effective date of the disqualification so it cannot be imposed. If including his anticipated earnings for January would result in a reduction in benefits, send timely notice before adding Harry and his income.

Situation 2: Harry comes into the branch on 1/15 to report and verify he is working 25 hours a week at $9.50 an hour. He is now exempt. Lift the disqualification for February after completing the penalty period (following add-a-person policy). Add both Harry and his anticipated earnings to FSMIS. Send a 10-day continuing benefit decision notice if this change results in less benefits for February than were issued in January. Do not remove the LV1 coding as Harry began to serve the disqualification before showing that he was exempt.

Example 3: **Job quit without good cause in 30 days prior to apply for SNAP, one-person filing group:**

Filing date: 2/26
Household composition: Robert (age 35)
Work Registration status: Mandatory
OFSET & ABAWD status: Mandatory.

During the interview it was determined that he walked off the job on 2/15. The branch determined he did not have good cause for the job quit.

Notices: Denial notice (DHS 456) stating he is not eligible due to a voluntary job quit and will not be eligible before 4/1 and until he shows cooperation.

One calendar-month period of ineligibility due to a job quit: 2/15 - 3/1 not eligible; 3/1 to 3/31 is the one-month LV1 disqualification.

Example 4: **Job quit without good cause in 30 days prior to applying for SNAP, filing group greater than one:**

Filing date: 3/10
Household composition: Elizabeth (age 32) and two children (ages 7 and 10)
Work Registration status: Mandatory
OFSET & ABAWD status: OFSET mandatory. Elizabeth is not an ABAWD as the dependents are port of the filing group.

Elizabeth was employed 40 hours a week in Iowa. She quit her job on 2/18 and moved her family to Oregon. It was determined that she did not have good cause for the job quit. The family meets all other eligibility factors.

Notices: FSC1FJQ notice stating she is not eligible before 5/1. However, the children are eligible during this period so the case is approved effective 3/10.

One calendar-month period of ineligibility due to a job quit: 3/10 to 3/31 Elizabeth is not eligible; 4/1 to 4/30 is the one-month LV1 disqualification.

Example 5: **Voluntary reduction in hours during 30 days prior to applying for SNAP:**

Filing date: 4/19
Household composition: Richard (age 32)
Work Registration status: Mandatory
OFSET & ABAWD status: Mandatory.

During the interview it was determined his work hours were recently reduced. He was working 40 hours a week and is now working 20 hours a week. The branch determined that he asked to work fewer hours on 3/30 and he did not have good cause. This reduction is treated like a job quit.

Notices: Denial notice (DHS 456) stating he is not eligible before 6/1 and until he demonstrates cooperation.

One calendar-month period of ineligibility due to reduction in work hours: 4/19 to 4/30 not eligible; 5/1 to 5/31 is the one-month disqualification.

Example 6: **Involuntary reduction in hours during 30 days prior to applying for SNAP:**

Filing date: 1/21
Household composition: Miguel (age 30)
Work Registration status: Mandatory
OFSET & ABAWD status: Mandatory.

During the interview, Miguel said he was fired on 1/15. The worker called the employer to verify and was told he did not show for work, so the employer considers it a job quit. The branch determined he caused his own dismissal but did not voluntarily quit his job. Miguel is not subject to disqualification due to voluntary job quit.

Example 7: **SNAP recipient job quit:**

Certification period: October through March
Household composition: Zane (age 28), Marilyn (age 26), and three children (ages 2, 4, and 7)
Work Registration Status: Zane is mandatory; Marilyn is exempt to care for a child under 6.
OFSET status: Zane is exempt due to working 35 hours a week.

Situation: Zane reported in December he was no longer working. It was determined he quit his job without good cause.

Notices: NOTM FSC2FJQ was sent to Zane for a one-month penalty. The notice specifies Zane needs to do 12 job search contacts and leave four applications within a 30-day period before he could again receive SNAP.

Disqualification effective: 1/1 for Zane only. Marilyn and the children continued to receive benefits. Remember to change the cat el status to N if Zane is the HH on SNAP.

Situation 1: Zane arrives in the office on 1/24 with a completed Job Search Verification (DHS 475) showing he completed the requested job search. The disqualification was lifted and Zane was added to the SNAP benefits as of 2/1 as he completed the one-month penalty.

Situation 2: Zane arrives in the office on 2/8 with a completed DHS 0475 showing he completed the job search. Following add-a-person policy, remove the disqualification effective 3/1.

TANF What employment is reviewed?

Example 1: Sam was working for a department store. She has a child with several disability issues. Recently her son's conditions worsened. She was forced to leave work on a regular basis. Her employer was unable or unwilling to accommodate absences. Sam was fired. Worker determines that Sam was needed to care for her child with a disability. She would have good cause.

Example 2: Ruth and her children are currently receiving TANF. Ruth was hired to work a job full time but quits her job, without good cause before she receives her first pay check. Ruth's family is no longer eligible for TANF for 120 days from the date she quit her job. Send timely closure notice to end.

Example 3: Patrick and his wife Laurie are applying for TANF. Patrick states that he was working full time, but was terminated last month due to a scheduling issue. After follow-up questions, it is determined that Patrick does not have good cause for his separation of employment. The family is not eligible for 120 days from the date he was let go.

Example 4: Tom and his two children are current TANF participants. Tom gains employment and begins working more than 30 hours per week. This is expected to continue. His available monthly hours are more than 100 per month. Tom quits his job before his TANF closes and the department does not determine he had good cause for his job quit. The family is no longer eligible for TANF for 120 days from the date Tom quit his job.

TANF What is the penalty for leaving a job without good cause?

Example 1: Christina and her children are applying for TANF. The filing date for TANF program benefits was March 20. Christina left her last job, which she was working more than 100 hours, on March 10. She has not worked since that time. Since Christina's job ended less than 120 days from the filing date, the worker will need to determine good cause or not. After determination has been made, and if the worker does not find good cause, Christina is ineligible for TANF for 120 days from March 10: this would be July 8.

Example 2: Roxanne and her five children are currently receiving TANF. Roxanne accepts and starts a full-time job. After receiving her TANF closure notice, Roxanne contacts her worker and lets them know she has quit her job for reasons ODHS does not grant good cause. The worker sends Roxanne a timely TANF closure notice for employment separation and closes the ongoing TANF case. Roxanne is ineligible for TANF benefits for 120 days from the date she quit her job.

TANF What would be the date the caretaker relative left their employment?

Example 1: Johnny was working for a local business for the past six months. He worked 40 hours per week. On October 15, his boss informed him he was being fired and his last day would be on October 19. October 19 would be the date Johnny left his last job.

Example 2: Gretchen had worked full time for the past two years in a factory. She decided to go back to school and quit her job. She turned in her two-week notice on June 4 and left the job on June 22. June 22 would be the date she left the job.

Example 3: Martha was hired by a bakery to work 30 hours per week and was to begin working on July 7. She did not show up for work. The date she left the job.

Example 4: Erin was on maternity leave for the past eight-weeks. She contacted her employer on Aug. 29 and informed them she would not be able to return to work. Aug. 29 would be the date Erin left the job.

TANF Guidance for determining good cause?

Example 1: Accommodation or accommodations provided were not adequate enough to overcome a physical or mental impairment

Brenda is applying for TANF program benefits for her and her child. She was recently working for a medical equipment fabrication company. She was hired five months ago for full-time work. The company has a six-month trial period. At her second- and fourth- month reviews, she received a below average performance rating due to her inability to perform at the required level. Brenda tried to improve her skills but was unable to succeed. The company chose to let her go. Worker determines that Brenda did not violate her employer's standards of behavior. She was unable to perform the tasks associated with her job due to lack of skills. Brenda would be given good cause for leaving her employment.

Example 2: Accepted another job at a higher wage but less than 100 hours a month

Kristine was working for the local school district. She has a disability and required accommodations. The district provided the needed accommodations. Even with the accommodations, Kristine was unable to perform her assignments. The school district ended up letting her go from this job. The worker determined that Kristine is an individual with a disability. She needed accommodations in order to do her job. However, even with the accommodations her disability was preventing her from being successful. Kristine would have good cause for leaving this job.

Example 3: Caring for a family member with a disability

Joseph was working over 100 hours and earning $1,450 per month. Forty-five days ago, he left this job to accept a job paying $2,000 per month. He worked this job for one month before being laid off due to low company earnings. Joseph only worked 85 hours per month at this new job. The worker determines that Joseph left his job 45 days ago to accept a job at a higher monthly salary but less than 100 hours per month. He had good cause for leaving the one job to accept the other at a higher monthly salary. He was then laid off due circumstance beyond his control.

Example 4: Circumstance beyond the control of the applicant

Johanna was working at a restaurant. Last month there was a flood. The restaurant Johanna was working at was hit by a mud slide and damaged beyond repair. She lost her job and is now applying for TANF. Worker determines that Johanna lost her job due to the company going out of business. In Johanna's situation, good cause would be given for the reason she left her employment.

Example 5: When it's a court order

Darren was working for a fast food restaurant. He was court ordered to attend classes. He tried to work with his employer to set up a schedule around his classes but the employer was unable to accommodate. Darren knew that the classes were required and missing them could lead to serving jail time. Darren decided to leave this job and continue to attend the classes. The worker determines that Darren has good cause for leaving his job. He chose to attend the court mandated classes. The alternative would have been mandatory jail time and the potential loss of his child. Darren tried to work out a solution with his employer but his employer was unable to work with Darren's schedule.

Example 6: When an employer was unable or unwilling to provide a needed accommodation

Andrew had just secured a job six weeks ago. He has a disability and requires some accommodations. After Andrew was offered the job, he told his employer he would need a few accommodations. His employer was unwilling to provide the needed accommodation. Andrew tried to do the job but ended up leaving the job after only one month. The worker determines that Andrew would have good cause because his employer was unable or unwilling to provide a needed accommodation.

Example 7: When an employer engages in employment practices that are illegally discriminatory on the basis of age, sex, race, religious or political belief, marital status, disability, sexual orientation or ethnic origin.

Isabella was working as a payroll technician for a manufacturing company. She was asked to join a political organization affiliated with the company. She explained that she could not join this organization because of her religious beliefs. Three days later she was fired. The worker determines that Isabella was asked to join a political organization and refused due to religious beliefs she would have good cause for leaving this employment.

Example 8: When entered, or will be entering a residential treatment facility within 30dys

Julia, Mason and their three children apply for TANF. Mason has been working for the past three years with the same employer. Over the past year his use of alcohol has increased. It is now becoming a problem, which is threatening his job, family and himself. He is working with a local organization to get help. They recommend residential treatment. Mason attempts to work something out with his job but his employer is unable to accommodate. Mason leaves his job to enter treatment. The worker determines that Mason has good cause for leaving his employment. He entered residential treatment center to address his alcohol abuse and work toward family stability.

Example 9: **When recommended by Child Welfare or other agency**

Alison was working as a supervisor in a warehouse. She was working the swing shift. Alison has two children. She has a history with Child Welfare. Her case worker suggests that she leave the swing-shift and find a job working during the day because of her children's needs. Alison leaves the job and is currently looking for daytime work. She applies for TANF. The worker determines that Alison has good cause for leaving her employment.

Example 10: **When unable to obtain or maintain appropriate child care**

Sandy was working with a local computer company until two weeks ago. Her child, Michael, has special needs. Sandy had a good day care situation but her provider moved out of town. There were no other providers able to provide special needs care for Michael. She was forced to leave her job. Worker determines that Sandy has good cause for her job quit since she could not locate another special needs childcare provider.

Example 11: **When it is an unsafe workplace, risk to an individual's health and wellbeing**

Judith is a TANF applicant in the sixth month of pregnancy. You find out she left a job last month. She was working full time, 100 plus hours per month. You ask why she left and she tells you she was working in a job that required close contact with different types of chemicals. She asked her boss about other positions but none were available. She says she was scared for the health of her unborn and decided, after consulting her doctor, it was best to leave this job. The worker determines that Judith was being reasonable and tried to work out a different position with her boss and when that failed she took the advice from her doctor and left the job.

