COUNTY______________________________
CLIENT NAME__________________________
CASE ID______________________________
DATE OF APPLICATION__________________

DRUG SCREENING INFORMATION
ACKNOWLEDGEMENT AND UNDERSTANDING
(Pursuant to Code of Alabama Title 38, Section 38-1-7)

Based on a review of information you have given, it appears you will be required to take a drug test. When we need you to take the drug test, an appointment for the test will be made for you at the County Department of Public Health. You will be notified by mail of the date and time as well as about other information to take with you to your appointment. Please review the following information and indicate your understanding by your signature at the bottom. You will be given a copy of this form to take with you.

I acknowledge and understand that:

- Certain parent/stepparent grantee relatives must provide information in regard to drug related criminal convictions within the last 5 years and use of drugs within the last year and if required, take a drug test in order to be eligible to receive benefits. The information I provide is used to decide if there is reasonable suspicion that I am using drugs now and if so, to require a test.
- Failure or refusal to cooperate results in denial of my application or case closure.
- The results of the drug screening will not be used in any criminal proceeding.
- The drug test requires me to give a urine sample. By signing below, I agree to provide the sample. I also consent to and authorize the Department of Public Health to release my drug testing results to DHR.
- The penalties for testing positive for drugs without a valid prescription are as follows.
  - First test = a warning that another positive test will result in a loss of benefits and that further tests will be required;
  - Second test = loss of my benefits for a year;
  - Third test = permanent loss of my benefits and appointment of someone else to receive benefits on behalf of my family.
- After the first positive drug test I will be responsible for paying the cost of the test.
- Drug test(s) may be avoided by withdrawing my application or requesting my case be closed.

____
Signature of Applicant   Date

INSTRUCTIONS FOR DHR-FAD-2216

Drug Screening Information
Acknowledgement and Understanding

Use/Purpose

This form is used to document client acknowledgement and understanding of the program drug screening policies as well as agreement to cooperate with such policies for those individuals for whom it appears reasonable suspicion exists to require the screening.

General Instructions

This form is to be reviewed and signed by the identified applicants at the conclusion of the application interview.

Distribution: Original in the case record.
Copy to the client.

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

______________ COUNTY
DEPARTMENT OF HUMAN RESOURCES
DRUG SCREENING APPOINTMENT NOTIFICATION

DATE ______________

CASE ID ______________

PSD FILE NO ______________

☐ BASED ON STATEMENTS YOU MADE ABOUT DRUG RELATED CONVICTIONS AND USE DURING YOUR APPLICATION, IT HAS BEEN DETERMINED THAT REASONABLE SUSPICION EXISTS TO REQUIRE A DRUG SCREENING.

☐ BASED ON THE RESULTS OF AN EARLIER SCREENING, IT HAS BEEN DETERMINED THAT REASONABLE SUSPICION EXISTS TO REQUIRE A DRUG SCREENING.

☐ BASED ON YOUR CHALLENGE OF THE POSITIVE RESULTS OF YOUR DRUG SCREENING, ANOTHER DRUG SCREENING HAS BEEN SCHEDULED.

IT IS IMPORTANT THAT YOU GO TO THE APPOINTMENT LISTED BELOW AND TAKE THE DRUG SCREENING. IF YOU FAIL TO APPEAR AT THE DESIGNATED LOCATION AND TIME OR TO COMPLETE THE DRUG SCREENING, YOUR CASE MAY BE CLOSED.

IF YOU CANNOT GO ON THE DATE AND TIME SHOWN, PLEASE CALL ______________ IMMEDIATELY. YOUR WORKER WILL DETERMINE IF YOU QUALIFY TO HAVE THE APPOINTMENT RESCHEDULED. THANK YOU.

____
WORKER SIGNATURE

DRUG SCREENING APPOINTMENT

Location: ______________ Date: ______________ Time: ______________

____

ITEMS TO TAKE WITH YOU FOR THE DRUG SCREENING:

( ) Proof of identity for you:

ACCEPTABLE FORMS OF IDENTIFICATION:

- Current Driver's License
- Work Badge
- U.S. Passport
- School Identification Card, School Record
- Identification Card issued by Federal, State or Local Government
- Other Document with identifying data sufficient to establish proper identification
- Church Records
- U.S. Military Card
- U.S Immigration Document
- Marriage Record or Divorce Decree

( ) Other: $50.00 to cover the cost of the screening

DHR-FAD-2217
(October 2015)

INSTRUCTIONS FOR DHR-FAD-2217

Drug Screening Appointment Notification

Use/Purpose

This form is used to notify clients of the scheduled appointment for their drug screening at the County Department of Public Health and the reason for the appointment.

General Instructions

This form is to be completed by the worker and mailed to the client as instructed in Section 2575.

Distribution: Original mailed to the client.
Copy in the case record.

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

Date of Request ________ OMB NO.: 0960-0575

REQUEST FOR QUARTERS OF COVERAGE (QC) HISTORY BASED ON RELATIONSHIP

Complete the information below when requesting QC history for spouse(s) or parent(s) of a lawfully admitted non-citizen applicant. Mail the form to the Social Security Administration, PO Box 17750, Baltimore, MD 21235-0001.

Print Name: ____________________, ______________ ____
Last First M.I.

SSN ____-___-____ Date of Birth ___-___-___
MM DD YY

Relationship to Applicant ____________________

NOTE: COMPLETE THE YEAR COLUMN AND CIRCLE THE PERTINENT QUARTER(S) FOR THE YEAR. SSA WILL PROVIDE INFORMATION ONLY FOR YEARS AND QUARTERS YOU INDICATE.

YEAR	QC PATTERN 1ST Q	2ND Q	3RD Q	4TH Q	YEAR	QC PATTERN 1ST Q	2ND Q	3RD Q	4TH Q
____	____	____	____	____	____	____	____	____	____
____	____	____	____	____	____	____	____	____	____
____	____	____	____	____	____	____	____	____	____
____	____	____	____	____	____	____	____	____	____
____	____	____	____	____	____	____	____	____	____
____	____	____	____	____	____	____	____	____	____
____	____	____	____	____	____	____	____	____	____
____	____	____	____	____	____	____	____	____	____
____	____	____	____	____	____	____	____	____	____

State's Name & Address ____________________

____

____

Contact Person's Name & Telephone Number ____________________

____

Instructions for SSA-513
Consent for Release of Information

Use/Purpose

This form is to be used when an alien needs to be credited with qualifying quarters of Social Security coverage from a parent or spouse according to Section 2305C1(l), and the parent or spouse refuses to sign form SSA-3288, Consent for Release of Information.

General Instructions

Complete identifying information and the quarter(s) for which credit is needed. Only the specified quarters can be disclosed by SSA. Mail the original to the Social Security Administration, P.O. Box 17750, Baltimore, MD 21235-0001.

Distribution

Original: Social Security Administration
Copy: Case Record until the original is returned

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

Social Security Administration OMB No. 0960-0567

Consent for Release of Information

TO: Social Security Administration

______________________ ______________________ ______________________

Name Date of Birth Social Security Number

I authorize the Social Security Administration to release information or records about me to:

NAME	ADDRESS
Department of Human Resources	Montgomery, Alabama

I want this information released because:

Qualifying Quarters for Food Stamp and/or Family Assistance Eligibility

(There may be a charge for releasing information.)

Please release the following information:

X Social Security Number
X Identifying information (includes date and place of birth, parents' names)
___ Monthly Social Security benefit amount
___ Monthly Supplemental Security Income payment amount
___ Information about benefits/payments I received from ________ to ________
___ Information about my Medicare claim/coverage from ________ to ________
(specify) ______________________
___ Medical records
___ Record(s) from my file (specify)______________________

X Other (specify) (All quarters of information - 1937-Present).

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

Signature:______________________
(Show signatures, names, and addresses of two people if signed by mark.)
Date:______________________ Relationship:______________________

SSA-3288

Instructions for SSA-3288
Consent for Release of Information

Use/Purpose

This form is to be used when an alien needs to be credited with qualifying quarters of Social Security coverage from a parent or spouse, according to Section 2305C1(l), to obtain the parent's or spouse's permission to secure verification of coverage through IEVS.

General Instructions

Have the client's spouse or parent complete and sign the form.

Distribution

Original: Case Record.

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

PART II – SUP FORMS

DHR-PAD-640
February 1990

SUPPLEMENTATION BUDGET

Name ______________________ Case No. __________ County ______________

Worker ______________ Date Completed __________ Date Effective ______________

STEP 1 - FOR INDIVIDUAL. (When both individual and spouse are eligible, complete income amounts in Step I on a budget for each; then complete one Step IV for both. When the individual has an ineligible spouse, complete Step II before Step I.)

