The Finance Division will be responsible for referring to the Claims Unit any cases they deem appropriate in which the client has allegedly received and cashed the original and/or replacement checks. The Claims Unit will advise of any further action that may be necessary including whether a claim shall be entered on the automated claim system and whether collection shall be pursued.

If a person other than the payee endorses one or more assistance payment checks, the worker should advise the client to report the theft to local law enforcement authorities and provide the agency with a copy of the report for the file. No further action is required by the County Department.

22830 Fraudulent Activities Involving Replacement Checks

A. The Finance Division will be responsible for referring to the Claims Unit any cases they deem appropriate in which the client has allegedly received and cashed the original and/or replacement checks. The Claims Unit will advise of any further action that may be necessary including whether a claim shall be entered on the automated claim system and whether collection shall be pursued.

B. If a person other than the payee endorses one or more assistance payment checks, the worker should advise the client to report the theft to local law enforcement authorities and provide the agency with a copy of the report for the file. No further action is required by the County Department.

22840 After-Death Payments (Applicable to Optional Supplementation Only)

Alabama Law, Section 38-4-3, provides that when a recipient dies before delivery or negotiation of his assistance check for the month in which his death occurs, endorsement of such check by the County Department of Human Resources to the spouse or to a person named by the recipient shall be sufficient authority to the drawee bank to pay the check. The procedures below are to be followed in handling an unendorsed supplementation payment of a deceased recipient for the month of death.

A. The check is to be returned to the Finance Division in the State Office with a memorandum explaining the reason for the return.

B. The County Department must promptly confirm the date of death and identify the after-death beneficiary. If no one was designated as after-death beneficiary and there is a surviving spouse, the spouse is to be considered the beneficiary.[67]

C. When the OUTSTANDING RETURNED WARRANTS report is received with the deceased client's check listed, update the WARRANT STATUS UPDATE, COUNTY (ZE17) screen on FACETS. Depending on whether or not the beneficiary is entitled to the check, take action as indicated below:[68]

- If the beneficiary is not entitled to the check, use code “VO” to void the check.
- If the beneficiary is entitled to the check, use code “AD” to authorize an after-death check.
- If the client was entitled to the check, but there is no spouse and no beneficiary exists, follow procedures in the Note in H below.

D. The day following the “AD” disposition, the OUTSTANDING RETURNED WARRANTS report will reflect an interim “AD” disposition until a final disposition is made.[69]

E. The check will be sent by the Finance Division to the County Department for after-death endorsement.[70]

F. The County Director must promptly endorse the check as set out below:[71]

“The within recipient died _____and this
Date
check is endorsed to _____,the person
Name
legally authorized to receive such check.”

_____
Director
_____County

On the same day code “EC” must be entered on the WARRANT STATUS UPDATE, COUNTY screen on FACETS.[72]

After the County Director has endorsed the check, the county is to mail the check to the beneficiary.

G. The final disposition code “EC” will appear on the OUTSTANDING RETURNED WARRANTS report.[73]

H. In the event the endorsed check is subsequently returned to the State Office for any reason, the same procedures beginning with entry by the State Office on the returned check file must be initiated.[74]

NOTE: If a client dies without having endorsed any check(s) issued for a month(s) before the month in which s/he dies, such check(s) can be endorsed and cashed only by the executor or administrator of the client’s estate. If there is no executor or administrator and it is not contemplated that one will be appointed, unendorsed checks for a month(s) prior to death are to be canceled. Should an executor or administrator be subsequently appointed, the canceled checks are to be authorized according to procedures for authorizing assistance for closed cases for a prior period of eligibility.

22900 County Collection Responsibility and Reconciliation of Collections

Collection responsibility (as contrasted to the responsibility of establishing a claim which resides with the county which authorized benefits during the overpayment period) for active PA recipients lies with the County Department responsible for determining eligibility for public assistance benefits. Likewise, in

order to maximize collection effort, collection responsibility for a former FA or SUP recipient is to be assumed by the County Department where the client is currently participating in another Departmental program (such as food assistance), or by the County Department of the county where the former client is known to be living if not currently participating in any departmental program or by the county last having collection responsibility for collection if the client moves out of state or his whereabouts become unknown. However, as collection of outstanding claims is a Department-wide responsibility, a cash collection on an outstanding claim balance may be accepted by any County Department and posted to the claims system regardless of what County Department has collection responsibility. Such payment, however, may indicate the advisability of a transfer of collection responsibility. (See Section 20033 for the transfer procedure.)

22910 The Collection Process for FA and SUP

Record of any collections on FA or SUP received by the County Department will be maintained by the Department's automated claims system. Clerical staff should be used to make collections when possible. The worker (someone other than the CWOA) assigned to collect payments must give or mail the client a receipt of payment as provided in the Department's Administrative Manual. The payment is then posted to the claims system which maintains a record of all payments and current balances. Collections are to be deposited daily in the local funds account.

At minimum, weekly and monthly reconciliation of collections is required. This is a two-person process which involves the CWOA as also described in the Administrative Manual. The CWOA is responsible for reconciling total receipts written, total funds deposited as shown on the deposit slips, total funds received as shown in the cash journal, total deposits shown on the bank statement, and the reports of claims collections generated by the claims system.

Funds collected each month are to be submitted to the Finance Division by the 10th of the month following the month of collection. A check drawn on the local funds account will accompany the monthly reconciliation report. A separate automated report will be generated for each major program area (e.g., FA, SUP, Child Support or Food Assistance). A negative report indicating no collections is required.

In the event a client repays in excess of the actual overpayment, a refund may be made from local funds, if the monies have not been submitted to the State Office, or a refund may be requested from the Finance Division. If the latter alternative is selected, submit a letter to the Finance Division describing the circumstances and requesting that a refund be made to the client.

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[1] Rev 748 Jun 2005

[2] Rev 748 Jun 2005

[3] Rev 748 Jun 2005

[4] Rev 748 Jun 2005

[5] Rev 764 Oct 2009

[6] Rev 764 Oct 2009

[7] Rev 760 Apr 2008

[8] Rev 760 Apr 2008

[9] Rev 760 Apr 2008

[10] Rev 762 Nov 2008

[11] Rev 762 Nov 2008

[12] Rev 762 Nov 2008

[13] Rev 762 Nov 2008

[14] Rev 761 Feb 2008

[15] Rev 761 Feb 2008

[16] Rev 751 Aug 2006

[17] Rev 751 Aug 2006

[18] Rev 751 Aug 2006

[19] Rev 748 Jun 2005

[20] Rev 748 Jun 2005

[21] Rev 748 Jun 2005

[22] Rev 758May 2007

[23] Rev 748 Jun 2005

[24] Rev 748 Jun 2005

[25] Rev 748 Jun 2005

[26] Rev 760 Apr 2008

[27] Rev 760 Apr 2008

[28] Rev 760 Apr 2008

[29] Rev 760 Apr 2008

[30] Rev 760 Apr 2008

[31] Rev 760 Apr 2008

[32] Rev 751 Aug 2006

[33] Rev 748 Jun 2005

[34] Rev 748 Jun 2005

[35] Rev 763 Apr 2009

[36] Rev 763 Apr 2009

[37] Rev 763 Nov 2011

[38] Rev 748 Jun 2005

[39] Rev 748 Jun 2005

[40] Rev 748 Jun 2005

[41] Rev 748 Jun 2005

[42] Rev 760 Apr 2008

[43] Rev 760 Apr 2008

[44] Rev 760 Apr 2008

[45] Rev 757 Jan 2007

[46] Rev 757 Jan 2007

[47] Rev 757 Jan 2007

[48] Rev 757 Jan 2007

[49] Rev 757 Jan 2007

[50] Rev 760 Apr 2008

[51] Rev 748 Jun 2005

[52] Rev 748 Jun 2005

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[62] Rev 765 Jun 2010

[63] Rev 765 Jul 2010

[64] Rev 765 Jul 2010

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[66] Rev 765 Jul 2010

[67] Rev 748 Jun 2005

[68] Rev 748 Jun 2005

[69] Rev 748 Jun 2005

[70] Rev 748 Jun 2005

[71] Rev 748 Jun 2005

[72] Rev 748 Jun 2005

[73] Rev 748 Jun 2005

[74] Rev 748 Jun 2005

[75] Rev 775 May 2014

Chapter 23

Verification

23000 General

Requirements for verification of points of eligibility are found elsewhere in this Manual. This chapter is to cite kinds and sources of verifications to be used. Unless otherwise stated, documents and other sources listed are not all inclusive. Workers may accept other sound evidence. Refer to Sections 1125-C and 1125-F for guidelines regarding verification.

Computer matches of FACETS/IEVS data with files of other agencies can be accepted as verification of the point(s) of eligibility being matched as long as the match is with an agency that is the source of the information, or the data is not in conflict with the data in the FACETS file. IEVS match data with DIR Wage File, IRS Unearned Income File and SSA Bendex BEER file must be verified with a third party. However, DIR wage and SSA Bendex BEER match information may be used as verification of wages in overpayment computations. Computer match discrepancies showing information in conflict with other verifications require additional efforts on the part of the worker and/or the client to resolve the discrepancy.

Primary sources of verification are preferred over secondary sources. However, case actions must not be delayed if the only source of verification is secondary and there is no conflicting information to be resolved.

23005 Age

Kinds and Sources of Information for Verifying Eligibility

Letters in parenthesis following the source of verification are codes for FACETS screens found by accessing field and/or screen level help.

Eligibility Condition	Primary Sources and Codes	Secondary Sources and Codes
	Official birth certificate	Written statement of individual who has knowledge of person's of child's age
	RSDI records	Social agency records
	School records	Baptismal, confirmation or other church or parish records
	Hospital birth records	Bible or other family records
	Naturalization and immigration records	Other hospital records
	U.S. census records	Military records
	Mid-wife's records	Marriage records

		Voter registration and poll tax records
		Trade union records
		Licenses of various kinds such as hunting, fishing, barbers, etc.
		Insurance policy
		Newspaper records
		Employment records
		Fraternal or patriotic organization records

23010 Residence

Eligibility Condition	Primary Sources and Codes	Secondary Sources and Codes
State	Rent receipts	Reference statement
	Utility bills	Employment records or application for employment
	Tax receipts	Correspondence addressed to applicant/recipient at the residence
	Immigration records	City directory
Living in home of relative		
1. Relationship	Birth record (GR, MR)	Insurance policy (BR)
	School record (SR)	Other agency records (PA) e.g., Red Cr (PA), Family Services(AF), SSA (GR),Cen records(GR), VA (GR), Department of So Service records (AF,OT)
	Sworn notarized or witnessed statement (Form 1376) of reference, applicant/recipient (AF)	Bible records (CR)
	DHR-CSD-1875, Affidavit of Paternity(LD, AF)	Income tax records (GR, CR)
	NUMIDENT with IDN code “P” (GR)	Official records, e.g., school (SR), juve court (LD, GR)
	Hospital birth record (MR)	Other hospital records, clinic or he department records (MR, GR)
		Church record (PA, OT) military records (statement from a minister, priest or rabbi (R
		Baptismal certificate or other family reco such as wills, deeds (PA, CR)
		Court orders signed by the judge (no referee) where the relationship acknowledged as claimed and there is evidence to the contrary (LD)[11]
2. Presence in home	Recent census record	School record
		Reference statement

		Social agency records
		Church records
3. Temporary arrangement	Court record	Statement of service worker
	Hospital record	Reference statement
	Record of death	Social agency records
	Statement of service worker involved with the placement	
	Social agency records when the agency was involved with the placement	

23015 Citizenship Alienage

Eligibility Condition[2]	Primary Sources and Codes	Secondary Sources and Codes
Natural-born Citizens	Birth certificate or other official record showing place of birth (GR)	Client statement recorded in the narrative or the application form (CD)
Status as a Naturalized citizen	Naturalization papers (GR)	N/A
Satisfactory Alien Status	Identification documents issued by U.S. Immigration and Naturalization Service as verified through the SAVE system(GR, TE), Certification/Eligibility letters issued to victims of human trafficking by the Department of Health and Human Services, Office of Refugee Resettlement (GR), receipt from INS indicating that an application or petition for legal status has been filed but not yet adjudicated, a receipt for an application for permanent residence or replacement of lost or stolen immigration documentation,	N/A
legal Alien Status	A Final Order of Deportation from an immigration judge, an order from the Board of Immigration Appeals or Executive Office for Immigration Review (EOIR)(GR)	N/A
neligible Alien Status	Client statement/declaration recorded in the narrative, FACETS or on the application form (CD).	N/A

23020 Regular School Attendance

Eligibility Condition	Primary Sources and Codes	Secondary Sources and Codes
time or full-time basis of 16 to 19 olds	School record or training center record, (SR, OT)	School report card (SR)
	VRS record (RS, OT)	Client declaration (CD)
	Statement of school official (SR, RS)	