TANF Self-employment job

Example 1: **Self-employment and separation of employment**

Patrick is self-employed. He last worked five weeks ago. He had been selling goods at Saturday market. He earned $600.00 in the final full calendar month. You will need to figure out the number of hours he worked. For self-employed, the hours worked is based on the income divided by Oregon minimum wage. Divide $600 / Oregon minimum wage = < 100 hours. Since Patrick's total hours were less than 100, he is not subject to the job separation rule.

Example 2: Zoey has been receiving TANF for a year. It is time to re-determine her eligibility for TANF. She turns in her re-determination packet and you begin your eligibility determination. The worker will need to re-establish Zoey's eligibility and look at if there was any current job separation.

Example 3: Silvia is applying for TANF. You are reviewing her eligibility and are looking at her past jobs. You discover that Silvia was working about a month ago and she was hired part-time and worked 60 hours that month. Silvia's last job before this one was six months ago. The worker determines that the job separation rule does not need to be looked at, because Silvia only worked 60 hours a month within the last 120 days.

Example 4: Brighton and his two sons are applying for TANF benefits. He had a job four weeks ago but left this job to take a trip with his sister to Alaska. He worked 150 hours in the final full calendar month on this job. This is his last job. The worker determines that Brighton voluntarily left this job to take a trip with his sister. In this scenario, Brighton and his children would not be eligible for TANF program benefits for 120 days from the date he left his job.

Example 5: Jennie has come into your office to apply for TA-DVS. She is attempting to escape an abusive relationship. You remember that certain requirements can be waived when applicants are escaping domestic violence. You are able to waive the requirements of the employment separation rule when considering an application for TA-DVS. Remember, you are able to waive the requirements of the employment separation rule when considering Jennie's application for TANF program benefits. The reason you can do this is because of the risk to Jennie if we deny TANF, which could force her back to the abuser.

Example 6: Alma and Pat, along with their five children, come into your office to apply for TANF. Both Alma and Pat have worked in the past 120 days. You will need to determine how many hours per month Alma and Pat were working and the reason they left their last jobs. You find out Alma left her job because her hours were cut to 15 hours per week and the couple could no longer afford child care. Alma had the highest earnings. Pat was working 40 hours per week. He left his job when the company was laying off staff due to a downturn in orders. Since Alma's hours were cut to 15 hours per week, you will not need to look at the job separation rule, but you will need to look at the job separation rule for Pat, since he was working full-time hours.

Example 7: Lorena is a tattoo artist. A friend of hers, Brad, has let her set up a space in his store. She was working there for the past year. Two months ago, she got into an argument with her friend and he asked her to remove her things from his shop. The worker determines that Lorena was not working for Brad. She is self-employed and remains self-employed. At this time, she does not have a location to set up her equipment. She would not be affected by the employment separation as she has not separated from a job.

Two-week cooperation requirement

Individual program example(s)

TANF

Example 1: Lin is applying for TANF for herself and her child in August. Lin's TANF case closed at the end of June with an active disqualification, DQ2. Lin is JOBS-eligible and does not have good cause for non-engagement. Because Lin's TANF case closed with an active disqualification within three months prior to her filing date she would be pended to complete a two-week engagement period.

Example 2: Mateus is applying for TANF for himself and his three children in May. Mateus' TANF case went into DQR status effective March and April. Mateus is considered JOBS-eligible and does not have good cause for engagement. Because Mateus' case closed with an active disqualification within three months prior to his filing date he would be pended to complete a two-week engagement period.

Chapter 2, section 9: Employed persons with disabilities (EPD)

Participant fee

Individual program example(s)

OSIPM

Eligibility vs. participant fee calculation

Example 1: Geoff receives $1000 per month in SSB and $5000 per month in earned income from work. Geoff has $1000 per month in EIEs.

EPD Eligibility Calculation: $1000 SSDI is excluded. All unearned income is excluded for EPD eligibility.

Earned income:

Total Countable Earned Income	$5000
- $20 income deduction	$5000 - $20 = $4980
- $65 earned income deduction	$4980 - $65 = $4915
- ½ remaining earned income	$4915 / 2 = $2457.50
- EIEs, IRWEs, BWEs	$2457.50 - $1000 =
Total Adjusted Earned Income	**$1457.50**

$1457.50 is less than the EPD adjusted income standard. Geoff is eligible for EPD.

EPD Participant Fee Calculation: Unearned Income $1000, plus $5000, equals $6000. There are no earned income deductions like there are in the eligibility calculation.

Monthly Countable Income	Monthly Participant Fee
Under $850	$0

$805 - $1,073.99	$50
$1,074 - $2,683.00	$100
$2,684 and above	$150

According to the chart, the monthly participant fee is $150.

Example 2: Jo has $1000 in SSB/SSDI and $5000 per month in self-employment income. Jo has $1000 per month in business related expenses, which can be excluded under OAR 461-145-0920. Jo also has $1000 in EIEs.

EPD Eligibility Calculation:

Total Earned Income	$5000
Excluded Income (Business Expenses)	$5000 - $1000 =$4000
$20 Income Deduction	$4000 - $20 = $3980
$65 Earned Income Deduction	$3980 - $65 = $3915
½ Remaining Earned Income	$3915 / 2 = $1957.50
EIEs, IRWEs, BWEs	$1957.50 - $1000 =
Total Adjusted Earned Income	**$957.50**

Jo's adjusted income is below the EPD adjusted income standard. Jo is eligible for EPD.

EPD Participant Fee Calculation: Jo's unearned income is $1000. Earned income is $5000, but we would exclude the $1000 in business expenses, which are excluded under OAR 461-145-0920. This leaves a total of $4000 in countable earned income. $1000 + $4000 = $5000

Monthly Countable Income	Monthly Participant Fee
Under $805	$0
$805 - $1,073.99	$50
$1,074 - $2,683.99	$100
$2,684 and above	$150

According to the chart, Jo will owe $150 per month as an EPD participant fee.

OSIPM

Failure to pay the participant fee

Example 1: On February 1, a worker finds that Moana did not pay the $100 participant fee in January and overrides EPD to terminated in ONE effective February 28.

Example 2: Javier received notice that his EPD would be closed on February 28th due to failure to pay the participant fee. Javier calls on February 20 to request that EPD benefits stay open. The worker reopens the case and reminds Javier that the participant fee must be paid each month (including February) to avoid termination of EPD benefits. If Javier does not pay the participant fee in February, close the case once again in March.

Example 3: A worker finds in February that Mushu did not pay the participant fee in June, September, and December of last year and case notes do not indicate any hardship waivers were granted. No further action is needed as Mushu is current on the most recent participant fee payments and non-payment of participation fees was not discovered timely.

Chapter 2, section 10: Long-term care (LTC) services

Effective dates

OSIPM **Establishing effective dates**

Example 1: An individual applies for and establishes a DOR for OSIPM and services on 12/20/15. The individual meets eligibility requirements for services except that they have a disqualifying transfer of assets. The individual is over income for OSIPM without services. On 01/25/16 the disqualification ends. OSIPM eligibility begins 01/01/16 and services begin on 01/26/16.

Financial eligibility

Resources

OSIPM **Resource computation for couples with an institutionalized spouse**

Example 1: Mr. and Mrs. Smith are legally married. Mr. Smith enters an adult foster home on October 5. At the time of entry into the adult foster home, the couple's combined countable resources are $150,000.

One year later, Mrs. Smith applies for OSIPM for Mr. Smith, the couple's combined countable resources are $100,000. Mr. Smith's gross monthly income consists of Social Security benefits of $1,300. Mrs. Smith's gross monthly income is SSB of $2,025. Mrs. Smith's rent is $600 per month. Mrs. Smith is entitled to the SNAP full utility allowance (FUA).

How are the couple's resources evaluated to see if Mr. Smith is eligible for OSIPM?

Step 1: Determine Mrs. Smith's community spouse resource allowance. Mrs. Smith's resource allowance is the largest of the four following amounts:

- One half of the couple's resources at the time that Mr. Smith entered the adult foster home. This figure may not exceed $137,400.
- $27,480 (The state community spouse resource allowance).
- A court-ordered community spouse resource allowance for Mrs. Smith.
- An amount that would generate investment income to help raise Mrs. Smith's income to a computed monthly maintenance needs allowance.; i.e the amount required to purchase a single premium immediate annuity to make up the shortfall.

Step 2: Determine one half of the couple's resources at the time that Mr. Smith entered the adult foster home.

Mr. and Mrs. Smith's combined countable resources at the time Mr. Smith entered the adult foster home were $150,000.

One-half of $150,000 = $75,000

(It does not exceed the maximum amount)
Step 3: Compute the amount needed to purchase a single premium immediate annuity.

The resource amount allowed the community spouse by this method is $0. Mrs. Smith did not need any extra income for individual needs. (See Below)

Compute Monthly Maintenance Needs Allowance		
Monthly Maintenance Needs Standard		$2,288.75
Shelter		
Rent or Mortgage	$600	
Taxes/Insurance	n/a	
SNAP FUA	+$450	

Total Shelter	**= $1,050**	
Shelter Allowance	- $686.63	
Excess Shelter		+ $363.37
New MMNA (From SDS 450 Step 2b SUBTOTAL)		**= $2,652.12**

Do not exceed the cap of $3,435

Compute Spouse's Total Available Income		
New MMNA (From SDS 450 Step 2b SUBTOTAL)		$2,652.12
Mr. Smith's Gross Income	$1,300	
OSIPM Standard	- $841	
Available Income	**= $459**	
Spouse Gross Income	+ $2,025	
Total Spouse Income		- $2,484
Monthly Income Needed (if positive) Mrs. Smith needs $2,652.12; Currently has $2,484		**= $168.12**

If this is a negative number, STOP here.

Step 4: Compare all of the figures determined for a resource assessment and pick the largest amount that can be allocated to the spouse.

- $75,000
- $27,480
- No court order
- $0

Mrs. Smith gets to keep $75,000 of the couple's resources.

Step 5: Determine if the couple has to spend down any of their resources.

Determine what Mr. and Mrs. Smith's combined countable resources are at the time Mr. Smith applies for OSIPM.

The amount is $100,000.

Subtract Mrs. Smith's community spouse resource allowance from what the couple's combined countable resources are at the time Mr. Smith applies for OSIPM.

$100,000	Couple's combined countable resources at time of application
- 75,000	Mrs. Smith's community spouse resource allowance
$ 25,000	**Resources considered available to Mr. Smith**

Step 6: Compare the resources remaining after the subtraction in Step 5 to the OSIPM resource standard for one person.

$ 2,000 (OSIPM resource limit for one person)

$25,000 (Mr. Smith's resources)

Because Mr. Smith's resources are over the standard, he is not eligible for OSIPM until the couple's combined countable resources are reduced to the largest of the four following amounts:

$75,000	Mrs. Smith's community spouse resource allowance
+ 2,000	OSIP resource limit for one person
$77,000	

$26,076	State community spouse resource allowance
+ 2,000	OSIP resource limit for one person
$28,076	

A court-ordered community spouse resource allowance for Mr. Smith PLUS $2,000 (the OSIPM resource limit for one person) OR

An amount that would purchase a single premium immediate annuity PLUS $2,000 (the OSIPM resource limit for one person).

Because $77,000 is the largest amount, Mr. Smith will not be eligible for OSIPM until the couple's combined countable resources are reduced to $77,000.

Example 2: (Same as Example #1 except for income of Mrs. Smith.)

- Mr. and Mrs. Smith are legally married. Mr. Smith enters an adult foster home on October 5. At the time of entry into the adult foster home, the couple's combined countable resources are $150,000.
- One year later, Mrs. Smith applies for OSIPM for Mr. Smith and the couple's combined countable resources are $100,000. Mr. Smith's gross monthly income consists of Social Security benefits of $1,300. Mrs. Smith's gross monthly income is SSB of $1,515. Mrs. Smith is entitled to FUA and rent is $650 per month.