UNEARNED INCOME		EARNED INCOME	
SOURCES	AMOUNT	SOURCES	AMOUNT
RSDI		Wages	
VA		Farming	
OTHER		Self-Employment	
CASH CONTRIBUTION (Step II, I or K)		Commissions	

A. Total unearned income ______ B. Total earned income ______

C. General exclusion to be applied to unearned income . . . . -20.00 ______

D. Countable unearned income (A-C, not less than 0) . . . . ______

E. General exclusion to be applied to earned income (if A < $20) . . ______

F. Difference (B-E, not less than 0) . . . . ______

G. Earned income exclusion . . . . -65.00

H. Difference (F-G, not less than 0) . . . . ______

I. Remaining earned income exclusion (1/2 of H) . . . . ______

J. Difference (H-I) . . . . ______

K. Work expense and/or Plan for Self-Support (only if blind) . . . . ______

L. Remaining earned income (J-K, not less than 0) . . . . ______

M. Total countable income (D + L) . . . . ______

N. Individual FBR . . . . ______

O. Excess countable income to be applied in Step III computation . . . . ______

If applicant/recipient is single, go to Step III for State SUP computation

STEP II - COMPUTE INCOME TO BE DEEMED FROM INELIGIBLE SPOUSE

UNEARNED INCOME		EARNED INCOME	
SOURCES	AMOUNT	SOURCES	AMOUNT
RSDI		Wages	
VA		Farming	
OTHER		Self-Employment	
		Commissions	

A. Total unearned income ______ B. Total earned income ______

C. Children's allowance (Step V Total) . . . . ______

D. Unearned income after children's allowance (A-C, not less than 0) . . . . ______

E. Children's allowance not offset by unearned income . . . . ______

F. Earned income after children's allowance (B-E, not less than 0) . . . . ______

G. Total income of ineligible spouse after children's allowance (D + F) . . . . ______

H. 1/2 Individual FBR . . . . ______

If G is less than 1/2 of individual FBR, spouse has no income to deem, go to Step III. If G is greater than 1/2 individual FBR, compute I-K.

I. Difference (G-H) . . . . ______

J. Subtract appropriate SUP level . . . . ______

K. Difference (I-J) to be shown in Step I for SUP payment computation . . . . ______

STEP III - COMPUTE SUP PAYMENT

A. Level of supplementation (Combine levels if eligible couple) . . . . ______

B. Excess countable income (Step I, O or IV S if eligible couple) . . . . ______

C. Difference (A-B) . . . . ______

D. Deficit and SUP payment (C rounded to the nearest dollar. Divide by two, if eligible couple)

STEP IV - COMPUTE COUPLE INCOME (Use this step for eligible couple.)

A. Unearned income of applicant (Step I A) . . . . ________
B. Unearned income of spouse (Step I, A) . . . . ________
C. Couple's unearned income (A + B) . . . . ________
D. General exclusion to be applied to unearned income . . . . -20.00
E. Couple's countable unearned income (C-D, not less than 0) . . . . ________
F. Earned income of applicant (Step I, B) . . . . ________
G. Earned income of spouse (Step I, B) . . . . ________
H. Couple's earned income (F + G) . . . . ________
I. General exclusion to be applied to earned income (if C < $20) . ________
J. Difference (H-I, not less than 0) . . . . ________
K. Earned income exclusion . . . . -65.00
L. Difference (J-K, not less than 0) . . . . ________
M. Remaining earned income exclusion (1/2 of L) . . . . ________
N. Difference (L-M) . . . . ________
O. Work expenses and/or Plan for Self-Support (only if blind) . . . ________
P. Couple's countable earned income (N-O, not less than 0). . . . . ________
Q. Couple's total countable income (E + P) . . . . ________
R. Couple FBR . . . . ________
S. Couple's excess countable income to be applied in Step III computation . . . . ________

STEP V - COMPUTE INELIGIBLE CHILDREN'S LIVING ALLOWANCE (Only if there is ineligible spouse)

Child's Name	Basic Living Allowance	Monthly Income	Unmet Need (0 or more)

TOTAL ________

STEP VI - DETERMINE ELIGIBILITY BASED ON RESOURCES

A. Cash on hand . . . . ________
B. Cash in bank account(s) . . . . ________
C. Cash value of life insurance . . . . ________
D. Value of other liquid resources (stocks, bonds, etc.) . . . . ________
E. Nonexcluded automobile value _____ . . . . ________
F. Total value of other nonexcluded vehicles . . . . ________
G. Nonexcluded personal property value _____ . . . . ________
H. Value of nonexcluded real property . . . . ________
I. Value of other nonexcluded, nonliquid resources (by type and amount) ________

____

____

J. Total value of countable resources . . . . ________

Instructions for DHR-PAD-640
Supplementation Budget

Use/Purpose

This form is to be used according to Section 12125B for non-SSI SUP recipients who have an ineligible spouse to determine whether there is income to deem from the ineligible spouse and, if so, how much.

General Instructions

Step I - Complete this part, according to line by line self-explanatory descriptions, using only the income of the recipient to determine if s/he would be eligible considering only his/her income. If not, deny or terminate assistance. Otherwise, go to Step II.

Step II - Complete this part, according to line by line self-explanatory descriptions, using only the income of the ineligible spouse. The amount on line I in this part is to be entered as a contribution on ZC30 of the eligible spouse.

Distribution

Original: Case Record

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

DHR-PAD-641
Rev. Feb. 1990

SUPPLEMENTATION BUDGET FOR DEEMING PARENTS TO CHILDREN

Name________________________ Case No.__________ County____________

Worker__________________ Date Completed__________ Date Effective ____________

STEP I COMPUTE INELIGIBLE CHILDREN'S LIVING ALLOWANCE

CHILD'S NAME	BASIC LIVING ALLOWANCE	MONTHLY INCOME	AMOUNT PARENTS MUST MAKE UP (0 OR MORE)
		TOTAL	

STEP II - COMPUTE REMAINING PARENTAL INCOME AFTER DEDUCTION OF INELIGIBLE CHILDREN'S LIVING ALLOWANCE

A. Unearned income of parent(s) .... ________
B. Total of ineligible children's living allowance from Step 1 .... ________

C. Remaining unearned income (A-B, not less than 0) .... ________

D. Earned income of parent(s) .... ________
E. Children's allowance not subtracted from unearned income .... ________

F. Remaining earned income (D-E, not less than 0) .... ________

STEP III - DEDUCT EXCLUSIONS FROM REMAINING PARENTAL INCOME

A. Remaining unearned income from Step II, C .... ________
B. General exclusion .... -20.00

C. Remaining unearned income (A-B, not less than 0) .... ________

D. Remaining earned income from Step II, F .... ________
E. General exclusion not absorbed by unearned income (if A < $20) .... ________
F. Difference (D-E) .... ________
G. Earned income exclusion .... -65.00
H. Difference (F-G) .... ________
I. Additional earned income exclusion (1/2 of H) .... ________
J. Difference (H-I) .... ________
K. Work Expenses and/or Plan for Self-Support (only if blind) .... ________
L. Remaining earned income (J-K, not less than 0) .... ________
M. Total countable parental income (C+L) .... ________
N. Parental living allowance (FBR for individual, if 1 parent; or for couple).......... ________

O. Amount to be deemed to eligible children (M-N, not less than 0) .... ________

P. If two or more eligible children, divide amount in O by the number of eligible children to get amount to be deemed to each child (See Manual Section 12125-C, 9) .... ________

STEP IV - COMPUTE INCOME OF ELIGIBLE CHILD

UNEARNED INCOME		EARNED INCOME	
SOURCES	AMOUNT	SOURCES	
RSDI		WAGES	
VA		FARMING	
DEEMED PARENTAL INCOME (Step III, O or P)		SELF-EMPLOYMENT	
OTHER		COMMISSIONS	

A. Total unearned income ________ B. Total earned income ________

C. General exclusion to be applied to unearned income .... -20.00

D. Countable unearned income (A-C, not less than 0) .... ________

E. General exclusion to be applied to earned income (if A < $20) .... ________
F. Difference (B-E) .... ________
G. Earned income exclusion .... -65.00
H. Difference (F-G) .... ________
I. Remaining earned income exclusion (1/2 of H) .... ________
J. Difference (H-I) .... ________
K. Work expenses (only if blind) .... ________
L. Remaining earned income (J-K, not less than 0) .... ________
M. Total countable income (D+L) .... ________
N. Individual FBR .... ________

O. Excess countable income to be applied in Step V computation .... ________

STEP V - COMPUTE SUP PAYMENT

A. Level of supplementation .... ________
B. Excess countable income (Step V, O) .... ________

C. Difference (A-B) .... ________
D. Deficit and SUP payment (C rounded to the nearest dollar) .... ________

STEP VI - DETERMINE ELIGIBILITY BASED ON RESOURCES (Calculate parental resources first; subtract reserve limit for individual/couple; include excess parental resources in child's column as deemed resources.)