23025 Need

Eligibility Condition	Primary Sources and Codes	Secondary Sources and Codes
Cash, other liquid assets	Source having the facts at hand:	Reference statement (RS, CD)
	Bank and other business records (BR,AF)	
	Legal Documents (LD)	
	Computer matches (CV)	
Income from employment	Payroll (ES), check or check (PS)	Reference statement (RS)
Wage, salaries, commissions, employment, etc.	Written statement from employer, employer, includes Form 1532 (ES,AF)	DIR wage match data (CV,OT)
	Verbal statement from employer (ES)	SSA BENDEX BEER match data(CV,OT)
	Records kept by self-employed, which may include rent receipts, sale records, etc. (SE, OT, TX)	
	Records of employer (ES, BR)	
Pensions and compensations	SDX screen or report (CV)	Reference statement (RS)
	Verbal report from source of pension or compensation (RS,OT)	
	Letter from source of pension or compensation (AL, OT)	
	SSA – 1610, or information on BENDEX inquiry screen or report(CV, GR)	
	UC-PSEVR004A Wage/UC match report or online screen data(CV,AF)	
	Benefit check in client's possession (OT)	
Contribution		
1. From ineligible spouse, step-parent, parent of minor parent or parent of SUP child	Form 640 or 641 budget – Excess Income/resources in trial budget (AF)	Written or verbal reference statement by individual with knowledge of facts (RS)
	Note: Verification of income is required income is required for the ineligible spouse, same as for applicant/recipient.	
	Refer to 23025-A, B and C.	
	Verification of special expenses allowed for ineligible spouse by canceled checks, receipts, or other documentary evidence in client's hand (OT)	
2. From relative	Check (OT)	Interview with others knowing the facts (RS,OT)
	Money order (OT)	
	Personal interview with or letter from person making contribution (CS)	
. From others in or our outside household including alleged parent	Check (OT)	Reference statement(RS,OT)
	Money order (OT	
	Personal interview with or letter from) person making contribution (CS)	

23026 Child Support from Legal Parent

Eligibility Condition	Primary Sources and Codes	Secondary Sources and Codes
oluntary	Check (OT)	Reference statement (RS)
	Money order (OT)	
	Court record (LD, GR, OT)	
	Statement of absent parent (CS,OT)	
ourt-ordered	PSWCB107 (CV)	
	ALECS screens or documentation(CV, AF)	
	Court record (LD, GR, OT)	

23035 Additional Conditions

Eligibility Condition	Primary Sources and Codes	Secondary Sources and Codes
A. AB – Not soliciting alms		Reference statement
B. Blindness	Absence of both eyes	
	Award authorization for RSDI or SSI based on blindness, SSA-1610 or BENDEX, SDX	
	Social Security claim number from current check	
	Form 556, Physician's Report on Eye Examination, Form 672, Optometrist's report on eye examination	
C. APTD-Permanent and Total Disability	Award authorization for RSDI and SSI based on disability, SSA-1610 or BENDEX, SDX	
	Medical reports or copies of medical records from hospitals, clinics, VRS, VA RSDI, industrial organizations or written statement from a legally licensed doctor of medicine or a legally licensed osteopathic physician Form 667, Report of Physician's Examination	
	Social Security claim number from current RSDI check	
D. FA-JOBS Participation	Form 535	
	Other written communication (report)	

	from the JOBS Unit	
E. FA-Institution	List of nursing homes and related facilities licensed in Alabama	Statement of reference as to person's residence in institution
	Licenses issued to institutions by the State Health Department	
	Clearance with agency having knowledge of institutional status	
F. FA, APTD, OAP, AB-Providing a SSN (exclusive listing)	Written or oral statement of SSN, Social Security card, Social Security card stub, SSA-2853-OP3, a certified birth certificate or a copy of a certified birth certificate which indicates a SSN was applied for; IEVS enumeration, validation Code V,Q,2,3,4,5, SSA-5028 signed, computer generated facsimile of SSA-5028 or NUMIDENT or copy of SS-5, or 880 Social Security numbers log, receipt of application given to client at application for SSN	
G. APTD, OAP and AB-Receipt of SSI	SDX, SSA-1610, award authorization, benefit check in client's possession BENDEX screen, SSI indicator Y letter from SSA verbal report from SSA	
H. APTD, OAP, and AB-Living Arrangement Code	SDX, benefit check in client's possession (reduced amount)	
	Letter from SSA, verbal report from SSA	
I. FA, APTD, OAP, AB-Application for benefits and conversion of all other potential income	Award or denial letter from other agency	
	Court order	
	Verbal report notated in the record, automated voice response, letter from other agency	
	Registration or ID card for UC benefits, printed documents of DIR on-line account information which is client specific, information from DIR's automated voice response system noted in the record. (To facilitate verification or at the client's request, the online and telephone verification may be obtained, as time and space permit and with permission from the County Director, by a worker-supervised client via a computer or telephone in the county	

	office.)[2]	
J. Minor Parent Living Arrangement		
1. Presence in home	Refer to 23010-B.2	Refer to 23010-B.2
2. Exempt status	Statement from the parent, legal guardian, or other adult relative along with a corroborating statement from the minor parent.	Reference statement
	Court documents	
	Documentary evidence necessary to verify possible/actual jeopardy to the physical or emotional health or safety of the minor parent or dependent child as listed in Section 2606-F.4 5 and 6.	
K. Time Limits Hardships		
1. Caring for individual	Completed and signed Form 1876 (MR)	
2. Illness	Medical reports or copies of medical from hospitals, clinics, VRS, VA, industrial organizations, or written statements from legally licensed attending physicians (MR), VRS[10] Project information from JOBS case manager/ record (AF)[3]	
3. Incapacity(Exclusive Listing)	Form 770 completed by a legally licensed physician (AF) or VRS[11] Project information from JOBS case manager/record (AF)[4]	
4. Battered	Refer to 2606-F. (Code dependent on source.) SAIL safety plan initiated DHR-FAP 2080 (AF)	
5. Counseling	Drug, alcohol, mental health counseling agency (MR, SS), JOBS case manager/ record (AF)[5]	
6. Age	Refer to 23005[6]	
7. Personal Barrier (Exclusive Listing)	JOBS case manager/record (AF)	
8. Lives in ABAWD waiver county (Exclusive Listing)	Food Assistance Program Designation[7]	
L. Evidence of identity for furnishing a SSN		
1. Natural-born citizen	Drivers license, state identity card (GI)	Any other document providing

	voters registration (GR) school record report card, school identification card(SR) marriage record, divorce decree(GR), work badge, building pass (WI), military discharge papers, military dependent's ID (MR), U.S. Passport, U.S. citizen ID card (GR), baby's hospital wrist band(HR), newspaper birth announcement, baby book (OT), church membership or confirmation record (CH) clinic, doctor or hospital record, vaccination certificate, (HR), insurance policy (OT), daycare or nursery school records (SR). Record of child's membership in Boy Scouts, Girl Scouts or other youth organization (OT) U.S. immigration documents, naturalization certificates(IM)	identifying data sufficient to establish proper identity (OT)
2. A foreign-born person who is now a citizen of the U.S.	U.S. passport, naturalization certificate, consular report of birth (plus evidence of identity from above list), (IM), U.S. citizen identity card, certificate of citizenship (GR). U.S. military discharge papers showing U.S. citizenship (GR,MR)[8]	
M. Applicant Job Search		
	Completed and signed Form 1922, Verification of Job Search (AF) Business forms or letters (ES) Copy of a confirmation/acknowledgement of submission of an online application; copy of a confirmation number for an online application (ES)	Any other document providing sufficient information to support an application was made and accepted (OT)[9]
N. Drug Screening		
1. Proof of a valid prescription 2. Positive Screening Result 3. Negative Screening Result	Copy of prescription signed by doctor or designated authority under supervision of doctor. Printout from pharmacy, medical report. Document/report from Public Health. Document/report from Public Health.	Prescription bottle with label attached, hospital discharge.

[1] Rev 763 Apr 2009

[2] Rev 770 Apr 2012

[3] Rev 763 Apr 2009

[4] Rev 762 Nov 2008

[5]Rev 762 Nov 2008

[6]Rev 762 Nov 2008

[7]Rev 762 Nov 2008

[8]Rev 768 Nov 2011

[9]Rev 775 May 2014

[10]Rev 789 Jan 2019

[11]Rev 789 Jan 2019

APPENDIX I – TABLES AND CHARTS

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APPENDIX I – TABLES AND CHARTS

STANDARDS FOR FAMILY ASISTANCE	
Assistance Unit Size	Payment Standard
1	$165
2	190
3	215
4	245
5	275
6	305
7	335
8	365
9	395
10	425
11	455
12	485
13	515
14	545
15	575
16	605

RECOUPMENT STANDARDS FOR FAMILY ASISTANCE PAYMENTS		
FAMILY SIZE	PAYMENT STANDARD	15% RECOUPMENT AMOUNT
1	$165	$ 24
2	190	28
3	215	32
4	245	36
5	275	41
6	305	45
7	335	50
8	365	54
9	395	59
10	425	63
11	455	68
12	485	72
13	515	77
14	545	81
15	575	86
16	605	90

RECOUPMENT STANDARDS FOR SUP PAYMENTS

PAYMENT STANDARD	15% RECOUPMENT AMOUNT
$56	$ 8
60	9
110	16

PRORATED PAYMENT AMOUNTS FOR FA CASES WITH NO INCOME

Date of Application	Number in Budget Group															
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1	165	190	215	245	275	305	335	365	395	425	455	485	515	545	575	605
2	159	183	207	236	265	294	323	352	381	410	439	468	497	526	555	584
3	153	177	200	228	256	284	312	340	368	396	424	452	480	508	536	564
4	148	171	193	220	247	274	301	328	355	382	409	436	463	490	517	544
5	142	164	186	212	238	264	290	316	342	368	394	420	446	472	498	524
6	137	158	179	204	229	254	279	304	329	354	379	404	429	454	479	504
7	132	152	172	196	220	244	268	292	316	340	364	388	412	436	460	484
8	126	145	164	187	210	233	256	279	302	325	348	371	394	417	440	463
9	120	139	157	179	201	223	245	267	289	311	333	355	377	399	421	443
10	115	133	150	171	192	213	234	255	276	297	318	339	360	381	402	423
11	109	126	143	163	183	203	223	243	263	283	303	323	343	363	383	403
12	104	120	136	155	174	193	212	231	250	269	288	307	326	345	364	383
13	99	114	129	147	165	183	201	219	237	255	273	291	309	327	345	363
14	93	107	121	138	155	172	189	206	223	240	257	274	291	308	325	342
15	87	101	114	130	146	162	178	194	210	226	242	258	274	290	306	322
16	82	95	107	122	137	152	167	182	197	212	227	242	257	272	287	302
17	76	88	100	114	128	142	156	170	184	198	212	226	240	254	268	282
18	71	82	93	106	119	132	145	158	171	184	197	210	223	136	249	262
19	66	76	86	98	110	122	134	146	158	170	182	194	206	218	230	242
20	60	69	78	89	100	111	122	133	144	155	166	177	188	199	210	221
21	54	63	71	81	91	101	111	121	131	141	151	161	171	181	191	201
22	49	57	64	73	82	91	100	109	118	127	136	145	154	163	172	181
23	43	50	57	65	73	81	89	97	105	113	121	129	137	145	153	161
24	38	44	50	57	64	71	78	85	92	99	106	113	120	127	134	141
25	33	38	43	49	55	61	67	73	79	85	91	97	103	109	115	121
26	27	31	35	40	45	50	55	60	65	70	75	80	85	90	95	100
27	21	25	28	32	36	40	44	48	52	56	60	64	68	72	76	80
28	16	19	21	24	27	30	33	36	39	42	45	48	51	54	57	60
29	10	12	14	16	18	20	22	24	26	28	30	32	34	36	38	40
30/31	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20

Child Support and JOBS Sanction Amounts For Family Assistance Payments

Assistance Unit Size	Payment Standard	50% Sanction
1	$165	$82
2	190	95
3	215	107
4	245	122
5	275	137
6	305	152
7	335	167
8	365	182
9	395	197
10	425	212
11	455	227
12	485	242
13	515	257
14	545	272
15	575	287
16	605	302

FEDERAL BENEFIT RATE (FBR) CHART

		Gross Income Limit
Individual in own home	$794.00	$2382.00
Individual in household of another and receiving support and maintenance	529.34	1588.02
Individual with spouse in own home	1191.00	4764.00
Individual with spouse both in household of another and receiving support and maintenance (Couple standard)	794.00	3175.98
One-half of individual FBR	397.00	
One-half of individual FBR individual in the household of another	264.66	
Allowance for dependent child	397.00	
Individual in nursing home	30.00	
Medicare Premium	148.50	

January 2021

BASIC REQUIREMENTS FOR MANDATORY MONEY PAYMENT NURSING HOME CASES

Basic Requirements	OAP	APTD	AB
Clothing	$18	$12	$15
Incidentals	19	10	17
Personal Care	11	0	0
TOTALS	$48	$22	$32

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STATE SUPPLEMENTATION SPECIAL NEEDS STANDARDS/PAYMENTS

	Monthly Amount To Be Budgeted	Maximum Payment
Specialized Independent Homelife Care Supplement	60.00	60.00
Independent Homelife Care Supplement - Level of Independence "A"	60.00	60.00
Independent Homelife Care Supplement - Level of Independence "B"	56.00	56.00
Independent Homelife Care or Specialized Independent Homelife Care Supplement in Foster Care	110.00	110.00
Care in a Cerebral Palsy Treatment Center (APTD)	196.00	196.00