How are the couple's resources evaluated to see if Mr. Smith is eligible for OSIPM?

Step 1: Determine Mrs. Smith's community spouse resource allowance. The resource allowance is the largest of the four following amounts:

- One half of the couple's resources at the time that Mr. Smith entered the adult foster home. This figure may not exceed $137,400
- $27,480 (The state community spouse resource allowance.)
- A court-ordered community spouse resource allowance for Mrs. Smith.
- An amount that would generate investment income to help raise Mrs. Smith's income to a computed monthly maintenance needs allowance.; i.e the amount required to purchase a single premium immediate annuity to make up the shortfall.

Step 2: Determine one half of the couple's resources at the time that Mr. Smith entered the adult foster home.

Mr. and Mrs. Smith's combined countable resources were at the time Mr. Smith entered the adult foster home were $150,000.

One-half of $150,000 = $75,000

(It does not exceed the maximum amount)

Step 3: Find the amount needed to purchase a single premium immediate annuity to provide income to increase Mrs. Smith's income to a computed monthly maintenance needs allowance for the last bullet in Step 1 above.

The resource amount allowed the community spouse by this method is calculated below.

Go to https://digital.fidelity.com/prgw/digital/gie/

Instructions for the fidelity website:

Step 1: Select **Just me** to answer the question "Who is the annuity for?"

Step 2: Fill in the community spouse's **Date of Birth**, **Gender**, and **State of Residence**, then click **Next**.

Step 3:

- Select "How much I want to get each month" as the **Estimate type**.
- Enter the monthly income needed in whole dollars, rounding up to the nearest dollar if necessary, in the **Amount** field.
- Enter the first of the following month as the **Income start date** (if spend down takes a few months or more, you will need to go back in and enter a new date to get the correct information).
- Select "Non-Qualified" in the **Funding source** field.
- Make sure the **Increase 2% a year** option is de-selected.
- Click **See my results**.

The top "Cash Refund" amount is the allowed amount for purposes of OAR 461-160-0580(2)(c)(D) and (2)(f)(D). You can look up the community spouse's life expectancy in the "Period Life Table" published by the SSA and, for individuals for whom the Fidelity web site, above, will not calculate an annuity (e.g. those over 85 years of age, or who have a shortfall of less than $100 per month) allow, instead, the monthly shortfall multiplied by the number of months of the community spouse's actuarial life expectancy. REMINDER: There is no requirement that the community spouse actually go out and purchase an annuity. This is just the mathematical measure used. See Actuarial Life Table.

Compute Monthly Maintenance Needs Allowance		
Monthly Maintenance Needs Standard		$2,288.75
Shelter		
Rent or Mortgage	$650	
Taxes/Insurance	n/a	
SNAP FUA	+ $450	
Total Shelter	**= $1,100**	
Shelter Allowance	- $686.63	
Excess Shelter		+ $413.37
New MMNA (From SDS 450 Step 2b SUBTOTAL)		**= $2,702.12**
Do not exceed the cap of $3,435		

Compute Spouse's Total Income		
New MMNA (From SDS 450 Step 2b SUBTOTAL)		$2,702.12
Mr. Smith's Gross Income	$1,300	
OSIPM Standard	- $841	
Available Income	**= $ 459**	
Spouse Gross Income	+ $ 1515	
Total Spouse Income		- $1,974
Monthly Income Needed (if positive) Mrs. Smith needs $2,702.12; currently has $1,974		**= $728.12**

If this is a negative number, STOP here.

Determine Amount of Resources That Will Generate Needed Income

Amount needed to purchase a single premium immediate annuity =X

Step 4: Compare all of the figures determined for a resource assessment and pick the largest amount.

- $75,000
- $27,480
- $ 0 (No court order)
- X

The largest amount is the amount that Mrs. Smith can have of the couple's resources.

Step 5: Determine if the couple has to spend down any of their resources.

Disqualifying transfer of assets

OSIPM Determining if a transfer is disqualifying

Example 1: Transfer of a home by an individual

Clara lives in a home that she owns and has been receiving Medicaid and in-home services for the past 6 months. Clara decides to transfer the home to her daughter Debra for zero compensation. Clara states that the reason for the transfer was that she has always intended to leave the home to Debra. Debra works full-time, lives in an apartment and does not provide care to Clara.

This transfer of assets is disqualifying, because even though Clara does not say that maintaining eligibility for Medicaid benefits was a factor in the decision to transfer the home, it was. If Clara had transferred the home for compensation equal to its value, she would most likely have become ineligible for Medicaid (unless Clara was going to invest the proceeds into another home). Therefore, the decision to transfer the home for zero compensation was made to maintain eligibility and is a disqualifying transfer.

Example 2: Transfer not for the purpose of eligibility

Ben is in good health and gives his son George $40,000 for a down payment on George's first house. Two months later, Ben suffers a debilitating stroke and is in need of medical benefits and long-term care.

This transfer is not disqualifying, because it was done exclusively for a purpose other than to become eligible for medical benefits. The purpose was to help George buy his first house. At the time of the transfer, Ben did not anticipate a need for medical benefits. Therefore, the transfer was made without the asset limit for Medicaid as a consideration.

Example 3: Transfer with potential Medicaid need

Sadie resides in an assisted living facility and gives her son Joe $40,000 for a down payment on Joe's first house. Two months later, Sadie can no longer afford her care situation, so she applies for medical benefits. Sadie's assets are now under $2000 and her income has not changed.

This transfer is disqualifying, because although it was made for a purpose other than to become eligible for medical benefits (to help Joe buy his first house), at the time of the transfer Sadie could anticipate a need for Medicaid to pay for her cost of care. Sadie would not have gifted the $40,000 if she did not expect to become eligible for medical benefits when her assets dipped below the $2000 Medicaid limit.

Example 4: Transfer not for the purpose of eligibility

Raymond has $150,000 assets and is paying privately for care in an adult foster home. Raymond gives his grandchild Leonard $50,000 when Leonard successfully completes medical school. With Raymond's monthly income, he expects the remaining $100,000 will be sufficient to pay for his care for the rest of his life. However, 2 months later, Raymond's dog bites another resident's visiting granddaughter. The family sues Raymond and the court awards $100,000 in damages to the victim. Raymond cannot now afford his living situation and applies for medical benefits.

The $50,000 gift is not a disqualifying transfer, because it was made exclusively for purposes other than to become eligible for medical benefits. Raymond did not anticipate a need for medical assistance at the time that he made the $50,000 gift. Therefore, the transfer was made without the asset limit for Medicaid as a consideration. In addition, Raymond did not anticipate and had no choice in paying the $100,000 damages awarded by the court.

Example 5: Transfer by community spouse after eligibility

Sam and his spouse Ruth apply for medical benefits because Sam is in need of long-term care. In the resource assessment process, it is determined that Ruth can keep $110,000 in assets; Sam is determined eligible for long-term care. Within the next 6 months, Ruth gifts $30,000 to each of their 3 children for future grandchildren college funds.

The $90,000 was part of Ruth's community spouse resource allowance per 461-160-0580(2). As long as Ruth does not need long-term-care services, assets transferred by Ruth will not be evaluated as possibly disqualifying.

Example 6: Transfer with potential Medicaid need

Dorothy and her spouse Tom apply for medical benefits because Dorothy is in need of long-term care. In the resource assessment process, it is determined that Tom can keep the family home and $175,000 in assets; Dorothy is determined eligible for long-term care. Within the next 6 months, Tom's health also deteriorates and is placed in a nursing facility. Tom gifts $50,000 to each of their 3 children for future grandchildren college funds. Tom gifts the family home to their 4th child, spends down the remaining $25,000 paying privately for care, and then applies for medical benefits.

These transfers are all disqualifying, because although the assets were Tom's as a community spouse, when Tom became an applicant for medical benefits, the transfers must be evaluated. Tom was aware of his need for long-term care and could anticipate his need for medical benefits when he transferred assets to his children. Although Tom had other purposes for making gifts to his children, Medicaid eligibility was a consideration. Tom would not have transferred these assets if he did not expect to become eligible for medical benefits.

Example 7: Transfer with potential Medicaid need

Charles and his spouse Penelope apply for medical benefits because Charles is in an assisted living facility. In the resource assessment process, it is determined that Penelope, who receives care and resides in the same assisted living facility, can keep $50,000 in assets; Charles is determined eligible for long-term care. Within the next 4 months, Penelope's favorite sister passes away and wills Penelope $100,000. Penelope gifts the $100,000 to their daughter Amber to begin a restaurant business. Penelope spends down the remaining $50,000 paying privately for care, and then applies for medical benefits within 7 months.

This transfer is disqualifying. Although 461-140-0242 allows the community spouse to transfer their assets as determined in the resource assessment, a transfer of these assets could be disqualifying if the community spouse later needs long-term care services. Also, while not relevant to the decision that this transfer is disqualifying, the $100,000 was not part of Penelope's community spouse resource allowance. She received this asset subsequent to the resource assessment. Penelope was aware of her need for long-term care and could anticipate the need for medical benefits when she transferred this gift to Amber. Although Penelope had another purpose for making the gift, Medicaid eligibility was a consideration. Penelope would not have transferred this asset if she did not expect to become eligible for medical benefits.

OSIPM Calculating the disqualification period

Example 1: A transfer before July 1, 2006

Mabel, who is paying privately for a residential care facility, decides to give $50,000 to a family member to help with college expenses in March 2006. Combined resources were more than $2000 at the time. Mabel applies for Medicaid in August 2006. This gift is determined to be a disqualifying transfer of assets, because Mabel knew at the time the gift was made that services were needed and would not have taken the action if Medicaid was not expected to be available. $50,000 ÷ $4700 (Initial month is August 2006. See 461-140-0296) = 10.6382978. Because this transfer happened prior to July 1, 2006, the partial month is rounded down to the next whole month. This transfer causes a 10-month disqualification beginning in March, and Mabel is not eligible until January 2007.

Example 2: A transfer after July 1, 2006 in the applicant's look-back period

Violet, who is paying privately for a residential care facility, decides to give $100,000 to a family member to help with college expenses in August 2006. Violet had more than $2000 in resources at the time. Violet's date of request for Medicaid is November 10, 2006. This gift is determined to be a disqualifying transfer of assets, because Violet knew at the time the gift was made that services were needed, and would not have taken the action if Medicaid was not expected to be available. Violet is otherwise eligible. $100,000 ÷ $5,360 (from 461-140-0296) = 18.6567164. Because this transfer happened after to July 1, 2006, it causes an 18-month disqualification beginning on November 10, 2006 through May 9, 2008. The .6567164 is converted to additional days by multiplying it by 31 (the number of days in the last full month, May). Therefore, 31 X .6567164 =20.3582084 days. The partial day (.3582084) is dropped, and Violet is disqualified through May 29 (May 9 plus 20 days).

Example 3: A transfer with value of less than a day (after July 1, 2006)

At renewal in September 2007, Doris reports winning $130 on a lottery scratch-it ticket last month and decided to give it to a family member for their birthday. Doris had $2000 resources at the time of the transfer. $130 ÷ $5,360 = .0242537. Because this transfer happened after July 1, 2006, convert the disqualification to days. August is a 31-day month, so 31 X .0242537 = .7518647 days, which is rounded down to .75. The partial day (.75) is dropped and there are zero full months, resulting in no disqualification.

Even though gifting the money was a disqualifying transfer, the amount was so small that there is no resulting penalty to serve.

Example 4: Recalculation of disqualification period after assets are returned

Joseph decides to give $100,000 to a family member to study abroad in August 2006. Combined resources were more than $2000 at the time. Joseph's date of request for Medicaid is November 10, 2006. This gift is determined to be a disqualifying transfer of assets and Joseph is disqualified through May 29, 2008. The family member does not spend the entire amount while studying abroad and returns $50,000 in March. The disqualification period must be recalculated. $50,000 ÷ $5,360 (from 461-140-0296) = 9.3283582. The .3283582 is converted to additional days by multiplying it by 31 (the number of days in the last full month, August). Therefore, 31 X .3283582 = 11.1044604 days. The partial day (.1044604) is dropped and the new disqualification period is November 10, 2006 through August 20, 2007.