	Parental Resources	Child's Resources
A. Cash on hand		
B. Cash in bank account(s)		
C. Cash value of life insurance		
D. Value of other liquid resources (stocks, bonds, etc.)		
E. Nonexcluded automobile value (Manual Section 12315D)		
F. Total value of other nonexcluded vehicles		
G. Nonexcluded household goods and personal effects value (Manual Section 12315A)		
H. Value of nonexcluded real property		
I. Value of other nonexcluded nonliquid resources (by type and amount)		
J. Total value of nonexcludable resources of parent(s)		
K. Reserve limit for individual/couple		
L. Excess parental resources to be deemed to child (J-K, not less than 0)		
M. Total of child's resources (total A through I plus L)		

Instructions for DHR-PAD-641
Supplementation Budget for Deeming
Parents to Children

Use/Purpose

This form is to be used according to Section 12125C when a SUP recipient is a child under age 18 to determine whether his/her parent(s) and/or stepparent have income to be deemed to the child and, if so, how much.

Step I – Complete this part according to line by line self-explanatory descriptions, if there are other ineligible children under age 18 in the home for whom the parent(s) or stepparent is legally financially responsible.

Step II – Complete this part according to line by line self-explanatory descriptions, if Step I was completed.

Step III – Complete this part according to line by line self-explanatory descriptions. The amount in line O is to be entered as a contribution on ZC30 of the eligible SUP child.

Distribution

Original: Case Record

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

STATE OF ALABAMA
DEPARTMENT OF HUMAN RESOURCES

AFFIDAVIT

This is to certify that I, ______________________________ did not endorse the warrant described below which was mailed to me by the State Department of Human Resources for the month of __________________, 19__.

Warrant Number: ____________________ Amount: ____________________

Date of Issue: ____________________ Fund: 324

Name of Payee: ____

County: ____________________ Category: ____________________

Social Security Number: ____________ Check Register Date: ________

Case Number: ____________ Driver's License Number: ____________

I/we did not endorse the warrant described above, or authorize its endorsement, nor did I/we nor to my knowledge did a member of my/our family receive any benefits from the proceeds thereof. If I should later receive the warrant described above, I agree to return it immediately to the State Department of Human Resources. I understand that, if I should later receive the warrant described above and dispose of it in any manner other than as agreed upon herein, I may be subject to criminal prosecution under Alabama or Federal Law.

If the warrant described above has not been negotiated, I hereby request the State Comptroller to stop payment on the above warrant and issue a duplicate in lieu thereof in accordance with Title 41-4-58, Code of Alabama, 1975. I understand that fraudulently obtaining a duplicate warrant on the State Treasury is unlawful. (Title 13-4-92).

If the warrant described above has been negotiated, I give permission for the Department of Human Resources to furnish a copy of this affidavit and the warrant to the Postal Inspector and other appropriate persons.

I understand if the original check is cashed, it will be turned over to the Office of Fraud, Abuse, and Overpayments, Department of Human Resources. An ivestigation will be conducted to determine if evidence of forgery or other misuse exists. If there is sufficient evidence, the case will be prosecuted. I understand I will be expected to testify in court if necessary.

The above information is true and correct to the best of my/our knowledge and belief. I/we understand that filing a false claim or affidavit is punishable by law, and upon conviction the maximum penalty is a $500 fine or imprisonment for twelve (12) months or both.

____
Signature of Payee

____
Witness Name Address

____
Street Address

____
Witness Name Address

____
City State

Phone No. ____________________

Sworn to and subscribed before me this ________

____
Signature of Spouse

______________________________, 19__

____
Notary Public

Prepare original and four copies. Submit original and two copies to State Department of Human resources. Retain one copy for the county file and give one copy to the payee.

PSD-BFM-677
Revised 11/90

Instructions for PSD-BFM-677
Affidavit

Use/Purpose

This form is used when a SUP client claims her/his check was destroyed, lost or stolen before it was endorsed and cashed according to Section 22820.

General Instructions

Complete the information giving details of the warrant using the FACETS payment history inquiry screen ZC07. Obtain the client's signature in the presence of a Notary Public. Prepare the original and four copies.

Distribution

Original and two copies: Finance Division with PSD-BFM-829
Copy 3: Payee
Copy 4: Case Record until Original is returned

DHR-FAD 693
Rev. Sept. 2006

State of Alabama
APPLICATION FOR SUPPLEMENTATION

Complete all blanks on this form that apply to you, your spouse, or your parents if you are under 18.	**FOR COUNTY USE ONLY** County ____________ Case No. ________ FS No. ________

1. Write your full name and the month, day and year that you were born. ______________________

____

2. Write your spouse's full name and birthdate even if you are widowed, divorced, or separated. If you are under 18, write your parents' full name.____

3. Your Home Address:______________________ Mailing Address, if different ______________________

4. Phone No. where you can be reached ________________If not yours, whose is it? ________________

5. Do you receive SSI? (Supplemental Security Income)_____Yes;_____No. If "No", when were you denied?_________
________________ Why were you denied? ______________________________

____

You do not need to fill out the rest of this form. You cannot receive Supplementation if you do not receive SSI.

6. Check the marital status that applies to you. Give dates where asked for:
   a. _____Married, Date______________________ d. ____Divorced, Date ______________________
   b. _____Widowed, Date ______________________ e. ____Never Married
   c. _____Separated, Date ______________________

7. Check all items about your living arrangement that apply to you:
   a._____Own my Home d._____Live rent free g. _____Live with non-relatives j._____ Live in Public Housing
   b._____Buying my Home e._____Live alone h. _____Live with my parents k._____ Get Housing Subsidy
   c._____Rent my Home f._____Live with relatives i. _____Live in a Foster Home l._____ Live with another Welfare Recipient

8. Check the one that applies to you: a._____I am a United States Citizen b. ______I am a lawfully admitted alien

9. I live in Alabama and plan to stay. ______Yes; ______No.

10. Because of a disability, do you need help in bathing, walking, taking medicine, or help in doing anything you cannot do for yourself? ________Yes; ______No. If "Yes", and if form DHR-FAD-696 is enclosed, fill in your doctor's name and address and sign the authorization statement on the front. If someone helps take care of you, write his/her name, address and relationship to you;______________________________________

____

Are you chairfast? ______Yes; ______ No. Are you bedfast? ______ Yes; ______No.

(Continued on back)

11. Is your SSI check reduced because you live with someone who provides support and maintenance to you? ______ Yes; ______ No.

12. List any of the following numbers that you, your spouse, or parents have:

KIND OF NUMBER	YOURS	SPOUSE'S / PARENTS'
Social Security Account Number		
Social Security Claim Number		
Railroad Retirement Claim Number		
Veterans Claim or Serial Number		

13. Do you get a welfare check from any other State or County? ____ Yes; ____ No. Does your spouse? ____ Yes; ____ No. Do your parents? ______ Yes; ______ No. If "Yes", list: ______

14. Do you or any member of your household receive Food Stamps? ____ Yes; ____ No. If "Yes", write your Food Stamp No. ______.

15. Do you have health insurance other than medicare or medicaid? ____ Yes; ____ No. If "Yes", write the name of the insurance company. ______.

16. Send any check(s) due me at my death to. ______ (Full Name) (Age)

______ (Relationship) ______ (Mailing Address)

17. If the person named above is not living at the time of my death, I name the following person as the alternate to whom the last check(s) are to be mailed.

______ (Full Name) (Age) (Relationship)

______ (Mailing Address) (Date)

IF EITHER OF THE PERSONS NAMED ABOVE CHANGES HIS/HER ADDRESS, PLEASE LET THE COUNTY DEPARTMENT KNOW. IF FOR ANY REASON YOU LATER HAVE TO NAME ANOTHER PERSON TO RECEIVE THE LAST CHECK DUE YOU, PLEASE NOTIFY YOUR COUNTY DEPARTMENT.

18. I hereby authorize and consent for the Department of Human Resources to obtain information/documentation from any source for the purpose of determining eligibility for State Supplementation. I authorize this release to be in effect for as long as I am a recipient of State Supplementation regardless of date signed. Use of copies of this document in place of the original is also authorized.

19. I certify that the information I have given on this form is a true and complete statement of facts according to my best knowledge and belief. I agree to let my County Department know of any changes that occur in my living arrangements, income, resources, or expenses. I understand that if I deliberately give false or incomplete information or fail to report changes in my situation, I am liable to prosecution.

If my case is selected for a full review, I agree for the State Department to see whatever references or other sources of information are needed. I agree to repay any money received that I am not entitled to get from the Department of Human Resources. I have received papers explaining the rules about assistance, the right of appeal for a hearing, and a pamphlet about Civil Rights.

Sign your Name ______ Date ______

If you cannot sign your name, a witness to your mark must sign below.

Witness ______ Date ______

Instructions for DHR-FAD-693
Application for Supplementation

Use/Purpose

This form is the proper application form for State Supplementation.