APPENDIX II – FORMS AND INSTRUCTIONS

APPENDIX II – FORMS AND INSTRUCTIONS

I. FA FORMS

DHR-FAD-595	FA Summarized Eligibility Requirements
DHR-FAD-600	Cooperation in Child Support
DHR-FAD-601	Application for an Exception to the Cooperation Requirement in Child Support Activities
DHR-FAD-602	Notice of Good Cause Decision
DHR-FAD-603	Affidavit (Child Support good cause)
DHR-FAD-604	Request for Information/Documentation
DHR-FAD-650	Vital Statistics Verification
DHR-FAD-657	Notice of Action
DHR-FAD-660	Notice of Denial or Pending Status
DHR-FAD-686	Interview Notification
Form 689	Bank Clearance
DHR-FAD-690	Application for Family Assistance
DHR-FAD-703	Change Report Form
PSD-BPA-746	Record of Contact
DHR-FAD-752	Request for Verification of UCB
DHR-FAD-770	Time Limits Hardship Determination
DHR-FAD-799	Communications Memo
PSD-DFD-818	Overpayment Form
DHR-FAD-1132	Required Verifications
DHR-FAD-1328	Family Assistance Program Case Review Summary
DHR-FAD-1376	Declaration of Relationship
DHR-FAP-1389	Out-of-State Inquiry
DHR-FAD-1512	Family Assistance Program Case Review Summary
DHR-FAD-1532	Verification of Wages
DHR-OFA-1562	Repayment Agreement
DHR-WR-1674	Backup Application Information
DHR-FAD-1876	Time Limits Hardship/Caring for Individual(s) with Illness/Incapacity
DHR-FAD-1922	Verification of Job Search
DHR-FAD-2077(595)	Summarized Eligibility Requirements Family Assistance – Spanish version
DHR-FAD-2080	Special Assessment, Intervention & Liaison Project (SAIL)
DHR-FAD-2097(703)	Client's Written Statement Regarding Changes and Adverse Action – Spanish version

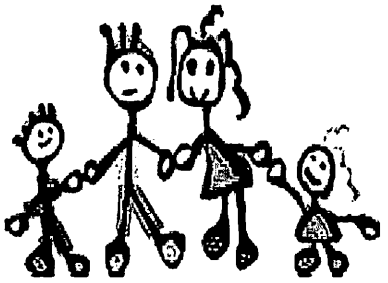
DHR-FAD-2098(1132)	Required Verifications - Spanish version
DHR-FAD-2099(686)	Interview Notification – Spanish version
DHR-FAD-2148(1970)	Affirmation and Agreement – Spanish version
DHR-FAD-2180	Agreement to Comply/Cooperate with the JOBS and/or Child Support Programs
DHR-FAD-2180a	Agreement to Comply/Cooperate with the JOBS and/or Child Support Programs Time Limit Extension
DHR-FAD-2209	Application for Family Assistance – Spanish version
DHR-FAD-2215	Alternate Grantee Relative Declaration of Qualifications
DHR-FAD-2216	Drug Screening Information Acknowledgement and Understanding
DHR-FAD-2217	Drug Screening Appointment Notification
SSA-513	Request for Quarters of Coverage (QC) History Based on Relationship
SSA-3288	Consent for Release of Information

II. SUP FORMS

DHR-PAD-640	Supplementation Budget
DHR-PAD-641	Supplementation Budget for Deeming
PSD-BFN-677	Affidavit (SUP check not endorsed)
DHR-FAD-693	Application for Supplementation
DHR-FAD-694	Statement of Income/Resources (SUP)
DHR-FAD-696	Physician's Recommendation
DHR-FAD-699	Consent of DHR to Appointment of Legal Representative
DHR-FAD-700	Physician's Certificate for Legal Representative
DHR-PAD-797	Agreement to Provide Homelife Care
PSD-BFM-829	Check Inquiry
PSD-BPA-1513	Public Assistance Case Review Checklist – SUP
PSD-BPA-1514	Public Assistance Case Review Summary – SUP
DHR-PAD-1801	Medical Statement for Homelife Care Provider

PART I - FA FORMS

DEPARTMENT OF HUMAN RESOURCES



FAMILY ASSISTANCE (FA) PROGRAM
SUMMARIZED ELIGIBILITY REQUIREMENTS

IS MY FAMILY ELIGIBLE?

Persons who apply for or receive cash benefits must meet certain requirements. They must help determine eligibility for benefits. They must participate in activities that will help them become able to support and better care for their families. This includes cooperating with child support, JOBS and drug screening. Persons who do not cooperate may be denied or may lose benefits.

TECHNICAL REQUIREMENTS

A. The child must live in the home of a parent or other close relative.

B. A person can only receive FA benefits as an adult for 5 years in his or her lifetime.

C. The child must be under age 18 unless in school. If in school, the child may receive benefits through the month before the 19th birthday or the last month in school, whichever is earlier.

D. The child must be a U.S. citizen or a legal, eligible alien.

E. The child must live in Alabama. A person who has been convicted of giving a false address to get help from two States at the same time cannot receive benefits for ten years.

F. The child cannot be receiving foster care from the Department of Human Resources.

G. The child must not be participating in a strike. No family member may receive FA if a parent or stepparent is on strike.

H. The relative must cooperate with Child Support unless the Department decides s/he has a good reason not to.

   Child support received for a child is assigned to the State Department of Human Resources when an application for FA is made for the child.

I. The relative must turn over all child support payments to the State.

J. The relative must give a Social Security number for each member of the assistance unit. If a member does not have a Social Security number, the relative must apply for a number. The number must be provided when received.

DHR-FAD-595
October 2019

K. The relative must participate in the JOBS program. The relative must accept a job unless the County Department tells him or her otherwise. Parents under age 18 who are dependent children are required to participate.

L. The relative must apply for any other benefits for which they may be eligible, such as Veteran's Benefits, Social Security, Unemployment Compensation, etc.

M. A parent who is under age 18 and his or her children must live with an adult. This adult must be a relative or a legal guardian. If an adult relative or guardian is not available, the parent under 18 and his or her children must live in an adult-supervised supportive living arrangement.

N. The relative must tell the worker about family circumstances. The relative may be asked to prove some or all of the family circumstances with documents.

O. A parent under age 18 with a child that is at least 12 weeks old must have a high-school diploma or be in school or a training program.

P. The child or relative must not be breaking a condition of parole or probation. The child or relative must not be a convicted felon who is on the run to avoid arrest, trial or jail. The child or relative must not have been convicted of a felony for the use or sale of a controlled substance or having a controlled substance unless his or her sentence has been completed.

Q. A parent must sign and meet the terms of their Family Responsibility Plan.

R. The applicant must participate in job search activities during the application process unless exempt or good cause exists not to do so.

S. A parent or stepparent grantee must cooperate with drug screening activities. This means providing information and taking and paying for drug screening(s). Activities are determined on a case by case basis.

FINANCIAL REQUIREMENTS

T. The child must be in need by agency rules and not have parents or stepparents who can support him/her. "In need" means the family does not have net monthly income that equals or is more than the payment standard and is eligible for at least $10. The payment standard is listed below. In determining need, the income of all persons in the assistance unit is counted. Before earned income is counted, a 20% work expense and childcare are subtracted from gross income.

FA STANDARDS

FAMILY SIZE	PAYMENT STANDARDS	FAMILY SIZE	PAYMENT STANDARDS
1	165	9	395
2	190	10	425
3	215	11	455
4	245	12	485
5	275	13	515
6	305	14	545
7	335	15	575
8	365	16	605

"Family" means all persons included that make up the family size. Generally, persons to be included are the parents and brothers and sisters of the child(ren) living in the home. Other children related to the parent(s) such as stepchildren and nieces, etc. may be included. (If a child in a group of brothers and sisters is included, all his/her brothers and sisters who live in the home must be included if eligible.) The income of all persons in the unit is used to determine eligibility. A family with income that is equal to or more than the payment standard for the family size is not eligible for FA.

Examples of Income:

Wages, commissions, salaries

Contributions

Social Security, VA, and Unemployment compensation

Child Support

Family assistance will be paid for recipients who are eligible for at least $10 for up to five years. Benefits are not paid for less than $10.

ADDITIONAL INFORMATION

- **WHERE TO APPLY**
  You must apply for FA at the Department of Human Resources in the county where you live. The application interview may start with a general explanation of the program to a group of applicants. You must take part in an in-office or telephone, private interview with a worker.

- **REPORTING REQUIREMENTS**
  Applicants: You must report any changes in your family's situation before your case is awarded.

  Recipients: You must notify the Department of any change in your family's situation within 10 days. You must give the Department all information needed for a complete review at least every twelve months. The County Department may ask for some of the information needed in a group interview with other recipients.

- **OVERPAYMENTS**
  If you get an overpayment for any reason, you will have to pay it back. If you receive an overpayment due to fraud you may be subject to prosecution or other penalty.

- **REVIEW OF ACTION TAKEN ON YOUR CASE**
  - You may notify the County Department or the State Department of Human Resources in Montgomery, Alabama if you are dissatisfied. You may ask for a conference with the County Department, a review by the State Department, or a formal hearing. (The State Department and the County Department operate under the same rules.)
  - You may make a written request for a hearing within 60 days of the action taken. The parent, other relative, legally appointed representative or other authorized person must make the request.
  - The hearing may be conducted by telephone.
  - Your attorney or someone representing you may be present with you at a hearing or conference.
  - You may withdraw your request for a hearing when concerns are otherwise resolved.

- **BENEFIT DELIVERY and RESTRICTIONS**
  Benefits are issued through an electronic benefits transfer (EBT) card. There are restrictions on where the card can be used and what can be bought. Places the card cannot be used are in a liquor, wine or beer store, gambling establishment, strip club, tattoo or body piercing store or a place providing psychic services. Benefits cannot be used to buy liquor, wine or beer, tobacco products, or lottery tickets. Misuse of the card and benefits results in loss of benefits and payback of monies misused.

- **CHILD SUPPORT SERVICES**
  Child support services are available to persons receiving FA. Child support services will continue even if FA payments are stopped unless you request that services stop.

- **DAY CARE**
  You may be eligible for childcare after your FA benefits have been terminated. You must need childcare because you are working and you must apply for the care within six months of FA closure and meet other requirements.

- **FOOD ASSISTANCE**
  You may be eligible for food assistance even if you do not get FA. For more information, contact your worker or your County Food Assistance Office.

- **HEALTH CARE COVERAGE**
  You and your family members may get free or low cost health care coverage even if you do not get FA. If you want to apply for Medicaid, ALL Kids, or help paying for insurance, apply online at **www.insurealabama.org or call toll-free: 1-888-373-5437 or 1-800-362-1504** if you have questions.

- **LEGAL ASSISTANCE**
  You may be able to get free legal help. You may contact a local Legal Services office or other community agency. Your county office can help you find them.

- **OTHER HELP AVAILABLE**
  You may want to access the Health and Human Services website at www.myalabama.gov for information about other programs and services available in the State.

- **NONDISCRIMINATION:** Program rules are the same for everyone. Your race, color, birthplace, sex, handicap, beliefs, age or religion do not matter. Tell us if you have a physical, mental or learning problem that limits a major life activity. We may be able to help you to fully use existing programs and services.

DHR-FAD-595
Family Assistance (FA) Program
Summarized Eligibility Requirements

Use/Purpose

This form is to be used according to Section 1120B during the application interview, and, as appropriate, during other contacts with the client.

General Instructions

Discuss each item with the applicant, providing detailed explanation or clarification, as needed, and giving opportunity for any questions from the client to be answered.

Distribution

Original: Client

STATE DEPARTMENT OF HUMAN RESOURCES

COOPERATION IN CHILD SUPPORT

YOU SHOULD READ THIS NOTICE

If you receive Family Assistance (FA) for a child(ren) living with you, any child support you receive for the child(ren) or for yourself will be assigned to the State. You must cooperate with the Department of Human Resources (DHR) in getting support from all absent parents unless you have "good cause" for not cooperating. This is the law.

If you feel you have "good cause" for not cooperating with child support, your worker will help you to establish the facts needed for the "good cause" claim. The Department of Human Resources will decide if you have "good cause".

HOW CAN THE CHILD SUPPORT PROGRAM HELP ME?

The program can help the child by:

- finding the absent parent,
- establishing who the father is,
- getting financial support from the absent parent, and
- getting the right to inheritance and the right to social security (RSDI), veterans or other government benefits.

HOW DO I SHOW "GOOD CAUSE" FOR NOT COOPERATING?

To show "good cause" you must show that cooperating in getting support from the absent parent would be against the best interest of the child.

HOW DO I KNOW IF COOPERATION MIGHT BE AGAINST MY CHILD'S BEST INTEREST?

Cooperation might be against your child's best interest if:

- contacting the absent parent would be likely to cause physical or emotional harm to you or to the child
- the child was born as a result of incest or rape
- you are planning to put the child up for adoption or
- you are working with any agency to decide if you want to keep the child or give him/her up for adoption.