Post-eligibility

OSIPM

Calculating the liability

Example 1: Mr. Smith has been found eligible for OSIPM while receiving nursing facility services. Mr. and Mrs. Smith's countable income is as follows:

Mr. Smith's gross monthly income consists of Social Security benefits of $1,000 and private pension of $800. Mrs. Smith's gross monthly income is SSB of $450. Mrs. Smith's monthly mortgage, taxes and insurance total $400 per month.

What are Mr. Smith's income deductions and adjusted income?

Follow the steps below:

Step 1: Deduct the standard earned income deduction. Because there is no earned income, Mr. Smith does not qualify for this deduction.

Step 2: Allow deductions under the plan for self-support. Mr. Smith does not have a plan for self-support. Therefore, there are no deductions to allow for this.

Step 3: Deduct one of the following needs allowances for Mr. Smith:

- $68.77 for residents of nursing facilities.
- $90 for residents of nursing facilities who are eligible for VA aid and attendance benefits. The $90 allowance is allowed only when the VA benefit has been reduced to $90.
- The OSIPM standard for one person, for individuals residing in a community-based care facility.

In Mr. Smith's case, the allowance is $68.77 for nursing facility care.

$1,800	Mrs. Smith's total income
-$68.77	Minus needs allowance

$1,731.23	Mr. Smith's available income

Step 4: Deduct a community spouse income allowance for Mrs. Smith. Calculate the community spouse income allowance as follows:

- First, calculate a maintenance needs standard for Mrs. Smith by adding the following amounts:
  - $2,288.75; PLUS
  - The amount over $686.63 that is needed to pay monthly shelter expenses for the Mr. and Mrs. Smith's principal residence. Monthly shelter expenses are rent or mortgage payments, taxes, insurance, required maintenance charge for a condominium or cooperative, plus the SNAP full standard utility allowance (FUA) for the spouse and eligible dependents.

Compute Monthly Maintenance Needs Allowance		
Monthly Maintenance Needs Standard		$2,288.75
Shelter		
Rent or Mortgage	$400	
Taxes/Insurance	n/a	
SNAP FUA	+$450	
Total Shelter	**= $850**	
Shelter Allowance	- $686.63	
Excess Shelter		+ $163.37
New MMNA (From SDS 450 Step 2b SUBTOTAL)		**= $2,452.12**

Compute Spouse's Total Available Income		
New MMNA (From SDS 450 Step 2b SUBTOTAL)		$2,452.12
Mrs. Smith's Gross Income	$450	
Monthly Community Spouse Income Allowance		**= $2,002.12**

Step 5: Deduct an amount for each eligible dependent whose monthly income is under $2,177.50. Determine the amount as follows:

- Subtract the eligible dependent's monthly income from $2,177.50; AND
- Calculate one-third of the amount remaining.

The Smiths have no eligible dependents and therefore do not qualify for this allowance.

Step 6: Deduct the cost of the following:

- Health insurance premiums (individual's portion only, if premium covers a spouse and/or dependent) prorated on a monthly basis; AND
- Other incurred medical expenses not covered by the State Plan, but recognized under state law code (e.g., dentures).

Mr. Smith does not have any of these medical expenses, therefore does not qualify for this deduction.

|

Step 7: Once Steps 1 through 6 are completed, code ONE with an LDS of either the calculated amount for the community spouse income allowance or the available income of the institutionalized individual, whichever is less.

Mr. Smith's available income ($1,731.23) is less than the calculated community spouse income allowance of $1,916.25, so the LDS amount is $1,731.23.

Mr. Smith's contribution toward the cost of care will be $0 ($1,800 - $68.77 - $1,731.23).

Mrs. Smith will have a total income of $2,181.23 ($450 + $1,731.23).

Note: For cases with no community spouse:

- The eligible dependent allowance is based on the TANF adjusted income standard. Use the individual and eligible dependents as the number in the need group to calculate the standard. (Individual plus 1 child =2). This amount is the eligible dependent's allowance.
- Do not reduce the TANF standard by the dependent's income, if any.

OSIPM Deciding to what extent to allow the CSIA

Example 1: A community spouse has $1,400.00 income and pays $600.00 rent and utilities. Currently the need standard is $2,288.75, the shelter standard is $686.63 and the SNAP full utility allowance (FUA) is $450.00.

$600.00 rent + **$450.00** FUA = $1,050.00 total shelter - $686.63 shelter standard = $363.37 excess shelter.

$2,288.75 need standard + $363.37 excess shelter = $1,925.38 total need - $1,400.00 spouse's income = $525.38 support (CSIA).

Therefore, $525.38 would be the appropriate CSIA amount if it is made available to the community spouse.

Example 2: **Zero CSIA - Individual refuses to pay support**

Cecil and Gerta are married but have been separated for 4 years, because they are on bad terms. The eligibility worker determines that Cecil is entitled to a $450 deduction from income for an CSIA. Cecil refuses to make this support available to Gerta. Cecil would rather (1) not get the deduction and (2) pay more income toward the cost of services. The worker allows zero CSIA because none of the CSIA is being made available to Gerta.

Example 3: **Zero CSIA - There is no benefit in transferring the money.**

George and his spouse Ethel are both on OSIPM in an assisted living facility. Their service costs are $942.00 each per month. George has $1,200.00 income and Ethel has $950.00 income. George could transfer $1,200.00 - $841.00 = $359.00 LDS to Ethel. If George did this, Ethel's income would be $950.00 + $359.00 = $1,309.00. Then Ethel's liability would be $1,309.00 - $841.00 = $468.00

If George and Ethel simply keep their own income and pay their liabilities, all the money, after deducting $841.00 each, is paid to the facility for the cost of services. If George transfers an LDS to Ethel first, the outcome is the same; all the available money after allowing the $841.00 is paid to the facility for the cost of services.

The worker allows zero CSIA because transferring the money results in no benefit to the couple.

Example 4: CSIA up to the OSIPM Standard - Results in Excess Maintenance Income (EMI)

Oswald and Lillian live in their own home and receive OSIPM services. Oswald has $2,000.00 income and services cost $400.00 per month. Lillian has $1,100.00 income and services cost $800.00 per month.

If Oswald makes available an CSIA of $161.00 to Lillian, the total income will then be $1,100.00 + $161.00 = $1,261.00 (Two-person OSIPM Standard) leaving zero income to pay toward the cost of services. Oswald will be left with $2,000.00- ($161.00 LDS + $1,341.00 OSIPM in-home maintenance standard) = $498.00. Oswald pays $400 for cost of services and is left with $98.00 EMI.

Although Lillian would be entitled to $2,000.00 - $1,341.00 = $659.00 LDS from Oswald, this would give Lillian a total of $1,100.00 + $659.00 = $1,759.00 income. After allowing $1,341.00, Lillian would have $418.00 to pay toward her $800 cost of services, resulting in zero EMI for the couple.

The worker allows an CSIA of $161.00 on Oswald's OSIPM case to bring Lillian's income up to the OSIPM standard, because making only part of the potential CSIA available results in $98.00 EMI. The worker also codes $161.00 of other income on Lillian's case.

Example 5: Partial CSIA is a benefit for other reasons

Leonard is on OSIPM, in a nursing facility and receives $390.00 income per month. Leonard's spouse Opal is on QMB with $800.00 income. Leonard has $390.00 - $68.77 personal needs = $321.23 available for an CSIA. If that amount is made available to Opal, income received would increase to $800.00 + $321.23 = $1,121.23. Opal would no longer be eligible for QMB, which pays Medicare copays, deductibles and Part B premium. Opal states that these costs exceed $321.23 each month.

The worker allows Leonard a partial CSIA deduction of $274.00 so that Opal will continue to be eligible for QMB ($800.00 income plus $274.00 CSIA = $1,074). Leonard pays the remaining $57.23 ($390.00 income minus $68.77 PIF and $274.00 CSIA) to the facility for the cost of services. The worker also codes $274.00 of other income on Opal's QMB case.

OSIPM Medical Costs

Example 1: Brenda paid a $50 medical bill on April 28th and provided proof on May 3rd. Approve a $50 medical deduction for the month of April.

Example 2: Tyler provided proof of a $100 medical bill he incurred in May and stated he would be paying it in full in June. The deduction was added for June. In July, he provided a bill from the same provider showing $150 in newly incurred costs along with the original $100 as unpaid. Allow only the new $150 deduction.

Example 3: In June, James provides proof of a payment plan for an allowable medical cost. He will be paying $200/month for three months starting July 1st. This amount is more than his liability of $150, but James states the hospital won't take any less. Code $150/month for three months, July-September.

Example 4: Alice is determined service eligible and approved for March through February of the following year with a liability of $150/month.

1. At application on March 8th, Alice provides proof of an allowable medical cost that she charged to a credit card on December 18th. She shows that the original cost was $500, the entire amount was charged to the card, and she has been paying $100 on the first of each month to the card starting in January.

Original cost	$500	
Prior payments	-$200	
Original cost remaining	$300	
Deduction coded	$100	March - May

$100/month deduction is allowed for 3 months even though the balance of the credit card may not be paid off due to interest, fees, or other charges.

2. April 20th, Alice provides proof that she charged another $1500 for an allowable medical cost to her credit card along with $300 in non-allowable costs. She intends to continue paying the same $100/month to the card.

Deduction balance	$100	
Additional deduction	+$1,500	
New deduction balance	$1,600	
Deduction coded	$100	through August of next year

3. In March, Alice provides proof that she paid off her credit card using her tax returns. The deduction is removed for April.

Example 5: Ally takes four name brand and two generic drugs consistently each month. At $5 and $2 co-payments, the amount of $24 can be anticipated until the next renewal and adjusted if the Ally reports a change in prescriptions.

Example 6: Tran has unstable medical conditions and changes prescriptions each month. Tran's costs cannot be anticipated, so he needs to report costs monthly and the liability requires adjustment monthly.

Example 7: Xavier pays a $30 co-payment every three months for a 90-day prescription. Convert by dividing $30 by 3 months and applying $10 per month to the anticipated costs projected until the next renewal.

Example 8: Willis is approved for OSIPM and services on 5/1/16. He has been residing at Happy Home ALF since February 1, 2016 but wasn't able to manage his money. As a result, he has an outstanding balance of $12,000 for the three months he was a private-pay resident. The all-inclusive rate was $4,000 and it covered room, board, and his ADL care. The facility administrator said there was no way to itemize for its private pay residents; therefore, $608 should be subtracted from the $4,000 rate for each of the three months. $12,000 - $608 - $608 - $608 = $10,176 total allowable costs. He agrees to make $500 payments to the ALF until it is paid off. $10,176 divided by $500 is 20.352. This means that a $500 medical cost should be applied for 20 months and $176 for the last month.

Chapter 2, section 11: Medical Related Payments (MRPs)

Accommodation allowance

OSIPM

Medical Costs

Example 1: **Temporary absence**

Pat is an OSIPM recipient whose income is $935.00 per month in SSB. Pat rents an apartment for $600.00 per month. In addition, Pat pays for all utility costs. A homecare worker provides Pat with 50 hours of care per month. Pat has a stroke on April 29 and spends four days in the hospital followed by a nursing facility admission for physical therapy and occupational therapy. Pat's doctor expects that Pat can go home after meeting certain therapeutic benchmarks and opines that these benchmarks will be met within 60-90 days of admission to the nursing facility. When the benchmarks are met, Pat will be physically able to return to the apartment and resume receiving care from the homecare worker.