General Instructions

This form should be furnished upon request to the staff of the Department of Senior Services or the Elderly/Disabled Waiver Case Managers of the Department of Public Health. After the form has been signed and returned to the Department by one of these agencies, any changes or additions to the information must be initialed by the applicant and dated; otherwise, the narrative must reflect the changes or additions.

Distribution

Otiginal: Case Record after completion

DHR-FAD-694
Revised Sept. 2006

STATEMENT OF INCOME/RESOURCES SUPPLEMENTATION

Name ______________________________ Case No. _________ County ___________________

Complete all blanks on this form that apply. A review of your income/resources is required each year to see if you are still eligible.

1. Do you have any money coming in from any source? Yes_____ No_____. Does your husband or wife? Yes_____ No_____. If "Yes", give the amount and if it comes in by the week, month or year.

	To You		To Your Husband/Wife	
	Amount	Week Month Year	Amount	Week Month Year
Social Security	$		$	
Railroad Retirement Benefits	$		$	
Veterans Checks	$		$	
Miners or Company Benefits	$		$	
Civil Service or State Retirement	$		$	
ASCS (Government Payment on Land)	$		$	
Money from leases (Coal, Oil, Gravel Rights, etc.)	$		$	
Interest from Savings	$		$	
Interest from Money out on Loan	$		$	
Other Income - (Specify)	$		$	
	$		$	
	$		$	
	$		$	

2. Do you or your husband or wife have any money or things you have saved, bought or had given to you? Yes_____ No_____. If "Yes", fill in this section.

In each instance, show yours, your husband's or wife's	Amount of Yours	Amount of Husband's or Wife's
Checking account in the bank	$	$
Savings account in the bank	$	$
Cash savings not in the bank	$	$
Amount that anyone owes you	$	$
Amount of this loan to be repaid to you during the next 12 months	$	$
Face value of life insurance-the amount on the front of the policy. Do not include burial, hospital or sick and accident policies.	$	$
U.S. Government E Bonds (Purchase price)	$	$
Other Bonds, Stocks, etc. (Present value)	$	$
Show current market value of a car, truck, tractor, tools, etc. that you own.	$	$

3. If you or your husband or wife own any real estate other than a home, complete this section. If you own a home, but are not living in it, list it in this section.

Include property owned individually or jointly. If you have a "life interest", check that column. Show your part only.	Yours	Life Interest	Your Husband's or Wife's or Parents	Life Interest
Current market value	$		$	
Mortgage on property that is still owed	$		$	
Required monthly payment on mortgage (Yours or husband's or wife's share)	$		$	

Date of Mortgage ______________________. Tell why mortgage was secured ____________

____

If property is jointly owned, how many people own a share of it? ______ If you, your husband or wife, have any income from property listed in this section, show the amount received each year by:
You: ______________________ Your husband or wife: ______________________

4. Does anyone give you or your husband or wife food, clothes or a place to live or pay for any of these things for you or your husband or wife? If so, explain: ______________________

____

____

____

5. I certify that the information I have given on this form is a true and complete statement of facts according to my best knowledge and belief. I agree to let my County Department know of any changes that occur in my living arrangements, income or resources. I understand that if I deliberately give false or incomplete information or fail to report changes to my situation, I am liable to prosecution.

Signature ______________________________ Date ______________________

NOTE: If you cannot sign your name, a witness to your mark must sign below.

Witness ______________________________ Date ______________________

Address ____

Signatures and addresses of persons helping to fill out forms:

Name ______________________________ Date ______________________

Address ____

Name ______________________________ Date ______________________

Address ____

Instructions for DHR-FAD-694
Statement of Income/Resources for Supplementation

Use/Purpose

This form may be used for obtaining updated income/resource information during reviews of non-SSI SUP cases when the client is not in the office.

General Instructions

This form may be mailed to the recipient for completion with a stamped, return-addressed envelope. Anyone of the applicant's choosing may help him/her complete the form. After the form has been signed and returned, any changes or additions to the information must be initialed by the recipient and dated; otherwise, the narrative must reflect the changes or additions.

Distribution

Original: Case Record after completion

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

_______________ COUNTY
DEPARTMENT OF HUMAN RESOURCES

county address

PHYSICIAN'S RECOMMENDATION

Client:	
Case ID:	
Category:	
PSD File No.:	

Dear Doctor:

Please complete the back of this form to give your recommendation as to whether the above-named person needs homelife care service due to being incapable of caring for him/herself because of illness or disability. In the case of a disabled child, base your recommendation on his/her disability rather than on his/her age.

Given below is the client's consent for you to furnish us the needed information. This information is confidential. The client will be referred to you if s/he wants any information about this report. If there is a fair hearing, however, it will be available to the client and to others involved in the fair hearing process.

The Department of Human Resources can pay a maximum of $10 for completion of this form in its entirety. Submit our signed bill in duplicate to the County Department of Human Resources.

Thank you very much for your cooperation in providing this information at your earliest convenience.

Signature of Director:	Date:

CLIENT'S AUTHORIZATION

I hereby authorize the physician to give the Department of Human Resources any necessary information about my need for homelife care in my home.

I also give permission for the medical information on the back to be released to the Department of Rehabilitation Services and the District Social Security Office, if necessary.

Signature of Applicant/Recipient:	Date:

DHR-FAD-696
Rev. Sept. 2006

STATEMENT TO BE COMPLETED BY PHYSICIAN

(Complete all sections)

1. Nature of Impairment: ____________________

____

____

2. Severity of Impairment: ____________________

____

____

3. Prognosis: ____________________

____

____

4. Need for Homelife Care Services

A. ❑ This individual requires Homelife Care Services.

B. ❑ This individual does **not** require Homelife Care Services at this time.

Homelife care services are defined as help (of either a professional or non-professional nature) with any one or more of the following:

(1) Conducting a prescribed exercise routine
(2) Changing bandages or dressings on the advice of the physician
(3) Administering prescribed medication
(4) Using prostheses or ambulation aids
(5) Locomotion
(6) Maintaining an acceptable state of cleanliness
(7) Maintaining adequate nutritional standards in the purchase and preparation of food
(8) Maintaining orientation to time, place and events
(9) Reminding of the need for medication, or other health related functions
(10) Performing other activities needed to help a person care for him/herself when his/her illness or disability prevents him/her from adequately doing so.

5. I expect this condition to last: ❑ Permanently ❑ More than one year
(Check one)
❑ Less than one year - approximate number of months ________

I understand that payment can be made for this information only if services are in compliance with the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and all other federal and state civil rights laws.

Signature of Physician: M.D.	Date:

Instructions for DHR-FAD-696
Physician's Recommendation

Use/Purpose

This form is to be used to obtain medical information to establish that the SUP applicant/recipient requires homelife care services.

General Instructions

As stated in Section 10120E and 12010A, process this form at application. If the need for care is not described as permanent or if improvement is noted, process this form at redetermination of eligibility as needed. Complete the front of the form including obtaining the client's signature and mail it to the client's physician with a stamped, return-addressed envelope.

Distribution

Original: Case Record after completion

CONSENT OF DEPARTMENT OF HUMAN RESOURCES TO APPOINTMENT OF LEGAL REPRESENTATIVE

State of Alabama)
)
____________________County)

KNOW ALL MEN BY THESE PRESENTS, that we; the Department of Human Resources, as provided by Act No. 674, Acts of Alabama, Regular Session, 1965, do hereby consent to the appointment of a legal representative to handle the public assistance payments of

____
(Name) (Address)

And we do hereby request that the Probate Judge make all such orders and decrees as may be necessary or proper legally to effectuate such appointment.

Given under our hand and seal this the ______ day of

______________________, 20 _____.

Department of Human Resources

By ______________________________
Title:

Instructions for DHR-FAD-699
Consent of Department of Human Resources to Appointment of Legal Representative

Use/Purpose

This form is to be used, according to Section 10315A, when someone other than DHR institutes proceedings for appointment of a legal representative for a SUP recipient to consent to such appointment with respect to managing the recipient's public assistance payment.

General Instructions

Complete this form in duplicate. Mail the original to the Probate Judge with the DHR-FAD-700, Physician's Certificate, attached. This form is not needed when the County Department petitions the Probate Court for the appointment of a legal representative.

Distribution

Original: Probate Judge
Copy: Case Record

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

State of Alabama)
)
_________________County)

PHYSICIAN'S CERTIFICATE
FOR LEGAL REPRESENTATIVE

I, ____, a physician duly licensed to practice medicine in the State of Alabama, hereby certify that I have examined ____ and upon examination believe **him/her** to be physically or mentally, or both, incapable of managing **his/her** public assistance payments.

This the __________ day of ______________________, 20_____.

_______________________________, M.D.

Physician's Address:

____

____

Instructions for DHR-FAD-700
Physician's Certificate for Legal Representative

Use/Purpose

This form is to be used, according to Section 10300, to secure a physician's written certification that a person is physically or mentally, or both, incapable of managing his/her public assistance payment.