WHAT SHOULD I DO IF I BELIEVE I CAN SHOW "GOOD CAUSE" FOR NOT COOPERATING?

First, tell your worker. Second, you must make an application in writing on a form that your worker will give you.

WHAT HAPPENS AFTER I APPLY FOR "GOOD CAUSE"?

You must provide any proof or information that your worker says is needed within 20 days after you apply. In certain situations, you may be given more time if you ask for it.

DHR-FAD-600
May 2004

The Department of Human Resources will study the situation and decide if you have good cause. The Department will base its decision on the evidence provided or on its investigation if no evidence is available when you claim physical harm.
Child Support staff may review the findings and basis for "good cause" and may come to any hearings.

WHAT KINDS OF INFORMATION WILL BE NEEDED FROM ME?

Ask your worker to tell you what papers you must provide. They might include any of the following:

- Records showing that the child was born as a result of incest or forcible rape. These may include birth certificate or medical or police records.
- Legal documents showing proceedings for adoption have been started.
- Records showing the absent parent might physically or emotionally harm you or the child. These could include court, medical, criminal, social services, psychological or law enforcement records.
- Any medical records that show the emotional health of you or the child.
- A written statement from a social agency showing that they are helping you to decide if you want to keep the child or give him/her up for adoption.
- Any other information that your worker says is needed before the Department of Human Resources can decide if you have "good cause".

WHAT WILL HAPPEN IF I NEED HELP IN COMPLETING THE APPLICATION FOR "GOOD CAUSE"?

If you ask your worker, he or she will help you in gathering any needed information.

WHAT KIND OF DECISION CAN I EXPECT?

If it is decided that you do not have "good cause", you must cooperate with the Department of Human Resources to get child support from all absent parents.

If it is decided that you do have "good cause", you will not have to cooperate with the Child Support Program. The Department of Human Resources may drop all efforts to establish paternity or get support or may try to get support without your help. This would depend on your situation based on the best interest of the child.

WHAT WILL HAPPEN TO MY FA BENEFITS WHILE THE DECISION OF "GOOD CAUSE" IS BEING MADE?

Your FA benefits will continue if you submit the requested evidence within 20 days. Assistance will not be delayed, denied, or terminated until a decision is made. You will be advised of the decision in writing.

WHAT IF I DO NOT AGREE WITH THE DECISION ON MY APPLICATION FOR "GOOD CAUSE"?

If you do not agree with the decision, you may ask for a conference with the County Department, review by the State Department of Human Resources or a formal hearing.

Instructions for DHR-FAD-600
Cooperation in Child Support

Use/Purpose

This form is to be used during the application process and when adding a child to the assistance unit to explain the Child Support Program, as discussed in Sections 1120 and 2615B.

General Instructions

Review all items on the form with the client and explain the right to claim good cause as an exception to the cooperation requirement. Note on the PSWC0075, Affirmation of Household Circumstances, that this form was given/sent to the client.

Distribution

Original: Client

STATE OF ALABAMA

_____ COUNTY DEPARTMENT OF HUMAN RESOURCES

APPLICATION FOR AN EXCEPTION TO THE COOPERATION REQUIREMENT IN CHILD SUPPORT ACTIVITIES

GRANTEE RELATIVE: _____ Circle One Applicant/Recipient

PSD File No.: _____

ABSENT PARENT: _____ Case ID No.: _____

I. TO BE COMPLETED BY CLIENT

CHILD'S NAME	DOB	RELATIONSHIP	CHILD'S NAME	DOB	RELATIONSHIP

I hereby apply to the Department of Human Resources for exception to the requirement that I cooperate in child support activities. Cooperating in child support activities is not in the best interest of the child(ren) for whom I am receiving or requesting assistance because:

1. ☐ Physical harm to the child(ren) would be the result of my cooperating
2. ☐ Emotional harm to the child(ren) would be the result of my cooperating
3. ☐ Physical harm to me would be the result of my cooperating
4. ☐ Emotional harm to me would be the result of my cooperating
5. ☐ The child was conceived as a result of incest or forcible rape
6. ☐ Legal proceedings for adoption of the child are pending before a court of competent jurisdiction
7. ☐ A public or private agency is assisting in deciding whether to keep the child or relinquish for adoption. (Three month limit)

☐ I agree to provide evidence needed to establish good cause to the Department of Human Resources within 20 days of the date of this application. Evidence includes any records or documents needed to support my claim.

☐ I also agree to cooperate in obtaining a Mental Health evaluation if one is deemed necessary and I give permission to release social information to the Mental Health Center for use in the evaluation.

☐ I request assistance from the Department of Human Resources in obtaining the evidence needed to document my claim.

☐ There is no available evidence to support my claim of physical harm. I, therefore, agree to cooperate with the Department of Human Resources in an investigation to determine if my claim is credible.

I wish to claim exemption from cooperating in child support because: _____

_____

_____

_____

_____ _____

DATE CLIENT'S SIGNATURE

DHR-FAD-601
REV. 9/06

II. TO BE COMPLETED BY ELIGIBILITY WORKER

TO: The County Good Cause Review Team

This application for good cause exception is based on a claim that cooperation would result in one or more of the items: checked in Part I of this form and documentary evidence related to this claim is being forwarded to you with this application.

☐ This application for good cause exception is based on a claim that cooperation would result in physical harm to the relative or child and the client has stated no documentary evidence to support the claim is available. Our investigation of the credibility of this claim is being forwarded to you with this application.

☐ This application for good cause exception is being submitted later than 30 days after it was received because:

_____

_____

_____

_____ _____

DATE SIGNATURE OF ELIGIBILITY WORKER

III. TO BE COMPLETED BY CHILD SUPPORT WORKER

If applicant/recipient is claiming "good cause" for the reason of possible emotional harm to the grantee or child, this section must be completed, dated, and signed by the CS Worker.

In this particular case the following activities may be expected of the applicant/recipient and/or the child (specify which):

_____

_____

_____ _____

DATE CHILD SUPPORT WORKER

IV. TO BE COMPLETED BY COUNTY GOOD CAUSE REVIEW TEAM

A. ☐ Good Cause Claim Approved - Do Not Pursue Child Support. Approval Based on No. _____ of Part I of this form.

B. ☐ Good Cause Claim approved for _____ months. Do not pursue child support for that period. Approval Based on No. _____ of Part I of this form.

C. ☐ Pursue Child Support Without Participation of Applicant/Recipient no earlier than the 11th day following date of notice to client that child support activities will begin unless he withdraws his application or requests that his case be closed. Based on No. _____ of Part I of this form.

D. ☐ Good Cause Claim Denied - Pursue Child Support. Denial Based on No. _____ of Part I of this form. Claim denied because: _____

_____

_____

E. ☐ Good Cause Claim is Being Returned for Clarification. Date _____ (See attached letter.)

_____

_____ _____

DATE

_____

_____

COUNTY GOOD CAUSE REVIEW TEAM

Instructions for DHR-FAD-601
Application for an Exception to the Cooperation Requirement in Child Support Activities

Use/Purpose

This form is to be used to establish good cause for not cooperating with child support activities when a client believes such cooperation would not be in the child's best interest, in accordance with Section 2606.

General Instructions

This form is designed to provide for the exchange of information from the point of application for exception to child support cooperation to the point of the decision on the application. Attach to this form evidence submitted by the client in support of the good cause claim before transmitting to the County Good Cause Review Team.

Part I – To be completed by the Client. Help the client complete this part including a detailed review of Section 2606B, C, D, E and F. The form may be sent to the client for completion/signature.

Part II – To be completed by the Eligibility Worker. If the good cause claim is based on emotional harm, forward the original and one copy to the Child Support Unit for completion of Part III. Otherwise, or upon return of the form with Part III completed, forward the original with corroborating evidence attached and a copy to the County Good Cause Review Team.

Part III –To be completed by the Child Support Worker if the good cause claim is based on possible emotional harm to the grantee or child. Otherwise, leave blank.

Part IV – To be completed by the County Good Cause Review Team.

Notify the client of the decision using form 602 and notify the CSU by proper coding of ZC32 and ZC40 on FACETS.

Distribution

Original: County Good Cause Review Team with evidence attached then, after Part IV has been completed, case record
1st Copy: Client after completion of Part I
2nd Copy: Child Support Unit if claim based on emotional harm or, if not, County Good Cause Review Team
3rd Copy: Case Record until original is returned

STATE OF ALABAMA

_____ COUNTY DEPARTMENT OF HUMAN RESOURCES

NOTICE OF GOOD CAUSE DECISION

GRANTEE RELATIVE

CHILD(REN)

PSD FILE NO. _____

CASE ID NO. _____

DATE: _____

FOLD FOL

☐ Your application for exemption in cooperating in seeking child support has been approved. Child support will not be pursued.

☐ Your application for exemption in cooperating in seeking child support has been approved for _____ months. After that time you will be expected to cooperate or you may submit a new good cause application.

☐ Your application for exemption in cooperating in seeking child support has been approved, but child support will be pursued without your participation. Child support activities will begin on the 11th day following the date of this notice unless you withdraw your application, request that your case be closed or request a hearing on this decision before that day.

☐ Your application for exemption in cooperating in seeking child support has been denied. Child support activities must be pursued and will begin on the 11th day following the date of this notice unless you withdraw your application, request that your case be closed, or request a hearing on this decision before that day.

The basis for the decision was the evidence, investigation submitted to the County Good Cause Review Team.

If you do not agree with this decision, you have the right to a conference with your County Department, ask the State to review your case, or ask for a hearing. See reverse side of this notice.)

FOLD FOL

_____

SIGNATURE OF WORKER

DISTRIBUTION:

1. Client
2. Copy in Record

DHR-FAD-602
Rev. 3/97

REQUEST FOR A CONFERENCE REGARDING THE ACTION TAKEN ON YOUR CASE

If you are not satisfied with the action taken on your case, or need further explanation, you have a right to discuss your case with the worker who made the decision. If you are not satisfied with the results on this conference, you may wish to request a hearing or a review by the State Department. A request for a conference will not affect your right to a hearing.

REQUEST FOR A HEARING

If you are not satisfied with the action taken on your case, you have the right to a hearing. A hearing request involving public assistance or medicaid must be in writing. A written request should state why you are dissatisfied and must include your correct mailing address and the mailing address of any person representing you in your request. It may be filed by you, your lawyer or legally appointed representative, or other authorized person. In the latter situation, the person representing you in your request must make a definite statement that he has been authorized by you to request the hearing.

LENGTH OF TIME YOU HAVE TO REQUEST A CONFERENCE OR HEARING

If you want a conference or a hearing, please contact this office or the State Department within sixty (60) days from the date of the action which is taken on your case.

HEARING PROCEDURES

If you request a hearing, a statement of hearing procedures will be mailed to you upon acceptance of your request.

WHO MAY HELP YOU AT A CONFERENCE OR HEARING

At a conference or hearing, you may present your information yourself or you may be represented by a friend, relative, attorney, or other spokesman of your choice.

WITHDRAWING A HEARING REQUEST

If you wish to withdraw your request before the hearing, you, your lawyer or legally appointed representative, or other authorized person should write the County or State Department that you wish to do so, and give the reason for withdrawing.

ADDRESS OF STATE DEPARTMENT

State of Alabama, Department of Human Resources, Persons Building, 50 Ripley Street, Montgomery, Alabama 36130.

NONDISCRIMINATION

The standards for participating in all programs are the same for everyone without regard to race, color, religious creed, national origin, or political beliefs.

Instructions for DHR-FAD-602
Notice of Good Cause Decision

Use/Purpose

This form is used, according to Sections 2606K and L, to advise the client of the decision on her/his claim for good cause in not cooperating with child support activities.

General Instructions

Mark the box that corresponds with the items in Part IV of the 601.

Distribution

Original: Client
Copy: Case record

State of Alabama

_____County

Case No._____

_____
Worker

AFFIDAVIT

Before me, _____, a Notary
(Notary Public)

Public in and for said County and State, personally appeared

_____, who being first duly
(Affiant)

sworn voluntarily deposes and says as follows:

_____
(Affiant)

_____
(Address)

_____
(City, State)

Sworn to and subscribed
before me this _____ day
of _____ , 20____.

_____
(Notary Public)

Instructions for DHR-FAD-603
Affidavit

Use/Purpose

This form is used to provide documentary evidence to corroborate a client's claim for good cause in not cooperating with child support activities based on emotional or physical harm to the client and/or the child or because the child was conceived as a result of incest or forcible rape, in accordance with Section 2606F.

General Instructions

This form is to be completed by a Notary Public in the county office or somewhere else of the client's choosing to transcribe the sworn statement of an individual other than the client with personal knowledge of the circumstances which provide the basis for the good cause claim. The affiant must state the circumstances of which s/he has personal knowledge and how s/he came to have such knowledge. Neither hearsay information nor the affiant's belief or opinion are acceptable for sworn statements.

Distribution

Original: County Good Cause Review Team, attached to the DHR-FAD-601 with any other evidence.

THIS FORM WILL NOT BE STOCKED. MAKE COPIES AS NEEDED.