$600.00 Rent + $341.00 Limited Standard Utility Allowance = $941 accommodation allowance payment

Example 2: Disability accommodation

Sasha is an OSIPM recipient who receives SSI. Sasha is paralyzed from the waist down but lives alone in a ground-floor one-bedroom apartment with a wheelchair accessible shower, widened doorways, and lowered counter tops. This apartment's accommodations allow Sasha to live independently. Sasha's apartment is one of four such accessible units in the apartment complex. The four accessible units rent for $600.00 per month. Sasha has provided a copy of a letter from the property management company stating that the other standard units in the apartment complex rent for $475.00 per month.

$600.00 rent for accessible apartment - $475.00 rent for a standard apartment = $125.00 accommodation allowance payment

Example 3: Additional bedroom for homecare worker

Angel is an OSIPM and in-home service recipient whose income totals $1175.00 per month in SSDI. Angel requires full assistance in mobility, eating, bath/hygiene, elimination, and dressing/grooming and is independent in cognition. Angel has several family members who are able to provide care during the daytime, but typically requires 12-16 hours per day of service from homecare workers throughout the night. Particularly, every 3 hours Angel needs to be repositioned and to have an undergarment change. Each occurrence takes approximately 15 minutes. Because a homecare worker needs to be available throughout each night, and because Angel's service needs can be scheduled, many of Angel's homecare workers work overnight. Angel has a 2-bedroom apartment, so the overnight homecare workers can sleep there. Angel's rent is subsidized through Section 8, and the unsubsidized rent is $1,200.00 per month. Angel's actual subsidized monthly rent payment amount is $342.60.

$342.60/3 = $114.20

$114.20 One-third of Angel's monthly rent cost + $341.00 Limited Standard Utility Allowance = $455.20 accommodation allowance payment

Special diet allowance

OSIPM **Example 1:** An individual provides the necessary documentation from an ODHS|OHA approved medical authority and from a licensed dietitian showing that they need an increased amount of high-quality protein, in this case the dietitian states they need 8oz of lean chicken breast a day and can no longer receive their protein from 6oz of ground beef a day, which they are currently purchasing for $25 a month, verified by receipt. The individual provides a recent receipt from their local grocer showing chicken breast is $4/lb and the individual states they will need $60.20 a month for the chicken breast. Because the individual will no longer be spending $25 a month on ground beef, the worker subtracts this from the amount needed and issues a Special Diet Allowance of $35.20.

$4/lb ÷ 16oz in a pound = $0.25 per oz.
$0.25 per oz. x 8oz a day = $2 a day
$2 x 7days = $14 a week
$14 x 4.3 = $60.20 a month

$60.20 - $25.00 = $35.20 special diet allowance

Chapter 3, Processes and procedures

Section 1: Periodic Report, SNAP only

Periodic Reports are sent for 12- and 24-month certifications as follows:

- For cases in a 12-month certification, the report will be sent out by the system on 1st of the 5th month, and it will be due by the end of that month. If not turned in by the end of the 5th month they will receive a warning notice that their benefits will end. The SNAP case will close at the end of the 6th month if the report is not turned in. Cases that have not been processed by the end of the 6th month will discontinue.
- For cases in a 24-month certification without earned income, the report will be sent on the 1st of the 11th month, and due by the end of that month. If the report is not turned in by the end of the 11th month, a warning notice is sent that their benefits will end, and the case will close at the end of the 12th month. Cases that have not been processed by the end of the 12th month will discontinue.
- For cases in a 24-month certification with earned income, the report will be issued on the 1st of months 5, 11, and 17, due by the end of the same month. These cases will need to submit a periodic report at these 6-month intervals after earned income is added to ONE. If not processed by the end of the 6th, 12th, or 18th month, SNAP will discontinue.
- A signature is required to process this report.
- This means even if the Oregonian is not reporting any changes, they would still need to check that box indicating “no changes” and still sign the form.

The Periodic Report will be requesting information about the following changes from the SNAP household:

- All changes in HH composition, such as the addition or loss of a HH member
- If the HH has moved the form will ask for updated information on the new shelter costs and utility costs if any.
- It will also request information on the new address and any new contact information
- Changes in the source of income, so a different source than what was entered into ONE
- Changes to the amount of income
- If someone joins the filing group and has income, this is a new source, and we will need verification of their income
- Verification is required when the total of all earned income changes by more than $125 per month from the amount currently used in the SNAP budget.
- Verification is required when unearned income changes by more than $125 per month from the amount currently used in the SNAP budget.

SNAP

Example 1: Melissa returned her Periodic Report timely, signed, marked the box 'I do not have any changes to report' and left the rest of the form blank. All income and deductions on the case remain the same until the next Periodic Report, renewal, or reported change. These include the excess shelter deduction or homeless shelter deduction, medical and childcare deductions, and court ordered child support already recorded in ONE.

Example 2: Jordan returned his Periodic Report timely, but reported his earned income increased by $550 a month. His earned income in ONE was currently below 130% FPL but the earned income reported on his Periodic Report moves him above 130% FPL. ONE will send an RPI requesting verification of his new earned income.

Example 3: Betty is sent a Periodic Report on the first of August, due the end of August. August is the 5th month in her 12-month cert period. No response is received, and on September 1st ONE sends a reminder notice of the extended due date of 9/10. She does not respond, and a decision notice is later issued, letting her know her SNAP case will close September 30. Betty then sends in her completed and signed Periodic Report on September 16, indicating 'I do not have any changes to report'. Her SNAP will continue through the end of the 12th month of her certification period.

Example 4: Leiloni is sent a Periodic Report on the first of August, due the end of August. No response is received, and on September 1, ONE sends a reminder notice of the extended due date of 9/10. She does not respond, and a decision notice is later issued letting her know her SNAP case will close September 30. October 5, Leiloni sends in her completed and signed Periodic Report. SNAP is to be restored to continue the certification period and October benefits will be prorated from 10/5.

Example 5: Ani is sent a Periodic Report on the first of August, due the end of August. No response is received and on September 1, ONE sends a reminder notice of the extended due date of 9/10. He does not respond, and a decision notice is later issued letting him know his SNAP case will close September 30. November 5, Ani sends in his completed and signed Periodic Report. Because it was not received before the end of October (discontinuance month), it is treated as a new request for SNAP and November 5 is the filing date. Ani must complete the application process.

Example 6: Pedro sends in his completed Periodic Report with information that his earned income has increased from $1000 to $1400 a month. He does not include income verification. Because the increase is more than $125, verification is required, and ONE will send an RFI.

Example 7: Ozzie sends in his completed Periodic Report with information that he is now married and requests SNAP for his new wife and her child. Ozzie reports that she has earned income but no verification is provided. ONE will issue an RFI.

Section 2: Acting on reported changes

Medical Reporting Requirements

Individual program example(s)

OSIPM **Prospective Changes**

Example 1: Dixie calls ODHS|OHA on May 12 to report winnings in the amount of $5,000 received on May 5. Dixie tells ODHS|OHA she has already spent all of her winnings. Even though the winnings exceed the $2,000 OSIPM resource limit, since the resource is already gone, there is no action to take on the case. Looking prospectively ahead to June, a reduction would be inappropriate.

Example 2: Dixie calls ODHS|OHA on Nov 19 to report a family member will be moving into the home on Dec 5. The family member meets all eligibility requirements for OSIPM. The family member is added to Dixie's case and OSIPM is approved effective Jan 1.

Adding or removing a household member

Individual program example(s)

ERDC **Example 1:** Nonie went into labor on Feb. 27. She contacted the ODHS branch office on March 2, to report the birth of the baby and her maternity leave. Nonie also states she will have less income for March. The March billing form can be adjusted. Verification of actual March, and her expected income during her maternity leave is needed. Pend using a DHS 0210A for required verification. Once it is received, the March billing form can be canceled and reissued with the lower copay. The AML coding is N/R AML 5/20.

OSIPM **Adding a New Person**

Example 1: Mrs. Harris is an SSI recipient and receives OSIPM. On June 19, Mrs. Harris reports that her estranged husband will move back into the household on June 27. Mr. Harris also receives SSI and requests medical benefits. All of his eligibility requirements are met on the day he moves in and are verified on July 5. The effective date is June 1. A basic decision notice approving benefits is system-generated.

Income changes

Individual program example(s)

ERDC **Example 1:** Sam lost his job on Dec. 30. He had anticipated the job loss would occur, so Sam had been looking for a new job. He was hired at his new job on Dec. 31. He reported the job change to ODHS on Jan. 4. At his new job, he is working more hours, but is paid at a lower rate causing his monthly income to be less. Because Sam reported timely his case can be updated effective January and the January CCB can be canceled and reissued with the higher hours and lower copay. Verification of income is needed before changes can be made, pend using a DHS 0210A.

Authorized work search (AWS)

Individual program example(s)

ERDC **Nonspecific return to work date**

Example 1: Larry calls his ODHS office on Jan. 23 to report he is no longer working due to layoffs and expects to be called back in two to three months. The worker completes a "Report a Change" action and on the income screen, selects "yes" to the question "Is the individual temporarily on leave from employment without pay?". They should enter March on the "expected date of return" question because this the shortest time period. In March Larry calls the office and says he is still not back to work. The worker can extend the "expected date of return" to April based on Larry's original statement.

Example 2: Margie contacted her worker on June 13, stating she was laid off for a month. The worker entered the layoff in ONE with a return to work date of July 13, and the system approved AWS through July 31. In July, Margie called and reported she had not returned to work and was told it would be another two months. The worker updated the return to work date to Sept. On Sept. 25, Margie called again and reported she had not yet returned to work and was told at least another two months. The worker entered the return to work date again as Nov., which caused the system to send an RFI for verification of the return to work period, with a due date of Oct. 12. AWS was extended through Oct. 31.

If information verifying the return to work is not received, the case will auto close on Oct. 31.

ERDC Coding examples

Example 1: Mia called her ODHS office and reported she lost her job on Aug. 15. The worker asks Mia if she was fired, quit, laid off, or has a break in work. Mia states she was told she was laid off but does not have a call back date. The worker updates Mia's case with the employment termination information which grants Mia AWS through Nov., which is three months from the last month worked.

Example 2: Karla calls her ODHS office and reports she was laid off July 25. The worker asks Karla if she was fired, quit, laid off, or has a break in work. Karla states she was laid off; her employer told her they should be calling people back about Sept. 23. The worker updates Karla's case with return to work date of Sept. 23. This puts the case into an AWS period through Sept. 30.

ERDC When a job loss or temporary break in work occurs in months 10–12

Example 1: Robert calls to report he was laid off on Dec. 12. His employer expects to call him back to work in April. Robert's end certification date is Dec. 31. AWS is granted through March by entering the lay off and return to work date in the system. If Robert returns to work between Dec. and March, he will need to recertify when he reports his return to work because his certification end date is Dec. If he does not return to work by March, his case will automatically close with timely notice. If the reservation list is active, Robert would meet the reservation list exemption of a break in benefits of less than two months even if he does not return to work until May.

ERDC Employment or return to work date in certification month 12 or one of the following 3 months due to AWS period

Example 1: The end certification date is July 31. The participant reported a job loss on May 5; the worker added the employment termination information which granted AWS through Aug. (One month past end certification date).

The participant reports on Aug. 20 they are employed. A new application will need to be completed because the recertification is due. If the participant received the recertification application in June and returned it to the office, that application can be used. If new job verification was not received, an RFI would be sent requesting income verification, hours and work schedule and anything else needed. The ERDC interview must be completed. Generally, this is done prior to the pend notice but can be completed after pended items are received.

The new certification period starts Sept. 1, if the participant meets all eligibility requirements.

ERDC When a job loss, lay off, or break in work is reported late

Example 1: If the job loss occurred in April, but was not reported until June, the third work search month is July. July is the only month AWS is granted and the copay is waived

ERDC Two parent families and AWS coding

Example 1: Parent 1 is employed. Parent 2 reported timely on May 5 they are no longer working. The worker determines good cause and adds the employment termination information to ONE. AWS is granted through Aug. Parent 2 reports on June 26 they have new employment and they are working more hours than the previous job. The worker enters the new employment information in the system and an RFI goes out requesting verification of work hours and work schedule. The verification comes in showing more work hours for the parent, but less of an overlap in work hours. The worker does not adjust the caretaker schedule in ONE.

