Texas Works Handbook

Other Medical Programs

TWH, Part A, Determining Eligibility

TWH, A-100, Application Process

Revision 18-1; Effective January 1, 2018

A—110 Application Procedures

Revision 11-2; Effective April 1, 2011

A—111 Pre-Application Process

Revision 15-4; Effective October 1, 2015

TANF

Before the Application process begins, staff deliver an up-front Texas Works message to the Temporary Assistance for Needy Families (TANF) applicants explaining that:

- TANF is temporary and has time limits;
- there are other alternatives and options for the applicant instead of TANF benefits;
- an applicant should consider jobs and other resources (such as child support) before pursuing TANF;
- if an applicant chooses to apply for assistance, the individual is requesting help finding a job; and
- even if an applicant chooses not to apply for TANF, the individual still may apply for Medicaid and the Supplemental Nutrition Assistance Program (SNAP) to support employment while working toward self-sufficiency.

Staff must consider and determine which messages are appropriate for a particular applicant.

A—112 Application Assistance

Revision 15-4; Effective October 1, 2015

All Programs

If an applicant needs help completing the application packet, a volunteer or staff member must help. Anyone helping the applicant complete a paper application must initial the completed sections or sign the form showing that a volunteer or staff person helped complete the application.

A—113 Application Requests and Submissions

Revision 15-4; Effective October 1, 2015

All Programs

Applications must be given to anyone who requests the form. Each household has the right to file an application on the same day the household contacts the office during office hours. The local office must ensure that a person can obtain an application packet within 15 minutes of coming into the office.

Staff must advise the household that an applicant does not have to be interviewed before filing the application. The household may file an incomplete application as long as the form contains the applicant's name, address, and signature as explained in A-121, Receipt of Application.

Program	Ways to Request an Application*	Ways to Submit an Application	Applications

TANF	• Online through YourTexasBenefits.com;
	• In the local office;
	• By mail;
	• By fax; or
	• By phone.
		• Online through YourTexasBenefits.com;
		• In the local office;
		• By mail; or
		• By fax.
			• YourTexasBenefits.com
			• Form H1010, Texas Works Application for Assistance — Your Texas Benefits:
			  ○ Staff must also provide the following forms with the application:
			  ▪ Form H1830, Application/Review/Expiration/Appointment Notice;
			  ▪ Form H0025, HHSC Application for Voter Registration;
			  ▪ Form H0050, Parent Profile Questionnaire, for each absent parent;
			  ▪ Appropriate program pamphlets; and
			  ▪ A postage-paid return envelope.

SNAP	• Online through YourTexasBenefits.com;
	• In the local office;
	• By mail;
	• By fax; or
	• By phone.
		• Online through YourTexasBenefits.com;
		• In the local office;
		• By mail; or
		• By fax.
			• YourTexasBenefits.com
			• Form H1010, Texas Works Application for Assistance — Your Texas Benefits:
			  ○ Staff must also provide the following forms with the application:
			  ▪ Form H1830, Application/Review/Expiration/Appointment Notice;
			  ▪ Form H0025, HHSC Application for Voter Registration;
			  ▪ Appropriate program pamphlets; and
			  ▪ A postage-paid return envelope.
			
			Note: Form H1805, SNAP Food Benefits: Your Rights and Program Rules, must be included in the application packet or given to the applicant during the interview.

Program	Ways to Request an Application*	Ways to Submit an Application	Applications

Medical Programs	• Online through YourTexasBenefits.com;
	• In the local office;
	• By mail;
	• By fax; or
	• By phone.
		• Online through YourTexasBenefits.com;
		• In the local office;
		• By mail;
		• By fax; or
		• By phone.
			• YourTexasBenefits.com
			• Form H1010, Texas Works Application for Assistance — Your Texas Benefits:
			  ○ Staff must also provide the following forms with the application:
			  ▪ Form H1830, Application/Review/Expiration/Appointment Notice (if applicable);
			  ▪ Form H0025, HHSC Application for Voter Registration;
			  ▪ Appropriate program pamphlets; and
			  ▪ A postage-paid return envelope.
			• Form H1205, Texas Streamlined Application:
			  ○ Staff must also provide the following forms with the application:
			  ▪ Form H1830, Application/Review/Expiration/Appointment Notice (if applicable);
			  ▪ Form H0025, HHSC Application for Voter Registration;
			  ▪ Appropriate program pamphlets; and
			  ▪ A postage-paid return envelope.