REQUEST FOR INFORMATION/DOCUMENTATION

_____ County Department of Human Resources

_____, Alabama
(Box or Street) (City)

TO: _____ Re: _____ Case No. _____

_____ Child: _____

_____ Absent Parent: _____

An applicant for or recipient of Family Assistance in Alabama is required to cooperate with the Department of Human Resources in obtaining support from the absent parent. This may involve identifying or helping to locate the absent parent, and participating in court or other proceedings needed to establish paternity. The only exception to this requirement occurs when a determination is made that such activities would likely result in physical and/or emotional harm to the child and/or person caring for the child; when a child was conceived as the result of incest or forcible rape; or when adoption proceedings are pending or being considered, and cooperation would not be in the child's best interest. Since this client claims exemption from the cooperation requirement and must present documentary proof within 20 days from the date of the claim, please supply this agency with the information checked below to assist us in making a determination.

_____ _____
Date County Department of Human Resources Representative

I do hereby give my consent for the release of records and or information as requested to the

_____ Department of Human Resources.

Date: _____ Signature: _____

1. ☐ Documentary evidence such as a birth certificate, medical or law enforcement records which indicate that the above named child was conceived as the result of incest or forcible rape.
2. ☐ Court documents or other records indicating that legal proceedings for adoption are pending before a court of competent jurisdiction for the above named child.
3. ☐ A written statement from you that you are assisting the applicant/recipient in resolving the issue of whether to keep the above named child or to relinquish him/her for adoption and the discussion has not gone on for more than three months. (3 months does not apply to unborn)
4. ☐ Documentary evidence such as court, law enforcement, criminal, psychological, medical, service, or other records which indicate that the absent parent might inflict physical and/or emotional harm to the client and/or child if cooperation is required.
5. ☐ An evaluation which would assist this agency in establishing the existence of an emotional impairment which, if cooperation is required, is reasonably anticipated to result in a serious and identifiable emotional problem for the client and/or child named above. Please include the present emotional condition; a history of the emotional instability in terms of occurrence and frequency with identification of precipitating factors and consequences of such emotional instability; and a statement of the intensity and probable duration of any emotional instability.
6. ☐ Other (Specify)

Instructions for DHR-FAD-604
Request for Information/Documentation

Use/Purpose

This form is to be used when the client requests assistance in obtaining evidence in support of her/his claim for good cause in not cooperating with child support activities, in accordance with Section 2606G.

General Instructions

Use this form to request documentation from any agency having the necessary documentation, or to request a service or mental health evaluation when it becomes necessary to assist the client in establishing the existence of an emotional impairment which would be aggravated if cooperation is required. Complete the upper part of the form and have the client sign the release of information. Check the appropriate box indicating the material that is being requested and, if only one or two items are specifically needed, circle those.

When the requested information/documentation is received, attach it with any other evidence to the DHR-FAD-601 before forwarding it to the County Good Cause Review Team.

Distribution

Original: Service unit, other appropriate agency or client.
Copy: Case record.

THIS FORM WILL NOT BE STOCKED. MAKE COPIES AS NEEDED.

_____ COUNTY

DEPARTMENT OF HUMAN RESOURCES

_____, ALABAMA

To: _____ Date _____

Address: _____

VITAL STATISTICS VERIFICATION

Please verify the (birth) (marriage) (age of death) of: - Name _____

Present address _____ Sex _____ Color _____

Which is said to have taken place in _____
City County State

on the _____ day of _____ Year _____

Maiden name of (mother _____
(wife

Name of (father _____
(husband)

If birth verification, name of attendant at birth _____

If marriage verification, minister's name _____

Thank you for your cooperation.

Sincerely,

_____
Director

Our records show that _____

(was born) (died) on _____ day of _____ Year _____

Age given at time of marriage was _____

Date Filed: _____

Certificate No. _____
Year Volume Page

Our files between _____ and _____

show no record of the above (birth
(marriage
(death

Reported by _____

Agency _____

City _____ State _____

MARK OUT WORDS THAT ARE NOT APPLICABLE.

DHR-FAD 650
Rev. Sept. 2006

Instructions for DHR-FAD-650
Vital Statistics Verification

Use/Purpose

This form may be used for verification of births, deaths, and marriages, in accordance with Sections 1125B, 23005 and 23010B.

General Instructions

Prepare the upper part of the form in duplicate.

Distribution

Original: Bureau of Vital Statistics
Copy: Case record until original is returned

THIS FORM WILL NOT BE STOCKED. MAKE COPIES AS NEEDED.

_____COUNTY

DEPARTMENT OF HUMAN RESOURCES

NOTICE OF ACTION

☐ **Family Assistance** ☐ **Food Assistance** ☐ **SUP**

Food Assistance Case #. _____

Family Assistance Case #. _____

Worker

Telephone # Date of Notice

The item(s) checked below give information about your case. Items not checked do not apply to you.

1. ☐ **Your cash assistance case:**

☐ You have been approved for Family Assistance. You will receive $_____ for the month of _____. It should be available in your EBT account on or about the _____ of _____. After this payment, you will receive $_____ each month and it will be available in your EBT account about the 5th of each month unless you are otherwise notified.

☐ You have been approved for a SUP payment. You will receive $_____ for the month of _____. Your regular monthly SUP payment in the amount of $_____ will usually be mailed to you no later than the 2nd workday of each month unless you are otherwise notified.

☐ Your cash payment will be changed to $_____ effective _____, 20____.

☐ Your cash payment is being stopped effective _____ 20____. You will receive your last payment for the month of _____, 20___.

☐ Because a safety plan was made for you, we allowed you extra time to provide all necessary information. Because we have not received all the information we needed by the deadline we gave you, your cash assistance case will be closed effective _____, 20____. You will receive your last payment for the month of _____, 20____.

2. ☐ **Your food assistance case:**

☐ You have been approved for food assistance. You will receive $_____ in food assistance the first month. After the first month, you will receive $_____. You are certified from _____ 20____ to _____ 20____. To prevent loss in food assistance benefits, please re-apply before _____, 20____.

☐ The amount of your food assistance benefits will be changed from $_____ to _____ effective _____, 20____.

☐ Your food assistance benefits are being stopped effective _____, 20____. You will receive your last food assistance benefits for the month of _____, 20____.

☐ Because you needed food assistance right away, we did not ask you to give us certain information right away. Before you can get any more benefits, you should bring or mail in the information listed here: _____

_____

_____.

If this information causes a change in your benefits, the change will be made without advance notice to you.

3. ☐ Other action being taken in your case is as follows: _____

_____

_____

4. ☐ The action checked above is being taken because _____

_____

_____.

5. ☐ The Department policy used as a basis for the action(s) checked above is found in Assistance Payments Manual/Points of Eligibility Manual, section(s)

_____

_____

If you request it, we will show you a copy of the material in our office.

6. ☐ The action checked above will be taken unless you request a hearing before the date shown, (or for PA, unless you submit additional information which affects the action). Refer to the section "REVIEW OF ACTION ON YOUR CASE" on the back of this notice for more information about hearings.

Refer to the back of this notice for other important information.

_____ **COUNTY**

If you want a conference, State Office review, or fair hearing, fill out this form, tear it off, and mail to:

_____County Department of Human Resources

_____

_____

Mark (X) the box to show if you want a conference, a State Office review, and/or a fair hearing and mark (X) in the space beside the type of assistance.
Your request for a conference on your food assistance case will not delay or replace your request for a fair hearing.

- ☐ I want a conference on my _____ public assistance case and/or _____ food assistance case.
- ☐ I want a State Office review on my _____ public assistance case.
- ☐ I want a fair hearing on my _____ public assistance case and/or _____ food assistance case.

The reason I want this: _____

_____

_____

- ☐ I do not want to continue receiving the amount of public assistance and/or food assistance I now receive until the hearing is over.
- ☐ I do want to continue receiving the amount of food assistance I now receive until the hearing is over.

_____ _____

Signature Telephone Number

IMPORTANT NOTICE

FOOD ASSISTANCE: You may be eligible for food assistance even if you do not get FA. For more information, contact your worker or your County Food Assistance Office.

HEALTH COVERAGE: You and your family members may get free or low cost health coverage even if you do not get Family Assistance. If you want to apply for Medicaid, ALL Kids, or help paying for insurance, apply online at www.insurealabama.org or call toll-free: 1-888-373-5437 or 1-800-362-1504 if you have any questions.

TRANSITIONAL CHILD CARE PROGRAM: You may get help with child care after your FA payment stops if you need child care in order to work. If you need child care you must apply at the Childcare Management Agency serving your county within six months of closure of your FA case. You must provide information and pay any fees that may be required.

CHILD SUPPORT SERVICES: If your FA application is denied, you may apply for child support services. If your FA case is closed, child support services will continue unless you request these services to stop. If you have any questions about child support, contact the County Child Support Unit.

REVIEW OF ACTION ON YOUR CASE:

- You may notify the County Department or the State Department of Human Resources in Montgomery, Alabama if you do not agree with the action on your case. You may ask for a conference with the County Department, a review by the State Department, or a formal hearing. (The State Department and the County Department follow the same rules.)
- You may request a hearing within 60 days of the action for FA. You may request a hearing within 90 days for Food Assistance. To continue your benefits until after the hearing, you must request a hearing within 10 days from the date of this notice. If your benefits are continued and the hearing decision is not in your favor, or if the hearing request is withdrawn or abandoned, you will have to repay any benefits to which you were not entitled.
- A hearing request for FA must be in writing. You may mail or deliver it to the State or County Department. You must sign it. You may have your lawyer or legally appointed representative or other authorized person sign it for you. You may request a hearing for food assistance orally or in writing.
- The hearing may be conducted by telephone.
- You may withdraw your request for a hearing when your complaint is otherwise resolved.

LEGAL ASSISTANCE AND OTHER HELP: TO OBTAIN FREE LEGAL ADVICE, CONTACT LEGAL SERVICES ALABAMA STATEWIDE INTAKE TOLL-FREE NUMBER AT 1-866-456-4995 OR AT THEIR STATEWIDE ONLINE INTAKE WEBSITE AT WWW.ALABAMALEGALHELP.ORG

NONDISCRIMINATION: Program rules are the same for everyone. Your race, color, birthplace, sex, handicap, beliefs, age or religion do not matter. Tell us if you have a physical, mental or learning disability that limits a major life activity. We may be able to help you to fully use existing programs and services.

Instructions for DHR-FAD-657
Notice of Action

Use/Purpose

This form is used as a manual notice of award, change of status, or termination for FA, Food Stamps or SUP, when an automated notice is not available or inadequate according to Section 1140.

For food stamp purposes, this form is also used in the following circumstances:
1. Advance notice of action for reduction or termination is required.
2. Variable issuance will occur during the certification period.
3. The case is approved for expedited benefits.

General Instructions

Process the form to reach the client around, but not later than, the effective date of action. When advance notice of action is required, mail the form at least 10 days before the effective date of the action. Mail the original to the client and maintain the copy in the case record.

Complete the top section being sure to sign and date the form (date on which it is mailed) and provide your office telephone number. Show the client's correct name and address in the brackets to be visible through a window envelope.

Check all items that apply and complete each checked item. Most items are self-explanatory.

Item 1 – Check if the form is processed for FA or for SUP. Then check and complete each applicable item. For effective dates, show the month, day and year.

Item 2 – Check if the form is processed for Food Stamps. Then check and complete each applicable item. For effective dates, show the month, day and year.

Item 3 – Use this item to inform the client when a change was received but had no effect on his/her food stamps, or when a medicaid only SUP case is terminated.

Item 4 – Be specific in explaining the reason(s) for the action taken. For reductions and terminations, state every condition or circumstance which had an impact in causing the change.

Item 5 – Complete for reductions in payment or allotment and for terminations. It need not be completed for awards or increases in benefits. List all Assistance Payments Manual references first and then list the Points of Eligibility Manual references. Separate the Assistance Payments Manual references from the Points of Eligibility Manual references by a diagonal line. If references of only one manual are used, strike through the printed name of the one not being used. If references of neither manual are used, strike through the printed names of both and write in full the reference used, such as Administrative Letter No.___, etc.

Item 6 – When the form is being sent as advance notice of reduction or termination, this item must be checked.

On the back of the form, enter the name and address of the County Department in the spaces provided.

Distribution

Original: Client
Copy: Case Record

_____ COUNTY

DEPARTMENT OF HUMAN RESOURCES

NOTICE OF DENIAL OR PENDING STATUS

☐ Family Assistance ☐ Food Assistance ☐ Other _____	
Food Assistance # _____	
Family Assistance # _____	
Worker	
Phone	Date of Notice

This is to notify you of action taken in your case. Please refer to the item(s) checked below.

1. ☐ Your application for assistance has been disapproved because _____

2. ☐ Your application for food assistance has been denied because _____

3. ☐ Your application was denied because you did not do everything you needed to do so that we could find out if you are eligible for food assistance. Here is what you still need to do: _____ _____ . If you do this by _____ we will reopen your case. It will also be necessary to report all changes that have occurred since you filed your application. You will have to reapply if you do not take action by this date.

4. ☐ 30 days have passed and we have not reached a decision on your food assistance about your eligibility for benefits. Here is the reason this happened: _____

   If we find you are eligible when we finish processing your application, you will receive all your benefits back to the date you applied.