- Remind the participants they must report income at or above the ongoing ERDC income limit;
- Allow for timely notice.

Example 2: Parent 1 is unemployed, with no return to work date. They reported timely on June 15; good cause was given. AWS is granted through Sept. On July 26 Parent 2 called to report they have been laid off. Their employer gave them a return to work date of Oct. 1.

AWS is granted for Parent 2, however the case will close at the end of September if Parent 1 has not returned to work. On Aug. 1, Parent 1 called to report they have a new job. If needed, verify hours or income. Update the case, which will remove AWS from Parent 1 and apply AWS to Parent 2. The copay will not increase since Parent 2 is still laid off. Parent 2 will need to contact ODHS before the end of October if they return to work or the case will close.

ERDC One-parent family becomes a two-parent family

Example 1: Dad calls on June 10, to report mom is now in the home. During the conversation the worker determines Mom returned in April. Mom is not employed. AWS is granted through July.

Authorized medical leave (AML)

Individual program example(s)

ERDC Maternity leave

Example 1: Participant is placed on bed rest five months into her pregnancy. Medical documentation will be required because the leave extends beyond three months.

ERDC Medical leave coding beyond end certification date

Example 1: Christy's ERDC end certification date is March 31. She contacted her worker on Jan. 25 to report she will be on maternity leave Feb. 1 through April 5. The worker will enter the information in the temporary leave without pay section on the Employment details screen for Christy's job which will grant AML through April 30. Christy will be required to complete her recertification in April to continue receiving ERDC. The Employment Related Day Care (ERDC) Re-Application and Supplemental Nutrition Assistance Program (SNAP) Application (DHS 7476) form will be mailed to Christy about Feb. 15.

ERDC Returning to work after AML

Example 1: Marylou has an open ERDC case. On Dec. 22, she reports she will be off work due to surgery. The worker asks Marylou if she will have any income changes while she is off work. Marylou states she will not receive any income from her job, but will continue to receive child support. The worker requests verification of the medical situation including diagnosis, prognosis and expected time off work. The verification received shows Marylou should be able to return to work on Jan. 15. The worker enters this information on the temporary leave without pay section and AML is given through Jan 31. Marylou's child care billing form will most likely need to be canceled and reissued for January by emailing DPU. The reporting date of Dec. 22 may not give her enough time to get the verification by compute deadline.

Marylou's return to work: Marylou calls Jan. 16 to report she did return to work. The worker tells Marylou she will add the income from her job back on her case and notification will be sent of the change. If Marylou had stated her income has changed since she went on medical leave the worker would need to ask if change in income is more or less than it was prior to the medical leave. If the income is more, no action is taken, if it is less the worker will add an income record in ONE and an RFI for verification will go out.

Authorized military transition (AMT)

Individual program example(s)

ERDC **Example 1:** Sam returned home on March 25. His wife Sheila reported to ODHS on May 10 that he had returned to the home. The worker determined Sam and his family meet the criteria for Authorized Military Transition (AMT). The return home date was March 25, and the first month of AMT is April. Six months is allowed, which gives an AMT date of Sept. The copay waiver is not effective until June 1, because the change was not reported until May.

If the report had been received in March, the AMT copay waiver would have been effective April 1 (the end date of Sept. for AMT is the same).

Chapter 3, section 4: Individual loss and restoration of benefits

Negotiated check replacement procedures

Example 1: In the process of issuing cards to several individuals, the card issuer enters a card number on Mary Munro's case but assigns the card to Bad Pitt and helps Bad select his PIN. Bad Pitt's case was in pending status and with no benefits but Mary Munro has available both TANF and SNAP benefits. Bad Pitt takes his new card (on Mary Munro's case) and leaves the office. To Bad's delight, he finds both cash and food benefits available and promptly depletes both accounts. ODHS|OHA realizes the error after Bad emptied both accounts. ODHS|OHA deactivates Bad's card, issues a card and PIN to Mary, and replaces the amount of lost benefits.

Example 2: Tobey reports on May 15 that his brother, William, has left the household. ODHS|OHA removes William from the case effective June 1 but fails to note that he is an alternate payee. In June, William continues using Tobey's benefits. Because ODHS|OHA failed to cancel William's access to Tobey's benefits, we must restore the loss to Tobey.

Chapter 5, Temporary Assistance for Domestic Violence Survivors (TA-DVS) Program

Section 1: Intent and overview of program

SSP definition of domestic violence

Example 1: Soto and her children are living with two other individuals. Soto is in the office applying for TA-DVS.

The worker asked Soto what has occurred to bring her in to the office. Soto explains that landlord/roommate has been informing her for the past few months that if she does not clean the house to his approval, he will not allow her to access the refrigerator for food, so she has been storing food away in her room. The reason she is in today, is that last week, Jim attacked her for not doing his laundry and she fears what he may do in the future. The worker determines that Jim is a household member and the situation Soto is describing meets the TA-DVS policy on domestic violence.

Example 2: Desiree is in the office applying for TA-DVS. She informs her intake worker that recently her neighbor Angie has been harassing her. Desiree states that Angie is accusing her of weird things and threatening her. Desiree does not feel safe and would like to move. The worker confirms with Desiree that she has never lived with Angie, they are not relatives and they are not intimate or past intimate partners. The worker explains to Angie that even though her situation does sound unsafe and scary, her situation does not meet TA-DVS policy. The worker denies Desiree's request but offers her the opportunity to speak with co-located advocate and offers resources in the community.

Example 3: Cindy is in the office applying for TA-DVS. She reports that her brother Bobby became angry with her regarding her not paying her half of the rent this month. As the argument escalated, he physically assaulted her. She states that this has never happened before and there has been no history of abuse or controlling behavior before this incident. This situation does not meet the SSP definition of domestic violence, as this is a one-time incident due to no pattern of domestic violence.

Example 4: Veronica comes into the office to apply for TA-DVS. She reports that she works at a convenience store during swing shift. Recently, a man had been coming in and verbally threatening her, so she called the police. The night after calling the police, she was walking to her car after work and was assaulted by this man. She called the police again and he was arrested. He is getting out of jail in a few days and Veronica no longer feels safe where she is living. The worker determines the man who assaulted Veronica does not meet the relationship criteria for TA-DVS, so the request is denied. The worker provides Veronica with other appropriate resources and co-located advocate information.

Example 5: Ilvan is in the office applying for TA-DVS. He was recently evicted from his apartment due to no fault of his own. TA-DVS funds were used to help him move into the apartment two years ago. Ivan states that he is worried that if he is without a stable place to live, his abuser may be able to find him and his daughter. Through conversation, the worker determines that Ivan and his daughter are now having to stay with family and his abuser knows where the family lives and has been driving by the house. In the past, the abuser has verbally and physically assaulted him when he stayed with his family and he is afraid this will happen again.

Because the abuser has located them and has continued use of tactics known to the survivor as threatening behavior, there is a future risk of domestic violence. the worker approves the TA-DVS request.

Example 6: A parent applies for TA-DVS because their 17-year-old daughter is in a domestic violence relationship with their 17-year-old boyfriend. There are reports of ongoing verbal and emotional abuse, and the family needs to flee. There is a domestic violence safety concern for a minor child in the filing group. This situation is eligible for TA-DVS.

If a mandatory report is required, consulting with Child Welfare could be a valuable addition to safety planning.

Example 7: A parent applies for TA-DVS because they learned their minor child is being sexually assaulted by their

uncle, the father's biological brother. This has happened multiple times, whenever the uncle provides child care, and the family needs to flee. There is a domestic violence safety concern for a minor child in the filing group. This situation is eligible for TA-DVS.

If a mandatory report is required, consulting with Child Welfare could be a valuable addition to safety planning.

Chapter 5, section 2: Application

Application time frames

Example 1: Sarah comes in at 4:00 p.m. on Friday afternoon and applies for TA-DVS. There are no intakes available same day. Assess what the safety concerns are and make sure that, at a minimum, the survivor is safe and can return for their TA-DVS intake next business day. ODHS completes the TA-DVS Safety Screening form (DHS 7802) and narrates.

Example 2: Amber's application for TA-DVS was received 2/15 at 4:30 pm and reviewed for safety. Front staff notates that Amber needs her TA-DVS eligibility determined within 16 working hours. Amber is scheduled for 2/16 at 10:00 am. This is an acceptable scheduling of an intake because Amber will be seen, and her eligibility will be determined within the 16 working hours.

Example 3: Joseph is applying for TA-DVS on 4/1. Front staff asks Joseph if he is available for an intake later today. Joseph replies that he is safe and unable to come back to the office until 4/12. The worker schedules Joseph for 4/12 and narrates that Joseph requested his TA-DVS intake on a later date and he is safe. On 4/12 the intake worker will need to determine Joseph's TADVS eligibility within 16 hours of the date of intake time.

Certification period

Example 1: Jacyln contacts her worker on the 90th day of her TA-DVS eligibility period. She is wondering if her worker will extend her a few more weeks, so she can locate housing. She states that she has not had any luck finding a place to rent. The worker explains to Jacyln that there are no extensions. Her TA-DVS is ending today and if there is still a safety concern, Jacyln will need to reapply.

Example 2: Blake has an open TA-DVS case and the 90th day is in two months. Blake came in to the office today to request use of the $1200.00. He has located a safe housing and is ready to move in. ODHS makes payment for the housing. A month passes and Blake returns to the office requesting more TA-DVS funds, because the home he has moved into is not safe anymore. The worker explains to Blake that he has accessed the $1200 fund and his 90-day eligibility period will not expire for another month. The worker offers Blake other resources in the area and again offers Blake the option to meet with the co-located advocate.

Example 3: Jessica is approved for TA-DVS and uses $700.00 of her funds to move to a safe location in Nebraska. Once she has left Oregon and relocated, the worker closes her TA-DVS case as no further funds can be issued once she is no longer an Oregon resident. Two weeks later, her abuser locates her and the survivor flees and returns to Oregon. She is still within her original 90-day certification period and there is a domestic violence safety concern. The worker will review for TA-DVS eligibility and reopen her case for the remainder of the 90-day certification period.

Incomplete application process

Example 1: Soto was meeting with her intake worker for TA-DVS. During the intake Soto became distraught and requested to leave. She did not want to continue with the interview and walked out. In this situation, because we do not have a completed interview, we do not have enough information to determine TA-DVS eligibility. Hold the application for 30 days and narrate the situation. We can try to call Soto to reschedule, if we have a safe phone number.

When a new application is required

Example 1: An applicant comes in and is denied TA-DVS because there is no child in the home, and we are unable to determine when the child will be returned. If the applicant returns a week later and the child is now in the home, the applicant needs to complete a new application.

Narration

Example 1: Deborah applied for TA-DVS against her abuser, Brad. Brad is her ex-boyfriend. She reported during their relationship there was ongoing verbal abuse and financial abuse. He would control all her income and gave her an allowance. She reported once she left, he threatened physical violence. She has ongoing safety concerns that he will act on his threats and would like to flee.

Example 2: Amber is applying for TA-DVS against her abuser, Ryan. Ryan is her boyfriend of two years. Amber reported Ryan has always controlled all the money in the home. Her paycheck is deposited to his account. When she uses the money for even basic needs, he becomes physically violent and has threatened to kill her. She is concerned this will not stop and he will act on his threats.

Confidentiality

Example 1: Survivor asks for person alias because his abuser is the sister of a community partner. The community partner does not have access to our systems. There have not been threats that the community partner will look at survivor's case. Receiving benefits is not a safety issue. Naming the abuser is the safety concern. ODHS can store the DV narrative in a hard file and open the case as normal or narrate the DV intake and keep the abuser name in a hard file.

Example 2: Survivor asks for person alias because she has been tracked in six different states by her abuser. Her abuser works for military and has clearance to see statewide systems. Using her SSN in the last two states is how she was located. She cannot have her information in the system, because he can locate her SSN, then track where her information is being used. This case is approved for Person Alias.