General Instructions

Have the form completed in duplicate by the person's attending physician. After being completed by the physician, attach the original to DHR-FAD-699 to be sent to the Probate Judge if the Department is consenting to the appointment of a legal representative according to Section 10315A. If the Department is instituting procedures for the appointment of a legal representative, attach the original to the information forwarded to the Legal Office according to Section 10315B. It will be returned to the County Department along with the petition for forwarding to the Probate Court.

Distribution

Original: Probate Judge with DHR-FAD-699 or Department's petition
Copy: Case Record

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

DEPARTMENT OF HUMAN RESOURCES

AGREEMENT TO PROVIDE HOMELIFE CARE

State Supplementation Program

NAME ______________________ COUNTY ______________________

CASE NO. ______________________ WORKER ______________________

PART I--To be completed by the individual or agency providing and receiving payment for Homelife Care. See care definition below. (If not employed by a certified home health agency, also complete Parts III and IV on back and attach completed form 1801, Medical Statement for Homelife Care Provider.)

______________________ will provide care for ______________________
(individual's or agency's name)
beginning ______________________. Services to be provided include at least one or more of the services listed in the homelife care definition given below.

I/We agree to report any changes in this arrangement to the above-named client and to the County Department of Human Resources, including failure to receive payment for services rendered.

Signed ______________________ Phone No. ______________________
(individual or agency representative)

Address ______________________ Date ______________________

Homelife Care Definition: Care needed to enable an individual to live as independently as possible outside a nursing home. Services considered to enable a person to live as independently as possible include help with any one or more of the following: (1) conducting a prescribed exercise routine; (2) changing bandages or dressings on the advice of the physician; (3) using prostheses or ambulation aids; (4) locomotion; (5) maintaining an acceptable state of cleanliness; (6) maintaining adequate nutritional standards in the purchase and preparation of food; (7) maintaining orientation to time, place and events; (8) reminding of the need for medication; (9) performing other activities needed to help a person care for himself when his illness or disability prevents him from adequately doing so. Companionship for pleasure or convenience rather than protection and necessity is not included in this definition nor is the provision of chore services such as transportation, home or yard maintenance, running errands, etc.

PART II--To be completed by the applicant/recipient.

I certify that ______________________ provides homelife care for me and I am paying for the care.
(individual's or agency's name)
agree to report immediately any changes in this arrangement to my County Department of Human Resources.

______________________ ______________________
Witness (if signed by mark) Signature of applicant/recipient

____
Date

DHR-PAO-797
December 1991

PART III--To be completed by the care provider. DO NOT COMPLETE IF EMPLOYED BY A CERTIFIED HOME HEALTH AGENCY.

1. Do you have at least a 6th grade education? /_7 Yes /_7 No

2. Do you have a criminal conviction for a crime which involves any of the following?

   a. A sex-related crime. Such crimes include, but are not limited to: sexual abuse, sexual exploitation, molestation, rape, child pornography, sale or exhibition of obscene materials, sodomy, sexual mischief, incest, enticement for immoral purposes, prostitution, pandering, or promoting prostitution, and obscenity; or

   b. Serious intentional, reckless or negligent physical injury, danger or death of any person. Such crimes include, but are not limited to: murder, homicide, manslaughter, assault with a weapon, reckless endangerment, kidnapping, and unlawful imprisonment; or

   c. A crime against an elderly/disabled adult or a child. In addition to those crimes listed in (a) and (b), such crimes include, but are not limited to: abandonment, endangerment, and assault.

   /_7 Yes /_7 No If yes, explain ______________________________

   ____

   ____

3. Have you ever been fired or forced to resign from a position for an act of misconduct or dereliction of duty involving the provision of care to another person? /_7 Yes /_7 No

4. Are you mentally and physically capable of providing care to elderly and disabled individuals as verified by the attached medical statement. /_7 Yes /_7 No Attach DHR Form 1801.

PART IV--To be completed by the care provider. Signature must be witnessed by someone other than the applicant/recipient. DO NOT COMPLETE IF EMPLOYED BY A CERTIFIED HOME HEALTH AGENCY.

I certify that statements made by me in Part I and Part III of this form are true and correct to the best of my knowledge.

____
Signature   Date

____
Witness

Instructions for DHR-PAD-797
Agreement to Provide Homelife Care
State Supplementation Program

Use/Purpose

This form is to be used to document the homelife care arrangements for a SUP applicant/recipient as described in Section 12010.

General Instructions

This completed form will accompany the DHR-FAD-693 when eligibility is initially established. If eligible, it is to be completed at any time there has been a change in the homelife care arrangement. The C600 alert procedure, as described in Section 3320 of the FACETS Certification User Manual, serves to confirm the arrangement annually and the C600 form is to be maintained with the 797 in the client's case record.

Part I – To be completed by the homelife care provider.

Part II – To be completed by the applicant/recipient.

Part III – To be completed by the homelife care provider, if s/he is not an employee of a certified home health agency.

Part IV – To be completed by the homelife care provider, if s/he is not an employee of a certified home health agency.

Distribution

Original: Client and Homelife Care Provider
Copy: Case Record until Original is returned

STATE OF ALABAMA
DEPARTMENT OF HUMAN RESOURCES
CHECK INQUIRY

PART I

TO: Finance Division
Department of Human Resources

ATTN: ____________________

COUNTY ____________________ CATEGORY ____________________ SOCIAL SECURITY NUMBER ____________________

PAYEE'S NAME ____________________

CURRENT MAILING ADDRESS ____________________

____

DATE OF CHECK ____________ CHECK NO. ____________ AMOUNT $ ____________

The payee notified this office that the above check was: ( )not received ( )stolen ( )destroyed

ATTACH NOTARIZED AFFIDAVIT (PSD-BFM-677)

How claimant states check was lost or stolen, and possible suspects:

(Question about family members, stolen from mail box, person seen at mail box on delivery date, etc.) ____________________

____

SIGNATURE: ____________________ DATE: ____________________

PART II-STATE OFFICE USE ONLY

( )Check not paid. Duplicate being issued.
( )Check paid, photocopy and replacement check attached. Have payee examine endorsement, and advise what your investigation reveals. If improper endorsement, give replacement check to payee, return photocopy of check along with PSD-BPA-1233.
( )Check being held in our office. Advise proper disposition.
( )Check voided in accordance with HOLD ORDER dated ____________

COMMENTS: ____________________

____

SIGNATURE: ____________________ DATE: ____________________

PART III-FOLLOW UP

( )Client has examined endorsement and states it is not (his,her)signature.
( )Client acknowledges cashing check, replacement check returned to be voided.
( )Replacement check returned. Payee ineligible.
( )Client does recognize endorsement. See Comments.

COMMENTS: ____________________

____

SIGNATURE: ____________________ DATE: ____________________

PREPARE IN TRIPLICATE-SUBMIT IN DUPLICATE
PSD-BFM-829
Revised 11/90

Instructions for PSD-BFM-829
Check Inquiry

Use/Purpose

This form is used when a SUP client claims her/his check was destroyed, lost or stolen before it was endorsed and cashed according to Section 22820.

General Instructions

Complete the information giving details of the warrant using the FACETS payment history inquiry screen ZE07. Complete in triplicate.

Distribution

Original and copy 1: Finance Division with PSD-BFM-677
Copy 2: Case Record until Original is returned

DHR-FAD-1513
September 2006

STATE OF ALABAMA
COUNTY DEPARTMENT OF HUMAN RESOURCES

Public Assistance Case Review Checklist – SUP

Case Number: ____________________ Worker: ____________________

Case Name: ____________________ PSD File No: ____________________

Type of Action:
- ❑ Denial
- ❑ Termination
- ❑ Other
- ❑ Pending
- ❑ Approval
- ❑ Interim
- ❑ Redetermination

Category
- ❑ A (SUP-aged)
- ❑ D (SUP-disabled)
- ❑ B (SUP-blind)

Review Element	No Error	Procedural Requirement	Payment Error	N/A	Remarks
1. Age					
2. Residence					
3. Citizenship/Alienage					
4. Screening for SSI					
5. Disability (or Blind) Determination					
6. Homelife Care					
7. Homelife Care Provider					
8. Level of Care Designation					
9. Enumeration					
SSN(s) verified					
10. Medicaid Eligibility					
a. Retroactive					
b. Continued					
11. Trial Budgets					
12. Income					
a. Disregards					
b. Work expenses					
13. Resources					
14. Correction of Erroneous Payments					
15. Standard of promptness					
16. Accrual Rights					
17. Forms Completion					
18. F A C E T S Completion					
Totals					

Return by ____________________ Worker ____________________ Date ____________________

Reviewer ____________________ Date ____________________ Corrections Reviewed ____________________

Instructions for DHR-FAD-1513
Public Assistance Case Review Checklist - SUP

Use/Purpose

This form is to be used in supervisory case reviews as called for in Appendix IV - Workload Management.