5. ☐ Other _____

6. ☐ The Department policy used as a basis for the indicated action(s) is found in Assistance Payments Manual/Points of Eligibility Manual section(s) _____ . If you request it, we will show you a copy of the material in our office.

If you would like to discuss our findings or ask any questions about how a fair hearing works, you can call the worker named above.

Refer to the back of this notice for important information.

_____ COUNTY; COUNTY NO. _____

If you want a fair hearing, conference, or State Office review, fill out this form, tear it off, and mail to:

_____County Department of Human Resources

_____

_____

Check (✓) the box to show if you want a fair hearing, conference, or State Office review and check (✓) if it is for public assistance, food assistance or medicaid.

☐ I want a conference on my _____ public assistance case, _____food assistance case, or _____medicaid case.

☐ I want a State Office review on my _____ public assistance case or medicaid case.

☐ I want a fair hearing on my _____ public assistance case, _____ food assistance case, or _____ medicaid case.

The reason you want this: _____

_____

_____

_____ _____

Signature Telephone Number

FOOD ASSISTANCE: You may be eligible for food assistance even if you do not get FA. For more information, contact your worker or your County Food Assistance Office. You should inform the county office if you have been denied Food Assistance and you are later approved for Family Assistance and/or SSI.

CHILD SUPPORT SERVICES: If your FA application is denied, you are entitled to apply for child support services. If your FA case is closed, child support services will continue unless you request these services to stop. If you have any questions regarding child support, please contact the County Child Support Unit.

HEALTH COVERAGE: You and your family members may get free or low cost health coverage even if you do not get Family Assistance. If you want to apply for Medicaid, ALL Kids, or help paying for insurance, apply online at www.insurealabama.org or call toll-free: 1-888-373-5437 or 1-800-362-1504 if you have any questions.

REQUEST FOR A CONFERENCE OR STATE OFFICE REVIEW REGARDING THE ACTION TAKEN ON YOUR CASE: If you are not satisfied with the action on your case, or need further explanation, you have a right to discuss your case with a worker, a supervisor and/or the County Director. If you are not satisfied with the results of this conference, you may wish to request a hearing or a review by the State Department. A request for a conference or review will not affect your right to a hearing.

REQUEST FOR A HEARING: If you are not satisfied with the action taken on your case, you may request a hearing by notifying this office or the State Department within sixty (60) days from the date action was taken. A food assistance hearing may be requested within ninety (90) days from the date action was taken on your case. A hearing request involving public assistance must be in writing. A food assistance hearing request may be oral or in writing. A written request should state why you are dissatisfied and must include your correct mailing address and the mailing address of any person representing you in your request. It may be filed by you, your lawyer or legally appointed representative, or other authorized person. In the latter situation, the person representing you in your request must make a definite statement that s/he has been authorized by you to request the hearing. The address of the State Office is 50 N. Ripley Street, Montgomery, AL 36130-4000.

WITHDRAWING A HEARING REQUEST: If you wish to withdraw your request before the hearing, you, your lawyer, or legally appointed representative, or other authorized person should write the County or State Department that you wish to do so and give the reason for withdrawing.

LEGAL ASSISTANCE AND OTHER HELP: TO OBTAIN FREE LEGAL ADVICE, CONTACT LEGAL SERVICES ALABAMA STATEWIDE INTAKE TOLL-FREE NUMBER AT 1-866-456-4995 OR AT THEIR STATEWIDE ONLINE INTAKE WEBSITE AT WWW.ALABAMALEGALHELP.ORG.

NONDISCRIMINATION: Program rules are the same for everyone. Your race, color, birthplace, sex, handicap, beliefs, age, or religion do not matter. Tell us if you have a physical, mental or learning disability that limits a major life activity. We may be able to help you to fully use existing programs and services.

Instructions for DHR-FAD-660
Notice of Denial or Pending Status

Use/Purpose

This form is to be used to deny an application for assistance when the automated notice is inadequate, according to Section 1140, and to deny a food stamp application or place it in pending status.

General Instructions

Complete in duplicate. Complete the upper section being sure to sign and date the form (date on which it is mailed) and provide your office telephone number. Show the client's correct name and address in the brackets to be visible through a window envelope.

Check all items that apply and complete each checked item. Most items are self-explanatory.

Item 4 – Explain clearly why the application for food stamps is still in pending status. If additional space is needed, use item 5.

Item 6 – This item must always be completed. Be specific in explaining the reason(s) for the action taken and the policy used as the basis for the action. List all Assistance Payments Manual references first and then list the Points of Eligibility Manual references. Separate the Assistance Payments Manual references from the Points of Eligibility Manual references by a diagonal line. If references of only one manual are used, strike through the printed name of the one not being used. If references of neither manual are used, strike through the printed names of both and write in full the reference used, such as Administrative Letter No.___, etc.

Distribution

Original: Client
Copy: Case Record

_____ COUNTY
DEPARTMENT OF HUMAN RESOURCES
INTERVIEW NOTIFICATION

DATE _____

CASE ID _____

PSD FILE NO _____

_____

_____

_____

IT IS IMPORTANT THAT WE TALK WITH YOU. IF YOU CANNOT BE AVAILABLE AT THE TIME SHOWN BELOW, PLEASE CALL _____ OR EMAIL _____ IMMEDIATELY TO CHANGE THE DATE AND TIME OF THE APPOINTMENT OR LEAVE A MESSAGE. IF YOU RESPOND BY CALL OR EMAIL, PLEASE INCLUDE YOUR FULL NAME AND LAST FOUR NUMBERS OF YOUR CASE ID. IF YOU FAIL TO BE AVAILABLE OR COME TO AN INTERVIEW AS REQUESTED BELOW, YOUR APPLICATION MAY BE DENIED OR YOUR CASE CLOSED. THANK YOU.

_____
WORKER/APPOINTMENT CLERK SIGNATURE

PURPOSE OF INTERVIEW:
- ☐ Initial Application
- ☐ Review
- ☐ Other (specify) _____

INTERVIEW SCHEDULE

	Date	Time
( ) Please come to the		
( ) County Office	_____	at _____
( ) Other _____		
_____		
_____	_____	at _____
( ) I will contact you by telephone on	_____	at _____
( ) Please call me at _____ on	_____	at _____

ITEMS TO BRING WITH YOU WHEN YOU COME TO THE OFFICE:

( ) Proof of your relationship to the following children: _____
( ) Proof of identity for you and/or other adult(s): _____
( ) Social security numbers for you and your children: _____
( ) Information about the absent father/mother of the following children: _____
( ) Proof of income from: _____
( ) Proof of wages (pay stubs, statement from employer, etc.)
( ) Employer's address and phone number
( ) Written statement from the person you pay to take care of your child(ren) while you work, stating the amount you pay
( ) Other _____
_____

Instructions for DHR-FAD-686
Interview Notification

Use/Purpose

This form is used to schedule face to face or telephone appointments with a client according to Sections 1120D and 1125B and F.

General Instructions

The "Purpose of Interview" section must be completed to indicate what type of interview is being scheduled. Complete the bottom section of the form to advise the client of the case specific information/verification that s/he should bring to the interview.

Distribution

Original: Client
Copy: Case Record

_______________ COUNTY DEPARTMENT OF HUMAN RESOURCES

____

____

BANK CLEARANCE

TO:

RE: ACCOUNT NAME _______________
SSN: _______________
ACCOUNT NO: _______________
CASE NAME/ ID #: _______________
CASE #(s): FA _______________ FS _______________
WORKER _______________ DATE: _______________

I. Authorization for Release of Information

Please provide financial information for the individual listed above by completing all items checked on the front and back of this form. Include all accounts in which the named individual has an interest (any account on which the person's name appears). Authorization is provided as follows:

A. ☐ I, _______________________, give the Department of Human Resources permission to verify my bank account(s).

B. ☐ Authorization for release is conveyed by signature on required department forms which provide explanations of the Federally mandated use of social security numbers.

☐ II. Checking/Savings Account Information

C. Does the person named above have any checking/savings account(s), or did s/he have any during the period _______________ to _______________? ☐ Yes ☐ No. If yes, complete Account Work Space as appropriate. Please be sure to show name(s) exactly as it appears on the account(s). If joint account(s), indicate "and/or". Show balance in account(s) as of first of month.

	ACCOUNT WORK SPACE					
	SAVINGS ☐ CHECKING ☐ ACCOUNT NO: ________ NAME(S) ON ACCOUNT ________ ________ DATE OPENED: ________ DATE CLOSED: ________ CURRENT BALANCE: ________		SAVINGS ☐ CHECKING ☐ ACCOUNT NO: ________ NAME(S) ON ACCOUNT ________ ________ DATE OPENED: ________ DATE CLOSED: ________ CURRENT BALANCE: ________		SAVINGS ☐ CHECKING ☐ ACCOUNT NO: ________ NAME(S) ON ACCOUNT ________ ________ DATE OPENED: ________ DATE CLOSED: ________ CURRENT BALANCE: ________	
PERIOD MONTH/YEAR	BALANCE	INTEREST AND FREQUENCY	BALANCE	INTEREST AND FREQUENCY	BALANCE	INTEREST AND FREQUENCY
Jan 20__						
Feb 20__						
Mar 20__						
Apr 20__						
May 20__						
June 20__						
July 20__						
Aug 20__						
Sep 20__						
Oct 20__						
Nov 20__						
Dec 20__						

D. Additional checking/savings account work space.

ACCOUNT WORK SPACE						
	SAVINGS ❑ CHECKING ❑ ACCOUNT NO: ____ NAME(S) ON ACCOUNT ____ DATE OPENED: ____ DATE CLOSED: ____ CURRENT BALANCE: ____		SAVINGS ❑ CHECKING ❑ ACCOUNT NO: ____ NAME(S) ON ACCOUNT ____ DATE OPENED: ____ DATE CLOSED: ____ CURRENT BALANCE: ____		SAVINGS ❑ CHECKING ❑ ACCOUNT NO: ____ NAME(S) ON ACCOUNT ____ DATE OPENED: ____ DATE CLOSED: ____ CURRENT BALANCE: ____	
PERIOD MONTH/YEAR	BALANCE	INTEREST AND FREQUENCY	BALANCE	INTEREST AND FREQUENCY	BALANCE	INTEREST AND FREQUENCY
Jan 20__						
Feb 20__						
Mar 20__						
Apr 20__						
May 20__						
June 20__						
July 20__						
Aug 20__						
Sep 20__						
Oct 20__						
Nov 20__						
Dec 20__						

❑ III. Other Account Information

E. Does the individual have any other type account(s) such as IRA's, certificates of deposit, trust funds, money market, etc.? ❑ Yes ❑ No. If yes, complete Account Work Space below.

ACCOUNT WORK SPACE

TYPE ACCOUNT	NAME ON ACCOUNT	ACCOUNT #	AMOUNT	DATE OPENED	DATE CLOSED	DATE OF MATURITY	INTEREST RATE & FREQUENCY

F. Does this person have a safe deposit box? ❑ Yes ❑ No.

G. Other ____________________

❑ IV. Financial Institution Information

____
Signature of Person Completing Form

____
Title

____
Telephone Number

____
Date Completed

Instructions for Form 689
Bank Clearance

Use/Purpose

This form is used to verify bank (or other financial institution) information when the client cannot provide or asks for assistance in providing the information needed. NOTE: Use of this form by the worker when the client has not been asked to provide the verification means that the worker has assumed responsibility for obtaining verification of bank information. Failure of the bank or other financial institution to return the form requires contact with the client to request that the client provide the information.

General Instructions

The form is to be completed in duplicate with the copy maintained in the file until the original is returned from the financial institution. The worker must complete the address of the bank or other financial institution, client data, program(s) applicable and the worker's name and date and mail the form directly to the financial institution with a self-addressed stamped envelope. A faxed return copy is acceptable if Section IV is complete with legible signature.

Section I. Authorization for Release of Information

A. Check "A" only if the client has signed the form giving permission for release of the information requested.

B. Check "B" only if the information is being requested as a result of an IEVS match. If the form is being solely as a result of an IEVS prompting report for unearned income (IRS) or earnings (BENDEX BEER), no information from the screen such bank name/address, amounts, years/months involved, etc., may be written on the form. Department information to complete the RE: section may be filled in and other pertinent parts of the form checked. Do not address the form itself to the financial institution. (Envelope only.)

Sections II – IV are self-explanatory.

ALABAMA DEPARTMENT OF HUMAN RESOURCES
Family Assistance (FA) Program
Application for Assistance

Filing An Application

To apply you only have to fill in your name, address, then sign and date below. Complete as much of the form as possible. If you need help, the worker will help you complete the rest of your application. If you need interpreter services due to language or a sensory impairment, tell us so your worker can arrange for help at no cost to you.

Interpreter Needed: ☐ Yes ☐ No

Type: Language _____ (Specify); Sensory _____ (Specify)

AGENCY USE ONLY

Date given/mailed _____
Date received _____
County _____
Case File# _____
PSD File # _____
Appt. Date _____
Appt. Time _____
Worker _____

Your Name (Last, First, MI)	Other Names Used
Marital Status/Date ☐ Married Date_____ ☐ Separated Date_____ ☐ Widowed Date_____ ☐ Divorced Date_____ ☐ Single	Home/Cell/Message Phone Email Address

Address Where You Live	Apartment No.