Subsequent requests

Example 1: Karilyn was approved for TA-DVS in January. Her TA-DVS grant was approved from January to March. In February, Karilyn was approved to use $800 for first month's rent. In March of the following year, Karilyn applied for TA-DVS again. The request would need to be staffed jointly with Central Office because she received payment in the last 12 months, due to the final month of her eligibility period.

Authorized representatives and payees

Example 1: Jason comes into the office to apply for TA-DVS and explains he does not have a phone and wants

his mother, not the abuser, to have access to his case information when he requests payments. His worker talks with Jason and determines his mother is a safe person for him and it could benefit him to have someone with a phone call in regarding the status of his payment requests. Even though his mother is a safe individual based on conversation with Jason, she cannot be his authorized representative or payee on the TA-DVS case.

Instead, the worker offers for Jason to complete a Release of Information (MSC 3010) detailing that his mother can receive phone communication only from ODHS regarding Jason's situation with payment requests.

Chapter 5, section 3: Eligibility groups

Household group

Example 1: Jane is applying for TA-DVS in March and she states to her worker that both she and the father share custody, 50/50. The worker asks Jane what the parenting schedule looks like, do the parents truly split the child 15.5 days each. Jane chuckles and says no. She states that depending on her ex's work schedule and their child's social life this would dictate on who has the child more. Jane states that she has the child the majority of the time, but they try to keep as close to 50/50 as possible. Jane is potentially eligible for the TA-DVS program.

No children in the household

Example 1: Oscar is applying for TA-DVS and he states that he and his ex-wife have 50/50 custody of the children. The worker asks Oscar to explain the 50/50 schedule. Oscar states that he is currently house jumping due to the DV situation and his ex-wife has the child more than the 50/50 of recent. The worker asks that if Oscar was stabilized and safe in housing would the arrangements for the children still 50/50. Oscar states that if he was safe, the custody arrangement would be six days with him and six days with his ex. The worker asked if there is an extra day in the month who has the children. Oscar states that he normally does because he is not working currently. The worker determines that Oscar does have the children more than 50/50 and is potentially eligible for the TA-DVS program.

Example 2: A woman who has just left an abusive situation may need cash to help establish a new home before she can regain physical custody of her children from child welfare. The worker may decide to waive the requirement for a dependent child to live with her, if it is reasonable to assume that her children will move into her new home once she has secured it through a down payment or deposit. Such decisions should be based on intensive case management and be well documented in the case file.

Example 3: Scott is in the office applying for TA-DVS and during the intake, he states that his son was removed from the home by Child Welfare due to the domestic violence. Scott believes his son will be coming home as soon as he is able to locate safe housing. Since Scott has met all eligibility requirements, his TA-DVS is approved.

Abuser in the household

Example 1: Lourdes goes into her local ODHS office and submits a signed application for TA-DVS. Her safety is taken in to consideration and she is scheduled an intake the same day. On her application, she reports she still lives with her husband, the abuser. The worker will exclude the abuser from the household group.

Filing group

Pregnancy

Example 1: Talia comes into the office and applies for TA-DVS. Talia is five months pregnant, does not have any other eligible children, and does not have verification of proof of pregnancy. If Talia meets all other TA-DVS eligibility, we can approve her for the TA-DVS grant. No payments may be issued until we receive verification that Talia is pregnant.

Chapter 5, section 4: Individual information

Residency

Example 1: Carl recently moved to Oregon and set up a PO Box. He is in the office today requesting help with his DV situation. Carl states that his abuser located him in Oregon and he needs to flee the state. The worker determines that Carl meets all eligibility requirements, even though Carl plans on moving out of Oregon. The worker approves TA-DVS.

Example 2: Judah and his son fled had to flee from their family home over the weekend, away from Judah's abuser. He was able to locate a domestic violence shelter in Washington state as he lives close to the state border. He can stay at the domestic violence shelter until he can obtain safe and stable housing. He goes to a nearby ODHS office in Oregon to apply for TA-DVS. Judah meets residency requirements for TA-DVS as he is only out of the state for temporary safe shelter.

Chapter 5, section 5: Financial eligibility

Countable income

Example 1: Rosa is applying for TADVS and she states that she was paid last week but her partner emptied out their bank account. The worker reassures Rosa that the pay she received will not be counted against her in determining eligibility.

Example 2: Andrew is applying for TADVS with his two children. He states that he just received $733.00 in SSI income. The worker asks Andrew if he has access to the SSI and Andrew states that he does. He plans on using $250.00 for a hotel for himself and children. The worker explains since Andrew is using $250.00, we will only count $483.00. The worker looks at the countable income limit for three people and notes that $483.00 is below the countable income standard and Andrew is eligible for the TADVS program.

Chapter 5, section 6: Non-financial eligibility

Need to meet SSP definition of domestic violence

Verification of domestic violence

Example 1: Soto and her children are living with two other individuals. Soto is in the office applying for TA-DVS. The worker asked Soto what has occurred to bring her in to the office. Soto explains that landlord/roommate has been informing her for the past few months that if she does not clean the house to his approval, he will not allow her to access the refrigerator for food, so she has been storing food away in her room. The reason she is in today,

is that last week, Jim attacked her for not doing his laundry and she fears what he may do in the future. The worker determines that Jim is a household member and the situation Soto is describing meets the TA-DVS policy on domestic violence.

Example 2: Desiree is in the office applying for TA-DVS. She informs her intake worker that recently her neighbor Angie has been harassing her. Desiree states that Angie is accusing her of weird things and threatening her. Desiree does not feel safe and would like to move. The worker confirms with Desiree that she has never lived with Angie, they are not relatives and they are not intimate or past intimate partners. The worker explains to Angie that even though her situation does sound unsafe and scary, her situation does not meet TA-DVS policy. The worker denies Desiree's request but offers her the opportunity to speak with co-located advocate and offers resources in the community.

Example 3: Chelsea comes into the ODHS office on Monday and applies for TA-DVS against her boyfriend, Joe. Chelsea meets TA-DVS eligibility and is approved. On Tuesday Joe comes into the ODHS Office and applies for TA-DVS against Chelsea.

At this time, we need to determine whom the survivor is.

Joe's TA-DVS application is pended with a DHS 210 for verification that he is not the perpetrator of domestic violence. His case will not be approved without verification.

Chelsea's case is also pended, DHS 210A for verification that she is not the perpetrator of domestic violence. No payments can be made without verification. The case will close with the Notice of Decision and Action (DHS 456) taken if Chelsea does not respond to the DHS 210A timely.

Example 4: Cindy is in the office applying for TA-DVS. She reports that her brother Bobby became angry with her regarding her not paying her half of the rent this month. As the argument escalated, he physically assaulted her. She states that this has never happened before and there has been no history of abuse or controlling behavior before this incident. This situation does not meet the SSP definition of domestic violence, as this is a one-time incident due to no pattern of domestic violence.

Example 5: Veronica comes into the office to apply for TA-DVS. She reports that she works at a convenience store during swing shift. Recently, a man had been coming in and verbally threatening her, so she called the police. The night after calling the police, she was walking to her car after work and was assaulted by this man. She called the police again and he was arrested. He is getting out of jail in a few days and Veronica no longer feels safe where she is living. The worker determines the man who assaulted Veronica does not meet the relationship criteria for TA-DVS, so the request is denied. The worker provides Veronica with other appropriate resources and co-located advocate information.

Example 6: Ivan is in the office applying for TA-DVS. He was recently evicted from his apartment due to no fault of his own. TA-DVS funds were used to help him move into the apartment two years ago. Ivan states that he is worried that if he is without a stable place to live, his abuser may be able to find him and his daughter. Through conversation, the worker determines that Ivan and his daughter are now having to stay with family and his abuser knows where the family lives and has been driving by the house. In the past, the abuser has verbally and physically assaulted him when he stayed with his family and he is afraid this will happen again.

Because the abuser has located them and has continued use of tactics known to the survivor as threatening

behavior, there is a future risk of domestic violence. the worker approves the TA-DVS request.

Example 7: A parent applies for TA-DVS because their 17-year-old daughter is in a domestic violence relationship with their 17-year-old boyfriend. There are reports of ongoing verbal and emotional abuse, and the family needs to flee. There is a domestic violence safety concern for a minor child in the filing group. This situation is eligible for TA-DVS.

If a mandatory report is required, consulting with Child Welfare could be a valuable addition to safety planning.

Example 8: A parent applies for TA-DVS because they learned their minor child is being sexually assaulted by their uncle, the father's biological brother. This has happened multiple times, whenever the uncle provides child care, and the family needs to flee. There is a domestic violence safety concern for a minor child in the filing group. This situation is eligible for TA-DVS.

If a mandatory report is required, consulting with Child Welfare could be a valuable addition to safety planning.

Safety concern

Example 1: Brittany applied for TA-DVS against her ex-boyfriend, Francis. Brittany reported she and Francis got into a fight last week. He left the home and has not spoken with her since. When we ask if this has happened before, Brittany reported that the last time she and Francis got into a fight he left the home. He did not talk to her for two weeks and then he came back and the abuse heightened.

By asking about if this happened before and understanding the pattern, we can see why Brittany is concerned even though Francis has not talked to her in a week.

Safety plan

Example 1: Jordan applies for TA-DVS and is approved against her husband, Leo. Jordan reported that she has a job and will be getting paid next week. Jordan said she wants to move into a new location that Leo does not know and needs the $1,200.00 to help with move-in costs. Jordan also said she wants to file for divorce. She is referred to the ODHS DV Co-Located advocate to go with her to get the divorce paperwork and for further safety planning. Jordan's plan on the DHS 1543 is to look for a safe location, move into a new home that Leo does not know the location of, and to work with the co-located advocate. Jordan will use her paycheck to pay some of the move-in costs.

Example 2: Rachel is in the office applying for TA-DVS, and she is approved. She creates a DHS 1543) TA-DVS safety plan to move to another city in Oregon, to be closer to her mom.

Her immediate TA-DVS Plan is to contact her mother and start talking with her, work with an advocate to create a plan if the abuser shows up at her home before she can move and talk to the children's school about transferring. Her long-term TA-DVS plan is to find a location near her mom and move. Rachel will start working once she moves and plans to use the TA-DVS Grant for move in costs and a U-Haul.

Name of abuser

Example 1: Jona is in the office applying for TA-DVS and she is asked the name of the abuser. Jona is reluctant to tell her work his name. Jona's worker explains how ODHS|OHA documents that name, but it does not update the

system with the name or notify anyone. The abuser's name is not given to anyone that is not directly linked to the case, but more importantly, if ODHS knows his name, then we can hopefully help her in her safety. One example is if the abuser contacts Child Welfare and makes a false report, we would have in our case notes his name and the potential tactics he uses.

Chapter 5, section 7: Waiving eligibility requirements

What requirements can be waived

Example 1: Talia comes into the office and applies for TA-DVS. Talia is five months pregnant, does not have any other eligible children, and does not have verification of proof of pregnancy. If Talia meets all other TA-DVS eligibility, we can approve her for the TA-DVS grant. No payments may be issued until we receive verification that Talia is pregnant.

Example 2: Aliah is in the office applying for TA-DVS for herself and her daughter. She came to Oregon on a student visa 16 years ago. She has remained in the US beyond her visa eligibility period. Her daughter was born in Oregon and is a US citizen. The situation meets all other TA-DVS eligibility, citizenship requirements are waived for Aliah due to domestic violence related safety concern, and TA-DVS is approved.

Example 3: Lisa is in the office applying for TA-DVS for herself. She reports she is pregnant with her first child and is in her 3rd month of pregnancy. She has done a home pregnancy test and knows the date she conceived. Lisa meets all other TA-DVS eligibility. The requirement to be in her 9th month of pregnancy is waived. The worker approves TA-DVS and explains to Lisa that in order to access payments, she will need to provide verification of her pregnancy from a medical professional with her estimated due date.