General Instructions

The supervisor is to complete the identifying information in the heading when reviewing the case record. Check ( ) all appropriate columns for each element of eligibility. Checking 'No Error' means there are no errors indicated in any of the other columns for that element and that the eligibility requirement is applicable to the case under review. An error in 'Procedural Requirement' may result from failure to follow the appropriate policy, misapplication of policy, or failure to document or verify where required. Check 'Payment Error' when an error in procedural requirement results in ineligibility or an erroneous payment. Check 'N/A' when the review element is not applicable to the case.

Item 17, Forms Completion, relates to completing required forms used in determining initial or continuing eligibility.

Item 18, FACETS Completion, relates to entering appropriate information on automated systems (FACETS, IEVS, Claims) including filling all appropriate fields correctly and processing updates promptly.

Include instructions and comments under 'Remarks'. Identify each eligibility item to be corrected according to the number, e.g., item 6, need for homelife care not documented.

Distribution

Original - Eligibility worker for information and/or corrections
Copy 1 - Public Assistance Field Supervisor
Copy 2 - Suspense copy held by reviewing supervisor until original is returned
Copy 3 - Case Record

STATE OF ALABAMA
COUNTY DEPARTMENT OF HUMAN RESOURCES

Public Assistance Case Review Summary – SUP

COUNTY ______________________ WORKER/UNIT ______________________

NAME OF PERSON WHO COMPILED DATA FOR THE MONTH OF ______________________

______________________ NUMBER OF CASES REVIEWED______________________

DATE COMPLETED______________________ NO. OF CASES WITH PAYMENT ERROR __________

Review Element	No Error	Procedural Requirement	Payment Error	N/A	Remarks
1. Age					
2. Residence					
3. Citizenship/Alienage					
4. Screening for SSI					
5. Disability (or Blind) Determination					
6. Homelife Care					
7. Homelife Care Provider					
8. Level of Care Designation					
9. Enumeration					
SSN(s) verified					
10. Medicaid Eligibility					
a. Retroactive					
b. Continued					
11. Trial Budgets					
12. Income					
a. Disregards					
b. Work expenses					
13. Resources					
14. Correction of Erroneous Payments					
15. Standard of promptness					
16. Accrual Rights					
17. Forms Completion					
18. F A C E T S Completion					
Totals					

DHR-FAD-1514
September 2006

Instructions for DHR-FAD-1514
Public Assistance Case Review Summary - SUP

Use/Purpose

This form is to be used to provide a monthly tally for cases reviewed during the month. The unit tallies may be combined at the end of the month and a report prepared for the county. The supervisor may want to keep a six-month tally for each worker as part of worker performance evaluation. The worker, unit and county summaries should be used in planning local corrective actions.

General Instructions

Count the number of checks (✓) in each field on all the 1513s to be tallied and enter the total in the corresponding field on this form.

Distribution

Original and copies: County Office

______________________ COUNTY DEPARTMENT OF HUMAN RESOURCES

State Supplementation Program

Medical Statement for Homelife Care Provider

NAME ______________________________
(care provider)
ADDRESS ______________________________
____

For DHR Use Only - Complete as Needed When Returned

Client Name ______________________

Client ID ______________________

PSD File No. ______________________

To the Physician: The above-named is/will be providing homelife care as described herein to an elderly or disabled individual at the request of the elderly or disabled individual. The care provider must have this form completed and return it to our office.

A. The above named individual is free of communicable and infectious disease.

/_/ Yes /_/ No If no, Explain: ______________________________
____

B. The above-named individual is physically and mentally capable of providing homelife care to elderly and disabled persons. See definition below.

/_/ Yes /_/ No

______________________ M.D.
Physician

____
Date

Homelife Care: Care needed to enable an individual to live as independently as possible outside a nursing home. Services considered to enable a person to live as independently as possible include help with any one or more of the following: (1) conducting a prescribed exercise routine; (2) changing bandages or dressings on the advice of the physician; (3) using prostheses or ambulation aids; (4) locomotion; (5) maintaining an acceptable state of cleanliness; (6) maintaining adequate nutritional standards in the purchase and preparation of food; (7) maintaining orientation to time, place and events; (8) reminding of the need for medication; (9) performing other activities needed to help a person care for himself when his illness or disability prevents him from adequately doing so. Companionship for pleasure or convenience rather than protection and necessity is not included in this definition nor is the provision of chore services such as transportation, home or yard maintenance, running errands, etc.

NOTE to the Physician: The Department of Human Resources is not responsible for any fee related to completion of this form.

DHR-PAD-1801
December 1991

Instructions for DHR-PAD-1801
Medical Statement for Homelife Care Program

Use/Purpose

This form is to be used to document that a homelife care provider other than an employee of a certified home health agency is physically and mentally able to provide such care in accordance with Section 12010C.

General Instructions

Give or send the form to the client with a self-addressed, stamped envelope for the client to give to her/his care provider, or, at the client's request, send the form to the provider. The homelife care provider is to have the form completed by her/his physician and return it to the county office. Have the form updated if there is a change in the health of the care provider which may prevent or limit provision of care.

Distribution

Original: Case Record after completion

TABLE OF CONTENTS

APPENDIX IV – WORKLOAD MANAGEMENT

Group Explanations

Use of Support Staff in Public Assistance

Procedures for Supervisory Case Review

County HEA/SMA Certification Responsibilities and Procedures

Project Recall

Change PLUS

Log of FA Ineligibles Due to Felony Convictions/Permanent Disqualifications

GROUP EXPLANATIONS

Group explanations may be used to provide general program information, as described in **Sections 1120A and B**, when two or more applicants/ recipients are scheduled for their individual interactive interview with the worker using FACETS. Group explanations should be used when limited staff, rising caseloads, emergencies or other problems may prevent workers from being able to complete their caseload activities in a timely manner. Contact your Public Assistance Field Supervisor to discuss/ review your plans before instituting group explanations.

Client participation in group explanations is strictly voluntary. A private explanation must be given during the FACETS online interview to any client who does not wish to participate in the group explanation.

Group explanations require careful preparation and presentation skills. The lead worker(s) must be knowledgeable about policies and procedures, personable, enthusiastic about group explanations, and be able to take criticism and unexpected questions in stride. S/he should have poise, confidence and experience in speaking to groups. Additional workers, clerical staff or volunteers may be used to hand out materials as their contents are discussed.

Group explanations may be used for applications and redeterminations or to explain just a certain point(s) of eligibility to a homogeneous group of clients. For example, group explanations may be given about time limits to a group of clients who are nearing them, or about JOBS to a group of required participants, or about child support to a group of grantees for children whose parent(s) is not in the home.

USE OF SUPPORT STAFF IN PUBLIC ASSISTANCE

Use of volunteers and auxiliary staff members to supplement merit system and contract staff in County Departments is encouraged. It enables eligibility workers and supervisors to have more time for functions which can be handled only by merit system staff. Volunteers are recruited through the County Department volunteer programs. Auxiliary staff come from such programs as Senior Aides, student placements or prep placements, etc.

Support staff must be provided a complete and thorough orientation. Included in such orientation must be (1) an explanation of rules related to confidentiality, including completion of any required department forms; (2) an explanation of Public Assistance programs; (3) a complete job description; and (4) the need for maintaining contact with the supervisor.

Monitoring activity, conducting special training, hiring, supervising and dismissing staff are responsibilities of the County Department where volunteers are concerned. They are unpaid staff members and should be hired, dismissed, and assigned tasks in keeping with their abilities. Auxiliary staff, while not on the merit system payroll, are to abide by agency rules. Clerical merit system staff should be aware of their responsibilities as state employees. **Access to SCI-II and FACETS is limited to merit staff and certain contract staff only, and access to IEVS is limited to merit staff only.**

Following is a list of approved activities for support staff. The list is not all inclusive. County Directors may secure concurrence from the Family Assistance Division about which other tasks they may want to delegate to support staff.

Assignment of support staff depends on their education, skill level training and level of competence. In the list below, persons assigned functions in 'A' may also be assigned functions in 'B' and 'C'. Persons assigned functions in 'B' may also be assigned functions in 'C' but not 'A'.

A. Highly skilled volunteer and auxiliary staff, such as former workers, workers with college degrees and, in some instances, merit system clerical staff can assist eligibility workers in the following:

   1. Participate in group explanations by assisting with explanation of policies, completion of forms, handing out forms and distributing pamphlets

2. Telephone intake – Answer general questions regarding basic eligibility requirements. Take telephone messages from clients and pass them on to appropriate workers.

3. Assist applicants and recipients in completing change report forms.

4. Assist clients in the office in completing form 690 prior to their interview with the eligibility worker.

5. Explain general points of agency policy and procedure to clients prior to interview with the eligibility worker.

6. Secure necessary verifications as directed by workers. Gather information from references regarding specific points of eligibility.