* Staff must give the applicant an application on the same day it is requested. If a household contacts the local office by telephone and does not wish to come to the designated office to file an application on the same day of the request and prefers receiving the application by mail, staff send an application packet on the same day of the telephone request. For written requests, including those received electronically or by fax, staff mail an application packet on the same day the request is received.

The Texas Health and Human Services Commission (HHSC) must accommodate reasonable requests to receive communications by alternative means or at alternative locations. The individual must specify in writing the alternate mailing address or means of contact, and include a statement that using the home mailing address or normal means of contact could endanger the individual.

Note: Individuals applying for Medical Programs may also use the Marketplace-only applications explained in A-113.1, Application Forms. These applications can be submitted to HHSC in person, by fax, by mail, or via an account transfer explained in A-118, Coordination with the Federal Marketplace.

Related Policy
Registering to Vote, A-1521

A—113.1 Application Forms

Revision 15-4; Effective October 1, 2015

YourTexasBenefits.com

The online application on YourTexasBenefits.com integrates HHSC programs into one single application flow. Applicants only see the questions applicable to the programs they request. A PDF copy of the application information is created for applicants and advisors to view.

Individuals use YourTexasBenefits.com to apply for the following benefits:

- SNAP food benefits;
- TANF cash help for families;
- Health care for:
  - Children;
  - Adults caring for a child;

    - Adults not caring for a child (if this is selected, YourTexasBenefits.com will allow applicants to identify themselves as a refugee; if they are not a refugee, they will be redirected to HealthCare.gov);
    - Pregnant women;
    - Persons age 65 or older or persons with a disability; and
    - Persons under age 26 who were in foster care or who were unaccompanied refugee minors at age 18 or older;
- Medicare Savings Programs; and
- Long-term services and supports for:
    - Persons with intellectual or developmental disabilities; and
    - Persons with no intellectual or developmental disabilities.

Form H1010, Texas Works Application for Assistance — Your Texas Benefits

Form H1010 integrates Texas Works programs into one single application.

The addendum to Form H1010 — Form H1010-M, Applying for or Renewing Medicaid or CHIP? — captures the information needed to make an eligibility determination for Medicaid or the Children's Health Insurance Program (CHIP).

Individuals use Form H1010 to apply for the following benefits:

- SNAP food benefits;
- TANF cash help for families; and
- Health care for:
    - Children;
    - Adults caring for a child;
    - Adults not caring for a child;
    - Pregnant women; and
    - Persons under age 26 who were in foster care or who were unaccompanied refugee minors at age 18 or older.

Form H1205, Texas Streamlined Application

Form H1205 can only be used to apply for health care benefits.

Individuals use Form H1205 to apply for the following benefits:

- Health care for:
    - Children;
    - Adults caring for a child;
    - Adults not caring for a child;
    - Pregnant women; and
    - Persons under age 26 who were in foster care or who were unaccompanied refugee minors at age 18 or older.

Applications Solely Used by the Marketplace

The online Marketplace application is a single interactive application that is based on an applicant's selections. In addition, there are three paper applications for the Marketplace:

- **Application for Health Coverage** — for anyone who needs health coverage, but does not need help paying for health insurance costs.
    - Used by applicants who want to purchase a Qualified Health Plan (QHP) through the Marketplace.
- **Application for Health Coverage & Help Paying Costs (Short Form)** — for single adults who need help paying for health care coverage (mostly for states offering Medicaid expansion coverage to single adults ages 19 through 64) and who:
    - are not married, do not claim any tax dependents, and cannot be claimed as a tax dependent on someone else's federal income tax return;
    - were not formerly in the foster care system; and
    - are not American Indian (AI)/Alaska Native (AN).
- **Application for Health Coverage & Help Paying Costs** — for anyone who needs help paying for health care coverage, including:
    - individuals who are married, have tax dependents, or can be claimed as a tax dependent on someone else's federal income tax return;
    - individuals with or without current health care coverage;
    - families that include immigrants; and
    - individuals who were formerly in the foster care system.