City and State	Zip Code	County

Mailing Address (if different from above)

I CERTIFY UNDER PENALTY OF PERJURY THAT THE STATEMENTS ON THIS APPLICATION ARE TRUE AND CORRECT.

Your Signature or Mark	Date
Signature of Witness if Mark is Used/Interpreter/Other	Date

If you are eligible, you will get your benefits back to the date we received your signed application. Before you can get benefits, you must talk with a worker. We must have proof of the information you give us on your FA application and will take final action on your application within 30 days from the date we receive it. If anything you told us changes after your interview, you must report it to your worker immediately.

Past Support

How have you been supporting yourself and others for whom you want assistance and why do you need help now?

Applicant Information

LIVING in the HOME and AGE of CHILDREN: The children you list below must be living with you and be under the age of 18 (or age 18 if s/he is a full-time student in a secondary school or equivalent level of vocational or technical training). (Secondary school may include public, private, church and home schools for grades 9 through 12.)

PARENT Applicant: List yourself on line 1 below. Starting on line 2, list the children for whom you want to apply and their brothers and sisters. Also list any other parent of the children in your home and your spouse if living with you.

NON-PARENT Applicant: List yourself on line 1 below. Starting on line 2, list the related children for whom you want to apply and their brothers and sisters. Also list any parent or step parent of the children in your home. NOTE: As a non-parent, providing your social security number or information about your citizenship/alienage is optional.

NAME (Last, First, Middle) Use first line for yourself	Relationship to you	Date of Birth	Social Security Number	Sex	* Race / Ethnicity	Citizenship and Alienage: U.S. Citizen or National Yes/No	Citizenship and Alienage: In Satisfactory Immigration Status Yes/No
1.	Self						
2.							
3.							
4.							
5.							
6.							

Other Members

OTHERS - List your parents or step parent(s) if you are under age 18 and living in the same home.

Voter Registration

IF YOU ARE NOT REGISTERED TO VOTE WHERE YOU LIVE NOW, WOULD YOU LIKE TO APPLY TO REGISTER TO VOTE HERE TODAY?

- ☐ Yes, I would like to register to vote.
- ☐ Yes, I am registered but would like to change my address for voting purposes.
- ☐ No, I do not want to apply to register to vote.

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help in filling out the voter registration form, we will help you. You may seek assistance with the application form by seeking assistance at the time of your interview or by calling your local Department of Human Resources located within your county. The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you choose to apply to register to vote or if you decline to register to vote, the information on your application or declination form will remain confidential and will be used for voter registration purposes only.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of State at State Capitol, 600 Dexter Avenue Suite E-208, Montgomery, AL 36130 or by calling 334-242-7210 or 1-800-274-VOTE (1-800-274-8683) .

Race & Ethnicity Codes

*Collection of ethnicity is used for statistical and Federal reporting purposes only.

Providing this information will not affect your eligibility.

If you do not complete this information, it will be completed for you.

01=American Indian/Alaskan Native
02=Asian
03=Black/African American
04=Native Hawaiian/Other Pacific Islander
05=White
06=American Indian/Alaskan Native and White
07=Asian and White
08=Black/African American and White
09=American Indian/Alaskan Native and Black
12=Asian and Black
33=Hispanic/Latino/Cuban/Haitian
32=Other (worker will determine appropriate code at interview)

Civil Rights

Program rules are the same for everyone. Your race, color, national origin, sex, handicap, beliefs or religion do not matter. To file a complaint regarding the Family Assistance Program, write to the Department of Health and Human Services (DHHS), Office of Civil Rights, Room 509F, 200 Independence Avenue, S. W., Washington, D. C. 20201 or call 1-800-368-1019. The DHHS is an equal opportunity provider and employer.

State of Alabama Agency-Based Voter Registration Form

NVRA-1B-H
2019.06.27

FOR USE BY U.S. CITIZENS ONLY ◆ FILL IN ALL BOXES ON THIS FORM ◆ PLEASE USE INK ◆ PRINT LEGIBLY

To register to vote in the State of Alabama, you must:

- ▶ Be a citizen of the United States.
- ▶ Live in Alabama.
- ▶ Be at least 18 years of age on or before election day.
- ▶ Not have been convicted of a disqualifying felony, or if you have been convicted, you must have had your civil rights restored.
- ▶ Not have been declared "mentally incompetent" by a court.

FOR USE BY AGENCY OFFICIAL ONLY

Check one (1) box:

- ☐ Registrars
- ☐ Motor Voter
- ☐ State Designated Agency
- ☐ Agency-Based
- ☐ Disabilities Services Office

Signature of Agency Representative

Business Phone of Agency Representative

ID requested: You may send with this application a copy of valid photo identification. You will be required to present valid photo identification when you vote at your polling place or by absentee ballot, unless exempted by law. For more information, go to www.AlabamaVoterID.com or call the Elections Division: 800-274-8683.

① Are you a citizen of the United States of America? ☐ Yes ☐ No ← **ATTENTION! If you answer "No" to either of these questions, do not complete this application.**

② Will you be 18 years of age on or before election day? ☐ Yes ☐ No ←

③ Print Your Name:

First | Middle | Last | Suffix

④ Print Maiden Name / Former Name (if reporting a change of name)

First | Middle | Last | Suffix

⑤ Date of Birth (mm/dd/yyyy) | **⑥ Primary Telephone** ( ) | **⑦ Email Address**

Alabama Driver's License or Non-Driver ID Number: ☐☐ STATE ☐☐☐☐☐☐☐☐ NUMBER

IF YOU HAVE NO ALABAMA DRIVER'S LICENSE OR ALABAMA NON-DRIVER ID NUMBER

Last four digits of Social Security number: ☐☐☐☐

☐ I do not have an Alabama driver's license or Alabama non-driver ID or a social security number.

⑧ Addresses

Current

Address where you live: (Do not use post office box) — Home Address (include apartment or other unit number if applicable) | City | State | ZIP

Address where you receive your mail: — Mailing Address, if different from Home Address | City | State | ZIP

Old

Address where you were last registered to vote: (Do not use post office box) — Former Address | City | County | State | ZIP

⑨ Sex (check one)

☐ Female ☐ Male

⑩ Race (check one)

☐ White ☐ Black
☐ Asian ☐ American Indian
☐ Hispanic ☐ Other

⑪ Place of Birth City | County | State | Country

⑫ Map / Diagram

If your home has no street number or name, please draw a map of where your house is located. Please include roads and landmarks.

⑬ Did you receive assistance?

If you are unable to sign your name, who helped you fill out this application? Give name, address, and phone number (phone number is optional).

REGISTRARS USE ONLY

DATE ☐ APPROVED ☐ DENIED

_____ (mm/dd/yyyy)

County Pct _____

City Pct _____

_____ Board member

_____ Board member

_____ Board member

Voter Declaration - Read and Sign Under Penalty of Perjury

- ▶ **I am a U.S. citizen**
- ▶ **I live in the State of Alabama**
- ▶ **I will be at least 18 years of age on or before election day**
- ▶ **I am not barred from voting by reason of a disqualifying felony conviction (The list of disqualifying felonies is available on the Secretary of State's web site at: sos.alabama.gov/mtfelonies)**
- ▶ **I have not been judged "mentally incompetent" in a court of law**

I solemnly swear or affirm to support and defend the constitution of the United States and the State of Alabama and further disavow any belief or affiliation with any group which advocates the overthrow of the governments of the United States or the State of Alabama by unlawful means and that the information contained herein is true, so help me God.

YOUR SIGNATURE | **DATE** (mm/dd/yyyy)

If you falsely sign this statement, you can be convicted and imprisoned for up to five years.

The decision to register to vote is yours. If you decide to register to vote, the office at which you are submitting this application will remain confidential and will be used only for voter registration purposes. If you decline to register to vote, your decision will remain confidential and will be used only for voter registration purposes.

Instructions for Form DHR-FAD-690

Application for Family Assistance

Purpose

1. Initial Application: Form DHR-FAD-690 is the document that represents a formal application for Family Assistance when signed by the applicant and received in the County DHR office.

2. Application to Add Individuals to Existing Unit: Form DHR-FAD 690 is the document that represents a formal application to add someone to the assistance unit (required or optional member) when signed by the recipient and received in the County DHR office.

Reference: Assistance Payments Manual Section 1105A.

The 690 is to be used by the person responsible for registering the FA application in pre-screening all individuals to be included in the assistance unit.

General Instructions

A. Initial Applications

This form must be mailed or given the same day an individual requests an application for FA.

The individual may complete this form in the office or, if the form was mailed to the individual, it may be completed and mailed or otherwise delivered to the County DHR office. During the interview, update any information that has changed since the form was originally signed by the client and have the client initial and date each change. If the form is updated during a telephone interview, make a copy and send to the client to initial and date the changes. Include a return mail envelope. Make a reference to the change(s) in the narrative recording.

The 690 must be filed appropriately in the case record. Please refer to Assistance Payments Manual Section 20020 for additional filing instructions and ongoing policy. While the form may be a copy, an original signature is required. If the client is actively assisted by someone during the interview process, obtain their signature as well. This includes an interpreter if present in the office. Forms received by FAX or email are to be returned to the client per Assistance Payments Manual Section 1105A.5.

Form completion is generally self-explanatory. However, if there are more than 10 people in the assistance unit, list them and information pertinent to establishing eligibility (social security number, date of birth, citizenship, race, etc.) on a separate sheet of paper. Attach the sheet to the 690 and make a note on the back of the 690 referring to the additional clients.

Re-applications: The 690 can be reused after a denial provided the date of reapplication is within 90 days from the date of the original application. Update the form as needed and have the client re-sign and date the form. If the date is more than 90 days from the date of the original application, a new 690 must be completed.

B. Application to Add Individuals to Existing Unit

A new form 690 may be completed following usual instructions or the current form 690 may be updated. If the current 690 is updated during a face to face interview the client must initial all new entries and re-sign the form. If the current 690 is updated by the worker during a telephone interview, make a copy of the updated form and mail the copy to the recipient for signature with a return mail envelope. When returned the signed copy is to be filed with the current original 690.

Distribution

Case Record

STATE OF ALABAMA
DEPARTMENT OF HUMAN RESOURCES
FAMILY ASSISTANCE DIVISION

CHANGE REPORT FORM

County _____

Name _____ Program _____ Case No. _____

PART I. CHANGES

I want to report the following change(s) that has taken place in my income, resources, expenses or living arrangements and the date the change(s) occurred.

1. ( ) I am moving/have moved. Date _____. New address _____

_____

2. ( ) I have a new member in my household. Name _____

Relationship to me _____ Date moved in _____

3. ( ) A member of my household has moved out. Name _____

Date moved out _____.

4. ( ) _____ now receives SSI. Date _____

5. ( ) I request that my benefits be stopped. Date _____

Reason _____

_____

6. ( ) I have more/less resources. (Bank accounts, property, etc.) Specify _____

_____

Source _____. Date _____

7. ( ) I have more/less income. Specify _____

Source _____. Date _____

8. ( ) I am now employed. Date started _____ Wages _____ per _____

Date of first paycheck _____ Day of week pay received _____

Number of hours per week _____. Employer _____

Employer's Address _____ Tel. No. _____

(Continued on back)

9. ( ) I pay/no longer pay day care. Date _____ Amount _____ per _____

Day Care Center/Home (Name) _____

Address _____ Tel. No. _____

10. ( ) I am no longer employed. Date stopped _____ Date last pay received _____

Reason _____

11. ( ) Other: Explain _____

_____

_____

_____

_____ ( ) Applicant ( ) Recipient _____
(Signature) (Date)

Witness _____ Address _____ _____
(Date)

PART II. REQUEST FOR IMMEDIATE ADVERSE ACTION FOR BENEFIT REDUCTION/TERMINATION

As a result of the information I have reported, I understand that the items completed below show the effect this information will have on my benefits.

1. ( ) My benefits will be reduced to _____ effective _____

2. ( ) My benefits will be terminated effective _____

I understand that by signing this Request for Immediate Adverse Action, I am giving up the 10 day advance notice of such adverse action. I also understand that I am giving up continued assistance at the present level.

I want immediate action taken because _____

_____

_____

_____

I have read or had this form read to me.

_____ _____
(Signature) (Date)

Witness _____ Address _____ Date _____

Instructions for DHR-FAD-703
Change Report Form

Use/Purpose

This form is used to record a client's report of a change, in accordance with Section 1125G.

General Instructions

Fill in identifying information and complete Part I with the client. If the change will result in a reduction or termination of benefits and the client wishes to waive advance notice and have immediate adverse action taken, complete Part II checking applicable statements and filling in the blanks. Record the client's specific reason(s) for wanting immediate action and have her/him sign the form.

Distribution

Original: Client
Copy: Case Record until replaced by original

(Formerly)
PSD-251 Revised
November, 1976

Page _____

RECORD OF CONTACT

Name of Applicant/Recipient _____

Case Number _____

DATE AND PERSON/SOURCE	PURPOSE/RESULTS

Instructions for PSD-BPA-746
Record of Contact

Use Purpose

This form is used, according to Section 20025A, to record information which is pertinent to the case and not found on any other document or form in the case record.