What requirements cannot be waived

Example 1: Scott is in the office applying for TA-DVS. During the intake, he states that his only child was removed from his home by Child Welfare due to the domestic violence situation. Scott states that he is working with Child Welfare and believes his son will be returned to his care, once he stabilizes his living situation and obtains safe housing. The worker calls Scott's Child Welfare worker and is able to confirm that the reason the child is out of the home is due to the domestic violence situation, and that once Scott is stabilized his son will returned to his care. The worker approves TA-DVS eligibility and will need to reaffirm with the CW worker that the son will be coming into the survivor's care before approving payments.

Example 2: John is in the office today applying for TA-DVS. His girlfriend of two months, Katrina, is the abuser. John states that there has been a history of verbal and physical abuse, and he has fled with Katrina's 16-year-old daughter, Kylee. He is applying for TA-DVS for himself and Kylee. The worker determines that there is no caretaker relative relationship between John and Kylee, and John has no other children. TA-DVS is denied, the worker provides information for other resources and connects John to a co-located advocate.

Example 3: Ameer and her two children are in the office applying for TA-DVS. They came to Oregon last week, on a vacation to visit family from Texas. While they were here, Ameer disclosed to family that she is in an abusive relationship with her husband and wants to find a way to get her own place in Texas for her and the children. Because Ameer does not live in Oregon and was not fleeing to/through Oregon. , Ameer does not meet Oregon residency requirements and TA-DVS is denied.

The worker helps safety plan with Ameer, provides national resources, and information to co-located advocates locally for help with connection to other state resources as well as additional safety planning.

Chapter 5, section 8: Payments

Payment limit

Example 1: Alexis was approved for TA-DVS. Her safety plan was to get housing and she was waiting for her housing voucher. Alexis communicated this with her worker. Alexis got her housing voucher and her requested home passed inspection on day 88 of her eligibility period. Alexis got her rental agreement and brought to ODHS as soon as possible, at 4:00 on day 90 of her eligibility period. Her worker was not able to call the landlord and get the payment authorized before the end of the day. ODHS can make payment on day 91, because all information was received, and ODHS was unable to issue payment.

Example 2: Omar was approved for TA-DVS. His safety plan was to get housing and he was waiting for his housing voucher. Omar communicated this with his worker. Omar got his housing voucher and his requested home passed inspection on day 88 of his eligibility period. Omar got his rental agreement and brought it to ODHS a s soon as possible, at 4:00 on day 90 of his eligibility period. His worker was not able to call the landlord and get the payment authorized before the end of the day. ODHS can make payment on day 91, because all information was received, and ODHS was unable to issue payment.

Payment verification

Example 1: Sonoma is applying for TA-DVS. The worker can see that Sonoma has applied seven times in the past and has always claimed that she is pregnant. The worker verifies with Sonoma that she did not give birth to any children. Since the pregnancy is questionable, pend any payment requests for verification from a medical professional of the pregnancy. For benefit of safety planning for Sonoma, talk with her when the TA-DVS application is approved. Let her know before we can make any payments, we will need verification of her pregnancy from a medical professional. This gives Sonoma a chance to get verification before she needs a payment.

Example 2: Doreen turned in a rental agreement as request for payment. ODHS reviews the rental agreement and check's the assessor. ODHS determines the person listed as the landlord on the rental agreement does not own the home. ODHS calls the homeowner and discovers that the listed landlord is not authorized to sublease the home. Doreen's payment request is denied because once ODHS verified all information in her request, we learned the landlord was trying to help sublease to Doreen, inappropriately. We give Doreen a DHS 456 and help her to locate similar safe housing.

Issuing payments

Example 1: Honor has come to the office and requested a payment for a locksmith to help change out her locks quickly. The worker determines that the payment request will help meet her safety, her need to have this done today is due to the emergent situation and the worker verified that the costs to change the locks is reasonable. After verifying with the locksmith, the worker will complete the Authorization of Cash Payment (MSC 437) requesting a check out of office paid to the survivor. The worker explains that once the check is issued and given to the survivor, the check is now considered vested to the survivor.

Allowable payments

Shelter and relocation needs

Example 1: Carol was approved for TA-DVS. She intends to remain in her home because her abuser has been arrested for theft and domestic violence. Her abuser broke into her house, beat her up and took $500.00 she had set aside for buying money orders to pay her utilities. She has a utility shut-off notice for water and needs $200.00 to make the payment. Since the reason the individual cannot pay the utilities is related to the abuser's actions, we can make the payment to support stabilization. After a month or so, Carol brings in her electric bill. She is behind in payments, again due to the money the abuser took. She still has TA-DVS funds available. She receives SSI and will be able to pay future utility costs with those funds. We are not able to approve this request because it is a recurrent/ongoing expense. We would get Carol connected with community resources to address this need.

Example 2: George requested help to move to California. He has family there. His abuser has no idea where in California they live. He needs a U- Haul trailer and gas money to move, and since they live in southern California, he also needs to spend one night in a motel and will need food on the way. The worker issued a check to U-Haul, a pre-paid gas card to cover gas costs, and arranged to pay the motel. George will use his EBT card for food. (The abuser was not on the EBT card with George, so this does not present a safety concern.)

Example 3: Lupe requested help to purchase a travel trailer. She felt it would help her to be able to leave quickly if the abuser found her again. Program benefits for shelter do not include the purchase of travel trailers or other recreational vehicles. The worker denied the payment and provided the individual with a Notice of Decision and Action Taken (DHS 456) with the denial reason. The worker then referred Lupe to the local domestic violence program to see if they knew of resources that could meet her need. The worker told Lupe if she was able to find resources to pay for the trailer, we could help with costs for the space rent.

Example 4: Andy has come in to talk with her worker about the apartment she has located. Andy indicates that the monthly rent is more than her TANF grant. The worker asks Andy if she plans on meeting the ongoing rent since her TANF is only $432.00. Andy explains that her plan is to locate a roommate. Her worker adds the plan to locate a roommate on the DHS 1543.

Example 5: Miranda is requesting payment for two security cameras. One for each entrance to her home. She has already connected with the landlord and they will be installing them for her. She was able to relocate to a different apartment complex that her landlord also owns and is wanting to take additional safety measures to protect her family. The security cameras support the survivor's safety plan, and enhance ongoing safety, therefore the payment for cameras is approved.

Food

Example 1: Martina and her 3 children are fleeing to Virginia tomorrow morning on a train. The train trip will take 3 days to arrive at their destination. Martina used her SNAP benefits this month already on food for the home, however they had to leave it all when they fled. She requests to use $100.00 of her grant for snacks and meals during their travels. There is no community resource available for food that doesn't require refrigeration or a kitchen to cook, and the survivor has no other resource available. Payment for food is approved in this situation.

Roommates

Example 1: Jane and her daughter have been approved for TA-DVS. They are moving with a roommate to an apartment. Since Jane's roommate is not in the filing group, the worker will need to take the total move-in costs of $1,650.00 and divide by the whole household of three (1650.00/3=550.00). The worker will then multiply 550.00 by the benefit group of two (550*2=1100). The worker informs Jane that ODHS will help Jane with 1100.00 of the move-in costs and her roommate will need to pay the remaining cost of 550.00.

Example 2: Misty believes that if she and her friend Shawna move into an apartment together, that not only can she afford the monthly rent and utilities, she will be safer. Misty explains that Shawna is on SSI and receives a monthly check and at this time does not have any funds to help with the move-in costs, but Misty and Shawna discussed that Shawna will pay little bit more of the monthly rent until Misty locates employment. The worker determines that since rentals are hard to locate on a TANF grant alone and that Shawna is willing to pay more of the monthly rent until Misty locates employment and living together helps Misty to feel safe, that DSH will pay the full move-in costs.

Medical needs

Example 1: Katrina requested help with her prescriptions. She has applied for medical but because her abuser kept all her personal documents, she must wait until she can get a copy of her birth certificate from Idaho to get medical help. She has asthma and needs her medication to maintain her health. The worker issued payments to the pharmacy for Katrina's asthma medication. (Hint: Do not forget to code the special pay payment as a 2M payment instead of 22.)

Non-allowable payments

Example 1: Mary and her children went to the local domestic violence shelter with nothing but the clothes they were wearing. They are needing basic clothing and personal items. The shelter was able to help with hygiene items and a few used clothing items. Mary still needs some items that the shelter was not able to provide. After talking with her worker, Mary located the necessary items at a local department store. She asked them to hold the items. She brought an estimate to her worker for the cost and the worker verified with the department store that they would accept a state check. A check was issued to the department store.

Example 2: Lisa asked for help to pay for her attorney. Her abuser is trying to gain custody of the children. Program benefits do not include legal or attorney fees. The worker denied the payment, using the DHS 456 with the denial reason, and referred the participant to legal aid and the local domestic violence service provider that may know of attorneys willing to do pro-bono work in domestic violence cases.

Example 3: Natalia asked for help to pay for some replacement clothing for her children. When she left her home, the children only had the clothes they were wearing. She got some things from local resources, but winter is coming and she needs to get more warm items for the kids. Natalia needs verification of what she is wanting to get. A printout from the store of the clothing items she is looking at, showing that this is a cost-effective purchase, would be appropriate for verification.

Example 4: McKinley is requesting payment for self-defense classes. Her abuser has threatened he knows where she works, and she must walk a half mile to and from her vehicle each day before and after work. She found classes that will teach her to defend herself against an attacker. This payment request would not be allowable, as this would be considered using her body as a weapon. The worker denies payment and completes a DHS 456

Notice of Decision and Action Taken.

The worker safety plans with McKinley suggesting talking to her employer about relocation, alternate routes to and from work, walking in well-lit and busy areas, or walking in a group. The worker also refers McKinley to the local co-located advocate for additional safety planning support and resources.

Example 5: Brian's safety plan is to flee to Arizona where his family lives. His plan is to drive there using his truck to haul the family's needed essentials. Before leaving, Brian requests TA-DVS funds to pay for new brakes to ensure he makes it there safely as they have been smoking when he drives long distances. When the worker reviews vehicle information on screens, it is determined that the abuser is a co-owner of the vehicle. Because payments cannot benefit the abuser, the payment request is denied. The worker lets Brian know that if he can get the vehicle in just his name, we can redetermine the payment request and offers alternate methods of travel.

Example 6: Esme has been looking for permanent housing for herself and her son without success due to having only TANF as her income. She found an RV for sale for $1100.00 and has requested to use TA-DVS funds to purchase the RV for her and her son to live in. Because TA-DVS funds cannot be used to purchase a car, recreational vehicle, or travel trailer, the worker denies payment and completes a DHS 456 Notice of Decision and Action Taken.

The worker lets Esme know that if she is able to find a way to purchase the RV on her own, that ODHS could help with initial month of space rent if needed.

Reimbursements

Example 1: Iman and her worker have discussed that she will be moving in to her new apartment in two weeks. The worker has approved the move in and is now waiting to confirm with the landlord the actual move in date to verify the prorated rent amount. The weekend comes and goes and the following Monday, Iman contacts her worker saying an emergency occurred over the weekend and she had to move to the apartment immediately. Iman had to ask her friend to pay the move in costs and Iman was hoping ODHS would reimburse the money to her friend. In this situation the worker had already pre-approved the move in costs but not the total payment. After verifying the costs with the landlord, and verifying that Iman's friend paid, the worker can approve the reimbursement to Iman's friend.

Chapter 5, section 10: Program integrity

Fraud

Example 1: The survivor lied about the name of the abuser.

The abuser could be the father of the children and the survivor does not want to label the children's parent as an abuser.

The survivor might believe if we have this information, we have to report the name. If the name is reported and the abuser is contacted, there could be severe consequences for the survivor.

We have information from the DA that the survivor and the abuser are texting each other. Therefore, we think they are back together.

Consider, that the survivor may be pretending to placate the abuser until they are able to be safe. The most dangerous time in a domestic violence situation is when the survivor leaves the relationship.