Since these applications do not contain additional questions that were included on Form H1205, Texas Streamlined Application, advisors must send out Form H1020, Request for Information or Action, to request any additional information necessary to make an eligibility determination.

A—114 Applications Causing Conflicts of Interest

Revision 15-4; Effective October 1, 2015

All Programs

The advisor must avoid the appearance of impropriety or conflict of interest when determining eligibility. The advisor is not allowed to work on a case if the individual is a relative (by blood or marriage), roommate, dating companion, supervisor, or someone under the advisor's supervision. The advisor may never work on a case in which the advisor is a case participant or an authorized representative (AR).

The advisor:

- may provide anyone with an application and information about how and where to apply for benefits;
- may help a person gather any documents needed to verify eligibility; but
- must not take any other role in determining eligibility.

The advisor must consult with the supervisor if the individual is a friend, acquaintance or coworker. Generally, the advisor should not work on cases involving these individuals, but the degree and nature of the relationship should be taken into account. In remote areas where it is impractical for another person to process the application, the unit supervisor should be contacted to determine the best method to process the application.

A—114.1 Applications Submitted by Texas Works or Medicaid for the Elderly and People with Disabilities Employees

Revision 18-1; Effective January 1, 2018

All Programs

Give special handling to applications and redeterminations submitted by Texas Works and Medicaid for the Elderly and People with Disabilities employees.

- A Texas Works or MEPD employee at the next higher administrative position must complete the eligibility determination for another Texas Works employee.
- A designated supervisor must complete the eligibility determination for a Texas Works or MEPD supervisor or higher position.
- The employee's immediate supervisor or someone in the direct line of supervision may not process the Texas Works or MEPD employee's application.

A—115 Applications Filed in Hospitals and Clinics

Revision 15-4; Effective October 1, 2015

All Programs

Staff in these outstationed facilities are responsible for processing work from end-to-end and routing completed work to the vendor as Image Only.

When a Texas Works application is received, Texas Works outstationed staff:

- date stamp the document; and
- perform inquiry and complete Application Registration in the Texas Integrated Eligibility Redesign System (TIERS), if necessary.

If the individual requests a program that requires an interview or the individual requests an interview, the appointment will be scheduled through the State Portal Scheduler to the appropriate outstationed facility location listed in the State Portal Scheduler.

If an appointment is not required or requested, staff must manually create the appropriate Process task via the State Create Task page.

Once an appointment is scheduled in the State Portal Scheduler, an appointment task is created for the designated outstationed facility based on the interview type.

If an application/redetermination received in an outstationed facility meets the SNAP Desk Review criteria, staff should follow the Desk Review process.

SNAP and TANF

For SNAP or TANF applications filed at hospitals or clinic sites, staff must make arrangements for the household to obtain a Lone Star Card and personal identification number (PIN) at a nearby local office, if they are not available at the hospital or clinic site.

Medical Programs

If an individual is admitted to a hospital and the individual has a pending Medicaid application in a local eligibility determination office, the outstationed advisor must coordinate with the local office to assist in providing missing information, so the local office can complete the case.

TP 33, TP 34, TP 35, TP 43, TP 44 and TP 48

The file date is the date a contracted facility accepts the application. If the application is not forwarded to HHSC within three business days, the file date is the date the local eligibility determination office receives the application.

A—116 Special Application Processes

Revision 12-2; Effective April 1, 2012

A—116.1 Reserved

Revision 15-4; Effective October 1, 2015

A—116.2 Applications from Residents of a Homeless Shelter

Revision 16-3; Effective July 1, 2016

SNAP

Individuals residing in a homeless shelter may be potentially eligible for SNAP, regardless of the number of meals the facility provides, if the homeless shelter is an approved institution. A homeless shelter is an approved institution if it is either:

- a public or private, non-profit shelter for the homeless; or
- a certified SNAP retailer.

Staff must verify if the homeless shelter is an approved institution, if questionable.

Individuals residing in homeless shelters that are not approved institutions are potentially eligible for SNAP only if the facility provides half of their meals or less as described in B490, Determining Whether an Individual Who Resides in a Facility Is Institutionalized.