B. Volunteer and auxiliary staff with no special training may be assigned the following:

1. Make appointments for client.

2. Secure verifications from the Courthouse, Health Department, etc.

3. Stamp forms with the county's return address.

4. Assemble packets of pamphlets and/or forms.

5. Deliver messages.

6. Assist the receptionist by taking material (not case records) from her to the file room and from the file room to the worker.

7. Answer the telephone.

8. Make 'out' cards.

9. Insert carbon in pads of forms that are not pre-carbonized.

10. Fold signed mail and put in envelope.

11. Babysit for clients while they participate in their interviews.

D. Clerical staff, who are freed from routine clerical duties performed by auxiliary staff and volunteers, can be used more effectively to handle some work of eligibility workers and supervisors to free them for more highly skilled responsibilities.

The following tasks require greater knowledge of the internal mechanics of the County Department and may be handled by merit system clerical staff. In some instances, auxiliary staff and volunteers with adequate training can be used.

1. Maintain FACETS reports and provide statistical data for supervisors.

2. Sort and distribute material as it leaves workers' and supervisors' 'out' baskets.

3. Check the contents of form 690 to insure all needed information is provided.

4. Schedule appointments for workers as clients call for review or alert appointments. Make the 'out' cards.

5. Copy verifications that are brought in by clients before their interview.

6. Use FACETS and IEVS to work trial budgets, print payment histories, print outside information screens, such as BENDEX or SDX, etc. (but not BEER or Unearned Income). Merit staff only.

Procedures for Supervisory Case Review

Purpose:

The case review management information system has a four-fold purpose:

- To ensure systematic review of the work done in public assistance programs;
- To identify worker problems, etc.;
- To identify error trends and concentrations; and
- To monitor program performance

At the county level, the Case Review Checklist, unit tally and county summary will provide some of the information for worker performance assessment and local corrective action. The supervisor may use the checklist for training new workers and to identify areas of strengths and weaknesses for staff. Workers may use it to check their own work.

The county summaries and state summary will be used by State staff to monitor program performance to include identifying problems and error trends by county, region, and statewide. Analysis will be done to estimate the impact of program changes, to determine training needs, and to evaluate performance standards. The process may also be used for special projects.

Review Requirement:

The review requirement is five cases per month per allocated/attributed worker with program effort code 07 as of the first pay period in a month. For counties that show no 07 staff, at least one worker per county will be attributed. The fact that workers are new or on leave, or the fact that there is a delay in a PEC change does not remove the review requirement. For example, if there are five allocated (07) positions but during a month two of these five workers are on leave, the required number of reviews for the county is still 25. Results of case reviews in excess of the stated review requirements are not to be reported.

In implementing the case review, follow the procedures listed below:

Selection of Cases:

The alert list produced from FACETS (Screen ZE52 "Alert List") by caseload is to be used as the source in selecting cases for review. The alert list for all existing caseloads should be screen printed on the last workday of each month. The alerts should be pulled for the period beginning the first calendar day of the following month through the last day of that month. The list should be held by the supervisor or designee until the period specified on the alert list ends. The sample should then be selected and the cases reviewed during the following calendar month.

Example: To select cases for the month of June, (to be reviewed during July), the alert lists for actions due in June should be printed at the end of May.

On the first workday of the month the cases are to be reviewed, the supervisors should use the alert lists to select the cases for each caseload. Beginning with an arbitrary case on the listing, select every fifth case, either reading forward or backward from the starting point until five cases have been identified. After selecting the starting point, the supervisor shall use the same starting point for all workers in choosing the month's sample of cases. In the event there are fewer than 25 cases on the list counting from the starting point, count the remaining cases and return to the beginning of the list to complete the interval. For example, if the list has thirteen cases and only three remain after selecting the tenth case as the starting point and reading forward, it then becomes necessary to count the three remaining and return to the beginning of the list, thereby selecting the second case as the first in the sample.

Note: The alert lists in counties with smaller caseloads may not be sufficient to select the required number of cases. In this instance, use the caseload list (ZE73) to complete the selection process.

If the same case appears on the sample for two consecutive months, the supervisor should substitute another case by continuing the sampling process in the same pattern. For example, if the second case selected was reviewed in the prior month, select the next case and continue the counting interval from that point in order to come up with five cases to review. If preliminary review indicated that a selected case has been transferred to another county, another case shall be selected following the same pattern as above to replace the originally drawn case. If a case has been transferred between units within a county, the current supervisor shall review the most recent action.

The alert lists used to pull the case sample should be filed by month and maintained for a period of 12 months beyond the review month. These files are to be made available to the Field Supervisor or other state staff upon request.

The review of supplementation cases is optional; however, the procedure for selection is the same as that for FA.

<u>Completion of the Case Reviews</u>:

Use Form 1328 to document the results of each case review. In addition to copies in the county's files, this form may be found on the shared drive at: Shared/FA/PA/Forms/1328. The action to be reviewed on a selected case is the most recently completed eligibility determination, i.e. award/review/interim review or determination of ineligibility if the action is a denial. The supervisory review of the case record includes a review of all points of eligibility applicable to the time period covered by the review. For denials the time period is from the date of application through the

disposition. For award/reviews/interim reviews the time period that begins with the most recent award/review/interim review ends with the supervisory case review month but includes action taken if any in that month. If the action due (such as a pending application or review or interim review) has not been completed on the case review, the supervisor should review the case action to determine that the work done prior to the case review is correct beginning with the last complete eligibility determination, i.e. award/review/interim review and ending with the case review month.

Example 1: Supervisor selected record for month of March as alert (755) due in March. Case awarded November. Supervisory review period is November through March. Action to be reviewed includes the November award and ends with the March alert action if completed in March.

Example 2: Same as #1 but the last review was completed in December. The supervisor review period is December through March. Action to be reviewed includes the December review and ends with March alert if completed in March.

Example 3: Supervisor selected case in April from the alert list for the month of March as review was due (and completed) in March. The review period is March.

Compilation of Case Review Results:

At the end of the month in which the cases are reviewed, the supervisor shall tally the results on the Family Assistance Case Review Summary-FA (DHR-FAD-1512). In addition to copies in the county's files, this form may be found on the shared drive at: Shared/FA/PA/Forms/1512. If there are two or more supervisors, the Family Assistance Case Review Summaries will be given to a person designated by the County Director to compile the summary for the county (DHR-FAD-1512). The original summary sheets are to be sent to the Family Assistance Division by regular mail, fax (334-242-0513) or email. If sent via email, address to the DHR PA Help Desk selected from the global address book. (Do not address to an individual.)

Mail/email these in time to be received by the 15th of the month following the month in which the cases were reviewed by the supervisor. For example, cases reviewed in July (for June) will be pulled from the alert lists by caseload printed at the end of May. This summary for June activities is due August 15th. If the 15th falls on a weekend or holiday, the reports are due by the close of business on the next work day. Forms sent by regular mail and received after the 15th will be accepted as timely if postmarked no later than the 12th of the month. **NOTE:** Jefferson County will have two reports: Bessemer and Jefferson Main Office.

County HEA/SMA Certification Responsibilities and Procedures

The income and resource exclusions for FA and SUP applicants/recipients under the home energy assistance/support and maintenance assistance (commonly referred to as HEA/SMA) provisions may only be considered if the assistance was provided by an agency certified by the Department of Human Resources under the procedures described below. As the specific agencies or providers will vary from county to county, each County Department is responsible for maintaining their own listing of certified agencies and utility providers. It is recommended that one individual in each County Department be designated as the HEA/SMA Coordinator with responsibility for all certification activity and for maintaining the county file of certified agencies. For communication within the Department, form 799 may be used in requesting the certification of an agency by the designated HEA/SMA Coordinator.

The Certification Process

A. Definitions – The following definitions are central to the HEA/SMA certification process:

1. "Assistance based on need" means that the assistance is given to or on behalf of an applicant or recipient of a needs-based public assistance program. In Alabama, this is defined as an applicant or recipient of the FA or the SUP program.

2. "Private, non-profit organization" means a religious, charitable, educational or other organization which would be considered tax exempt under the Internal Revenue Code of 1954; however, actual tax exempt status is not a requirement.

3. "Rate-of-return entity" means a utility provider whose revenues are primarily received from the provider's charges to the public for utility service, and such charges are based on rates regulated by a State or Federal governmental body. In Alabama, such providers generally fall under the purview of the Alabama Public Service Commission.

B. Certification of HEA/SMA Providers

Agency certification of providers was originally described in Administrative Letter 5129, dated February 10, 1984; that initial effort to certify as many agencies as possible resulted in the publication of Administrative Letter 5129a on May 25, 1984 which provided a statewide listing of certified agencies. That listing and any subsequent individual certifications may continue to be used as the basis for the HEA/SMA income and resource exclusions provided the individual agency still meets all conditions for certification. A suggested format for maintaining a record of current certifications follows.