General Instructions

All entries are handwritten and must be legible, well organized and to the point. Enter the date of the contact and write the name of the person contacted or the source of the information secured under the date. If more than one contact takes place on the same day, enter 'Later' in place of the date for subsequent contacts. If the person or source of the later contact changes, write the new name or source under 'Later'. Record the narrative entry. Sign each entry after and to the right of the entry. If information from an earlier contact must be included after later information has already been entered, insert the date of the contact in chronological order and a note to reference where the misplaced entry may be found.

Distribution

Case Record

_____COUNTY DEPARTMENT OF HUMAN RESOURCES

TIME LIMIT HARDSHIP
Mental/Physical Incapacity

WORKER: _____

CASE ID #: _____

PSD FILE NUMBER: _____

CLIENT'S NAME: _____

DATE OF BIRTH: _____ ; GRADE COMPLETED: _____ ; SPECIAL TRAINING: _____

USUAL EMPLOYMENT: _____

_____; DATE LAST EMPLOYED: _____

NOTE TO PHYSICIAN

Receipt of cash benefits for needy families with children is time limited to a lifetime of 60 months. However, a temporary exception to the time limit rule can be made for individuals with a mental/physical incapacity that substantially reduces or prevents him/her from engaging in gainful employment even part time. The above named individual has claimed to have such a condition. This examination is needed to determine if this claim is supported by medical evidence.

THE DEPARTMENT OF HUMAN RESOURCES CAN PAY A MAXIMUM OF $15 FOR COMPLETION OF THIS FORM. YOUR BILL SHOULD BE SUBMITTED IN DUPLICATE AND MUST INCLUDE YOUR SOCIAL SECURITY OR FEDERAL ID NUMBER. TIMELY SUBMISSION OF BILLS (WITHIN 60 DAYS OF DATE OF SERVICE) WILL ASSIST IN TIMELY PAYMENT TO YOU.

PLEASE RETURN THE COMPLETED FORM TO THE COUNTY DEPARTMENT OF HUMAN RESOURCES.

I DO ☐ DO NOT ☐ AUTHORIZE PAYMENT FOR COMPLETION OF THIS FORM.

SIGNED: _____ DIRECTOR, _____ COUNTY
DEPARTMENT OF HUMAN RESOURCES

DATE: _____

SECTION I

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
(To be signed by client)

I authorize the examining physician or medical facility to furnish a complete report of my examination to the Department of Human Resources. This information may be shared with another agency or service to help me become self-supporting and/or self-sufficient.

SIGNATURE: _____ DATE: _____

WITNESS (if signed by mark): _____

NOTE TO PHYSICIAN: Complete Sections II, III and IV.

SECTION II

STATEMENT OF INCAPACITATING CONDITION
(PLEASE DO NOT ABBREVIATE)

LIST PRINCIPAL DIAGNOSIS RESPONSIBLE FOR PATIENT'S INCAPACITY: _____

_____

_____

DATE OF ONSET: _____ DATE OF SURGERY (IF ANY): _____

DATE OF LAST EXAMINATION: _____

SECTION III

LIMITATIONS ON EMPLOYMENT
(CHECK ONE)

☐ 1. NO AFFECT ON EMPLOYMENT.

☐ 2. PATIENT'S CONDITION IS SUCH AS TO PREVENT OR SUBSTANTIALLY REDUCE HIS/HER ABILITY TO WORK (NOT NECESSARILY AT HIS/HER USUAL EMPLOYMENT) EVEN PART TIME.

SECTION IV

PHYSICIAN'S/PSYCHOLOGIST'S AFFIRMATION AND UNDERSTANDING

I give my permission for the above information to be released to agencies and organizations if necessary to enable this patient to receive any and all services and benefits toward becoming self-sufficient and/or self-supporting.

I understand in the event of an administrative hearing, this report, as part of the agency's record will be available to the patient and to others present at the hearing.

I understand any voucher for payment for this examination will be based on services rendered in compliance with the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and ADA of 1990.

I HEREBY CERTIFY ALL THE ABOVE STATEMENTS ARE TRUE.

SIGNATURE: _____ DATE OF REPORT _____
(Physician's or Licensed/Certified Psychologist's Signature)

PLEASE PRINT/TYPE THE FOLLOWING INFORMATION:

PHYSICIAN'S/PSYCHOLOGIST'S NAME _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

OFFICE PHONE NO. _____

Instructions for DHR-FAD-770
Time Limit Hardship
Mental/Physical Incapacity

Use/Purpose

This form is used to obtain medical information to determine the existence of hardship due to a claim of mental/physical incapacity for clients who have already received for 60 months.

General Instructions

This form must be completed by a physician or licensed or certified psychologist. Complete all items in the upper part of the form and have the client sign in the lower part. Mail the form to the doctor for completion. Payment of up to $15 for information on this form may be made as an administrative expense. If the client is dissatisfied with the agency decision based on this medical information and wishes to have another examination, s/he may do so at his/her own expense.

Distribution

Case Record after completion

Revision No. 762 Nov. 2008

DEPARTMENT OF HUMAN RESOURCES

COMMUNICATIONS MEMO

Date _____

Unit Name of worker if known

TO: ☐ Eligibility _____

☐ Service _____

☐ Food Stamps _____

☐ Child Support _____

☐ JOBS _____

☐ Other (specify) _____

FROM: Worker _____

Telephone Number _____

☐ Eligibility Unit
☐ JOBS Unit
☐ Child Support Unit
☐ Service Unit
☐ Food Stamp Office
☐ Other (specify) _____

RE: Name _____

Address _____

_____ Zip _____

PA Case ID _____
PSD File No _____

FS Case No _____

Other (specify) _____

Reply Requested: ☐ Yes ☐ No

INFORMATION:

RESPONSE:

_____
(Worker) (Date)

DHR-PAD-799
January 1993

Instructions for DHR-PAD-799
Communications Memo

Use/Purpose

This form is used for intra-agency communication among units about common clients when automated notices are unavailable or inadequate.

General Instructions

Send a copy with the original when a response is requested. To facilitate routing of the response back to the original sender, the responding worker is to cross out on the copy to be returned the original 'To' information and complete new 'To' information.

Distribution

Case Record after completion

State of Alabama
Department of Pensions and Security

OVERPAYMENT FORM

(1) Page _____ of _____

(2) Check one

(a) ☐ SUSPECTED FRAUD/INTENTIONAL PROGRAM VIOLATION (IPV) — Attention: Division of Fraud Detection and Prevention.

(b) ☐ OVERPAYMENT/OVERISSUANCE Attention: _____ (Name of Bureau/Division)

☐ Administrative Error ☐ Client Misunderstanding ☐ PAL Error

(3) County Code: _____ (4) Date Discovered: __ __ / __ __ / __ __ (M M / D D / Y Y) (5) Date Prepared: __ __ / __ __ / __ __ (M M / D D / Y Y)

County Name: _____

(6) Is fraud suspected in any other program? ☐ No ☐ Yes _____ (Program) _____ (Approximate Amount)

(7) Is this correction of previous report? ☐ No ☐ Yes

(8) Case Name Information
Case Name/Head of Household for Food Stamps:

_____ (Last First MI)

SSN: _____ Case #: _____

DOB: __ __ / __ __ / __ __ (M M / D D / Y Y) Race: _____ Sex: _____

Eye Color: _____ Hair Color: _____

ID Marks: _____

Last Known Address: _____

(9) Suspect Information
Head of Household ☐ Yes ☐ No

Suspect other than Head of Household:

Name: _____

Alias: _____

Last Known Address: _____

SS #: _____

Eye Color: _____ Hair Color: _____

ID Marks: _____

(10) (a) Type Case (Check only one)

☐ ADC (Aid to Dependent Children) ☐ Adult Services ☐ Family & Children Services
☐ Food Stamps/NA ☐ Supplemental ☐ IFG (Individual & Family Grants)
☐ Food Stamps/PA ☐ AR (Aid to Refugees) ☐ Other (Specify) _____

(b) ☐ Case Active ☐ Case Closed as of _____ (Effective Date)

(11) Source of Discovery (Circle one)

A. Worker Observation
B. DIR Wage
C. QC Findings
D. M.E. Review
E. Employer
F. Neighbor/Public/Reference
G. Hotline Referral
H. Other Unit, Program, County
I. Other (give source) _____
J. UCB Match
K. Client

(12) Summary of Circumstances: (Attach additional sheets as necessary.)

BASIS OF ISSUANCE OF FOOD STAMPS, MONEY PAYMENTS, OR SERVICES

(13)[a] Date of App./Rev./ Recert.	(13)[a] Worker Name	(13)[b] Date Provided	(13)[c] Claimed by Recipient Income	(13)[c] Claimed by Recipient HHS	(13)[d] Amount Issued	(13)[e] Correct Income, HHS Income	(13)[e] Correct Income, HHS HHS	(13)[f] Correct Amount	(13)[g] Resulting Overpayment/ Overissuance (13)[d] - (13)[f]	(13)[h] C.S. Paid to State	(13)[h] Adjusted Overpayment (If CS ≥ (13)[f] Subtract CS from (13)[g] and enter diffenence. If CS < (13)[f] enter (13)[g] here.
TOTALS											

(14) Has collection action been taken by county: ☐ Yes ☐ No If yes, explain: _____

(15) For Food Stamps Only: Nonfraud amount if fraud is not confirmed _____

(16) FOR ADC ONLY: Client was eligible for Medicaid for the months where column (13)[f] shows zero, as follows _____

_____

_____

(17) I hereby certify that the information contained in this report is accurate to the best of my knowledge.

_____ Signature of caseworker/date

_____ Signature of supervisor/date

(18) **FOR STATE USE ONLY**

☐ 1. This case referred to prosecutorial agency. ☐ AG ☐ DA ☐ US Attorney

☐ 2. Administrative Disqualification Hearing action by county department. Date due _____

☐ 3. Concur with recoupment/voluntary action taken by county department.

☐ 4. Implement recoupment/seek voluntary restitution in accordance with appropriate manual policy.

☐ 5. Closed. No overpayment/overissuance.

☐ 6. Closed. Paid in full.

☐ 7. Closed. Other Reason _____

☐ 8. Returned to county for correction/other information _____

_____

Signature of State Reviewer _____ Date _____

Instructions for PSD-DFD-818
Overpayment Form

Use/Purpose

This form is to be used to document underpayments, according to Section 22010B, and may rarely be used in determining overpayments, although the same information is produced on an automated Overpayment Report which is generated by the Comprehensive Claims System when a claim is confirmed there.

General Instructions

Complete applicable items.

Distribution

Case Record

THIS FORM WILL NOT BE STOCKED. MAKE COPIES AS NEEDED.

COUNTY STAMP

_____COUNTY
DEPARTMENT OF HUMAN RESOURCES

REQUIRED VERIFICATION

Case ID No._____
Worker _____
Telephone No._____
Date _____

1. Items _____
to be returned by: (Date) _____
2. Items _____
to be returned by: (Date) _____

The items checked on this form are needed to determine if you are eligible for assistance. You must provide these items by the date(s) written above. If you do not provide these items, your application for help may be denied or your case may be closed. You may mail in the information, but it must reach this office on or before the date requested. If you cannot get the information, ask your worker to help you get it. Your worker can see you on the dates and times written below or you may call your worker to schedule an appointment.

WEEKDAY	Monday	Tuesday	Wednesday	Thursday	Friday
TIME					

PLEASE MAIL OR BRING IN THE FOLLOWING INFORMATION AND DOCUMENTS

GENERAL

1. ❑ Birth Certificate(s) for_____
2. ❑ Social Security number(s) for_____
3. ❑ Identification for _____
4. ❑ Signed statement from person who knows that the children for whom you made application live in your home
5. ❑ Naturalization Papers for_____
6. ❑ Alien Registration Document for_____
7. ❑ Divorce Papers for _____
8. ❑ Marriage License for_____
9. ❑ Separation Papers for _____
10. ❑ Legitimation/paternity forms for _____
11. ❑ Statement from child care provider of amount you pay him/her for keeping your child(ren) while you work
12. ❑ School enrollment verification for _____
13. ❑ Proof of application for Unemployment Compensation Benefits (UCB) for_____

INCOME

14. ❑ Proof of wages/salaries, i.e., pay stubs or statement from employer, bookkeeper, etc., for the month(s) of _____
15. ❑ Proof of self-employment for the month(s) of _____
16. ❑ Income tax return, financial records, receipts, etc. for the year of _____
17. ❑ Proof of Social Security, SSI, VA, sick or Worker's Compensation benefits for_____
18. ❑ Proof of Unemployment Compensation Benefits (UCB) for _____
19. ❑ Proof of child support or alimony
20. ❑ Proof of the amount of money given to you by friends, relatives, churches, etc., i.e., receipt or statement from the friend, relative, church, etc.
21. ❑ Proof of money you receive for babysitting/providing child care

OTHER (Specify)

22. ❑ _____
23. ❑ _____
24. ❑ _____