Homeless households must meet the same household composition, income, and resource standards as other households. If the household pays for room in a shelter, staff must consider the payments as shelter expenses.

Related Policy
Nonmembers, A-232.1
Prepared Meals for Homeless, B-462
Homeless Shelter Standard, A-1427
Determining Whether an Individual Who Resides in a Facility Is Institutionalized, B-490

A—116.3 Applications for Babies Born to Women in Prison

Revision 15-4; Effective October 1, 2015

Medical Programs

A pregnant woman who enters the state prison system is sent to the Texas Department of Criminal Justice women's facility. Before the baby is born, the prison social worker assists the pregnant woman to arrange for a responsible individual to pick up the baby from the hospital. The pregnant woman is sent to a prison section of the University of Texas Medical Branch (UTMB) in Galveston a few weeks before she is due to deliver, unless an emergency occurs earlier. If an emergency does occur, she will deliver at a closer facility when necessary. Before releasing the baby from the hospital, UTMB requires the individual who picks up the baby to complete an application for Medicaid. Designated Texas Works advisors ensure that the baby is certified for Medicaid using special application processing procedures and follow-up activities.

The designated advisors coordinate Medicaid certification by other advisors in special situations when the newborn needs to be added to an active case. Upon request by the designated advisors, which must be documented in the case record, an advisor must certify the newborn:

- for Medicaid (TP 43) from the date of birth (DOB), not the day the caretaker brought the baby home from the hospital; or
- after normal application time frames have passed. If needed, staff may follow procedures to request a timeliness exception.

State law requires Medicaid coverage for Texas newborns for at least 28 days after birth and possibly longer if the child is hospitalized at that time. If the hospital followed required procedures before releasing the baby, but the baby does not meet eligibility requirements for Medicaid, the designated advisor and State Office Data Integrity (SODI) staff certify the baby for TA 62, MA - State-Paid Coverage. Examples of not meeting eligibility requirements are:

- the individual caring for the child does not reside in Texas, and the baby will be taken out of state;
- the individual caring for the child refuses to apply for Medicaid; or
- the household is over the income limit.

Related Policy
Documentation Requirements, A-190
Medical Programs, A-240

A—116.4 SNAP Applications from a Contracted Community Partner (CP)

Revision 18-1; Effective January 1, 2018

SNAP

In March 2010, HHSC began a pilot program to allow CP staff from certain food banks to conduct the SNAP eligibility interview and collect as much information and verification as possible. A specially designed interview worksheet — Form H0901, HHSC Enhanced Data Gathering Worksheet — guides the CP interviewer through the interview process. Five specific CP food banks are taking part in the pilot program. HHSC contracts with the following food banks to provide application assistance:

- Houston Food Bank;
- North Texas Food Bank;
- San Antonio Food Bank;

- Tarrant Area Food Bank; and
- South Plains Food Bank (limited to six counties in Region 1 — Bailey, Crosby, Floyd, Hockley, Lamb and Lubbock).

The file date of the interviewed application is the date the contracted CP receives the application for SNAP assistance and any other type of Texas Works benefits requested on Form H1010, Texas Works Application for Assistance — Your Texas Benefits. For assistance beyond Texas Works programs, such as Medicaid for the Elderly and People with Disabilities program requests, advisors follow local office procedures to send the information through the appropriate channels.

If the CP accepts the application after traditional HHSC business hours or on a day that is not an HHSC workday (on a weekend or a holiday), the CP must advance the file date to the next HHSC workday. If the CP uses a date that is not an HHSC workday as the file date, the Texas Works advisor must correct the file date, enter the next HHSC workday as the file date, and document the reason for using the corrected file date. The advisor must also advance the interview date to the same date since the interview date cannot be any earlier than the file date.

CPs interview expedited and regular status households. The CP must send applications screened as potentially eligible for emergency benefits to HHSC on the day of receipt. The CP must send CP-interviewed applications with regular status, not expedited, to HHSC no later than three workdays from the date the CP receives the applications.