In order to certify an agency, the County Department must establish that HEA/SMA is provided based on need and that it is furnished by any agency as follows:

1. A supplier of home heating gas or oil, regardless of whether the assistance is in cash (such as a refund of payments) or in-kind; or

2. A municipal utility providing home energy, regardless of whether assistance is in cash or in-kind; or

3. A rate-of-return entity which provides home energy, regardless of whether the assistance is in cash or in-kind; or

4. A private, non-profit organization (such as a church) which provides home energy assistance or support and maintenance provided the assistance is in-kind.

(FORMAT)

CERTIFICATION LISTING OF AGENCIES PROVIDING HEA/SMA

COUNTY ______________________

DATE ______________________

HEA/SMA COORDINATOR ______________________

NAME OF (PROGRAM/AGENCY): ______________________

ADDRESS: ______________________

____

____

____

CONTACT REPRESENTATIVE: ______________________

TELEPHONE NUMBER: ______________________

TYPE OF AGENCY: (e.g., private, non-profit, rate-of-return entity, etc.)

TYPE OF ASSISTANCE: ______________ HEA ______________ SMA

METHOD OF DELIVERY: (e.g., cash, vendor, in-kind, etc.)

LIMITATIONS ON CERTIFICATION: (as needed)

____

____

DEPARTMENT OF HEALTH & HUMAN SERVICES

Social Security Administration

Refer to:

Dear

Subject: Home Energy Assistance/Support and Maintenance Certification (HEA/SMA)

The above named individual who is an SSI applicant/recipient has indicated receipt of: _____ HEA and/or _____SMA furnished by:_____________________

_____ Private nonprofit organization (includes religious, charitable, educational, or other such nonprofit organization).

_____ "Rate of return" home energy supplier (an energy supplier whose charges to the public for energy are regulated by the State or Federal Government).

_____ Other "rate of return" entity (an organization or company other than an energy supplier whose rates are regulated by the State or Federal Government).

_____ A municipal utility providing home energy (a public utility operated by a local government).

_____ Other supplier of home heating oil or gas (a private profitmaking energy supplier).

Amount and Form of Assistance (Date) (Frequency)

____

TO: Social Security Administration Date:_____________________

This certifies that the assistance specified above and provided by the organization identified is given for the purpose of home energy assistance/support and maintenance assistance. This assistance has been determined to be based on need.

Comments (Use reverse side if needed):

Enclosure:
Return Envelope

____

PROJECT RECALL

Project Recall is an <u>optional</u> case management tool to be used in the prevention of errors for cases with error prone characteristics. Workers select cases based on identified characteristics and clients are contacted two months after last contact with the worker to determine if any changes have occurred. In counties having intake units, the review or caseload unit would be responsible for recall activities.

I. Case Selection

A. From a month's award and/or reviews the worker will select cases for contact in two months. Set a worker alert for the selected cases for two months following the award or review. Maintain a list of selected cases (name, case ID and reason for selection) to be given at the end of each month of the supervisor. (The number to be selected is dependent on caseload size, number of workers, etc.)

B. Select cases with the following characteristics. Write down the question(s) you want to ask and attach it to the case record.

1. Client has recent work history or has a history of employment;

2. Client states during last interview s/he is expecting a change. For example: looking for work, trying to get in school, thinking about getting married, etc.

3. Client has high school diploma or GED.

4. Client has a history of failure to report changes.

5. Others as determined by staff. The worker's judgement, common sense and intuition should be used in determining other characteristics for case selection as well.

II. Client Contact

A. The supervisor may return the monthly listing to the worker for recording of findings for evaluation of the effectiveness of Project Recall.

B. If the client has a phone, call. If the client has no phone or if after several attempts the worker cannot reach the client by phone, send a letter to the client giving the worker's phone number and request the client call within seven days. If the client does not call, send a second letter requesting the client call within seven days. If the client still does not respond, put the

client on the list for recall next month. (If time permits, set a worker alert.) Follow the exact procedures as in the first recall month stated above.

If after the second recall month there has been no response from the client you can conclude the client is unlocatable. At this point process closure providing advance notice using code KMV.

NOTE: As Project Recall is an optional case management tool, NOT an eligibility requirement, under no circumstances is FA to be terminated due to client's failure to respond to requests for contact made solely as a result of Project Recall in the first Project Recall month. Termination can result due to inability to locate the client as indicated above when there is no response in two consecutive recall months.

III. **Client Interview**

A. Review the case record to remind you why the case was selected for recall.

B. During the telephone interview, explain to the client that periodically clients are contacted after award and/or between reviews to determine if changes have occurred. Remind the client of the requirement to report changes within 10 days.

- If you had difficulty reaching the client (i.e., did not answer, did not return your calls, failed to respond timely to your requests to call, etc.), ask the client why. Difficulty in reaching a client can be a clue to employment or change in residence.

- When an older child or adult other than the client answers the telephone and tells you the client is not at home, ask if the client is at work. If the person says yes, ask where. If the person answers no, ask when the client is expected to return. If the person gives a specific time late in the day (such as after 4:00) that may be an indication the client is employed. You may want to telephone again in another day to see if the result is the same.

- When an adult other than the client answers the telephone of a client who reportedly lives alone, ask the client or that person who they are. After ascertaining the client is not home, you might say, "I am ________________ from DHR, what is you relationship to ________________?"

- Do not be afraid to ask questions.

- Do not be afraid to point out discrepancies and ask for explanations.

- Should the client or the person you are talking with seem evasive, ask more questions.

- Subsequent to your conversation with the client, procedures in **Section 1125F** are to be followed in securing additional information/verification needed about reported changes.

IV. Recording

Record on a FACETS comment section or in the case narrative your contact and/or attempts to contact your client, information received from your client and, if appropriate, verification of reported changes.

Change PLUS

Change PLUS is an optional case management tool to be used in the prevention/identification of errors. At the time of action on any reported change, workers are to review and/or re-verify (as needed) one additional eligibility factor. Workers/supervisors will select the PLUS factor based on case reviews or other as identified by the staff. The factor can be changed quarterly or every six months as determined appropriate. If implemented, all cases are subject to this activity.

I. Reported Change

This means a change which affects the delivery or amount of benefits. The change can be reported by the client, other agency worker or third party.

II. PLUS Factors

The following factors have proven to be error prone: Composition of the assistance unit, unreported contributions, unreported wages, and enumeration.

III. Change as a Result of Change PLUS

Changes affecting eligibility uncovered as a result of this activity are subject to usual verification procedures, requests for information procedures and advance notice procedures if necessary.

IV. Examples of Change PLUS

1. Client calls to report a new job. (The PLUS factor is assistance unit.) As part of the processing of this change the composition of the assistance unit will be reviewed and/or re-verified with the client and/or other source as appropriate.
2. Client calls to report a child has left the home. (The PLUS factor is unreported wages.) As part of the processing of this change, inquiry will be made regarding wages. If client reports wages, usual procedures are followed to secure verification, etc.
3. Same as 2 above, but the PLUS factor is enumeration and this case contains a child with a T-number. As part of the processing of this change, inquiry will be made into receipt of the Social Security number. If received, usual procedures are followed to secure a copy of the card, etc.
4. Same as 2 above, but the PLUS factor is assistance unit. While reviewing and/or verifying the composition of the remaining assistance unit would be integral to the processing of this change, the requirement of the change PLUS activity would also be met.

Log of FA Ineligibles Due to Felony Convictions/Permanent Disqualifications

This log is used for manual tracking of FA ineligibles due to felony convictions and permanent disqualifications. It should be kept up-to-date by the PA Supervisor and used to compare ineligibles listed with applicants to assure that none are awarded. Each September, forward the county listing to SDHR, Family Assistance Division, for statewide list compilation. Names previously submitted will remain on the list and do not have to be sent in each year. If none are recorded for your county or no additional ineligibles are identified, a list annotated "none" or "no additions" should be submitted. If any previously disqualified individual has gained eligibility, indicate by entering the date of eligibility in the ELIG DATE column. This form will not be available from General Services. Make copies as needed.

DATE: Date of Conviction/Disqualification

TYPE CODES:

FF - Fleeing Felon
VP - Violating Probation/Parole
DB - Duplicate Benefits
CS - Controlled Substance
VQ – Voluntary Quit
SR – EBT Disqualification
TL – Time Limits (greater than 60 months, non-compliant with CS/JOBS)
RX – Drug Screening

LOG OF FA INELIGIBLES DUE TO FELONY CONVICTIONS/PERMANENT DISQUALIFICATION

COUNTY ____________________ Date ____________

SSN	NAME	DATE	TYPE	ELIG DATE

____
Contact

____
Telephone Number

____
Email Address

November 2017