CPs maintain the interviewed applications on an electronic list for tracking purposes. The CP then emails the interviewed applications to a designated secure regional HHSC Outlook mailbox using Voltage Encryption. The CP places Form H0901, used exclusively by the CP interviewers, at the beginning of each application packet for which the CP conducted an interview. Since there will still be some households who only receive application assistance from the CP, Form H0901 will serve as the flag to notify HHSC staff that the CP has interviewed the household for SNAP.

TANF and Medical Programs

There is no deviation from normal processing for TANF or Medical Program requests that the CP submits with SNAP applications. For those households interviewed for SNAP by the CP, the advisor processing the TANF or Parents and Caretaker Relatives Medicaid must still conduct the TANF/Parents and Caretaker Relatives Medicaid interview. The advisor may conduct this interview without first scheduling the appointment, but in order to meet the timeliness requirement, if the advisor is not able to contact the household to conduct the TANF/Parents and Caretaker Relatives Medicaid interview within three workdays after receiving the application, the office must schedule an appointment.

Assistance-Only Applications — All Programs

The CP routes assistance-only application packets to the Austin Document Processing Center for distribution to the proper local HHSC eligibility office (by applicant ZIP code) for normal processing. The file date of the assistance-only application is the date the contracted CP receives the application for SNAP assistance and for any other type of Texas Works assistance requested on Form H1010, Texas Works Application for Assistance — Your Texas Benefits.

While most CPs submit electronic applications online through YourTexasBenefits.com, some CPs use different computer systems that screen eligibility for various programs and services, including some services outside of HHSC programs. Two of these systems currently are able to submit electronic applications via an interface with HHSC, including applications for SNAP, Texas Works Medicaid and TANF. HHSC considers these applications e-signed the same as applications filed online. These applications display “E-signed” on all client signature lines and display the CP organization’s name in the People Helping You section. The Community-Based Organization (CBO) portal page does not report these applications, and the advisor does not need to complete the CBO Logical Unit of Work (LUW) with the CP’s information.

Pending Information

If the CP interviewer notes that more information is needed to complete the case, the CP interviewer will give a request for information form to the household.

The CP interviewer will give the applicant Form H0920, Notice from the Community Organization Helping You, explaining:

- what is needed;
- the due date for receipt of the information; and
- the address and telephone number of the HHSC eligibility office where the information listed on Form H0920 should be returned.

The household has the option of returning requested information to the HHSC eligibility office or the CP. If the household chooses to return the requested information to the CP, the CP will send the pending information to the local HHSC eligibility office. The CP logs the pending information received from the household and forwards it to the proper eligibility office by encrypted email within three workdays of receipt.

Eligibility Decision

If the CP interviewer believes that all of the information to complete the case is present, the CP interviewer gives the household Form H0920 and indicates by marking the appropriate check box on Form H0920 that the CP will send the information and verification to HHSC for the final eligibility decision.

Form H0920 also informs the household that HHSC may determine whether additional information is needed to complete the case.

Rights and Responsibilities

Before completing the interview, CP interviewers will:

- inform the household of their rights and responsibilities, using Form H1805, SNAP Food Benefits: Your Rights and Program Rules, including the right to appeal;
- explain the difference between streamlined reporting and non-streamlined reporting; and
- inform the household that HHSC will send them Form H1019, Report of Change, indicating the household's specific reporting requirements.

The CP interviewer addresses the following forms and activities:

- Form H0025, HHSC Application for Voter Registration;
- Lone Star Card training and materials; and
- referrals for additional resources, if known, or to *2-1-1 Texas—Finding Help In Texas*, if not known.

HHSC Action on CP-Interviewed SNAP Applications

The local HHSC office records receipt of all interviewed applications from the CP on an electronically maintained list. The Texas Works advisor reviews the application and the supporting documentation. If the supporting documentation and application are complete, the Texas Works advisor processes and disposes the application and sends the primary cardholder record to the Electronic Benefit Transfer (EBT) clerk for the CP-provided Lone Star Card. The HHSC advisor sends an eligibility notice and issues benefits.

If HHSC denies the application, HHSC notifies the individual about the denial action and the household's right to appeal the decision.

CP SNAP Interviews — Verification of Identity

CP staff who interview an applicant for SNAP and indicate on Form H0901 that staff verified the applicant's identity must include a copy of the document used to verify identity in the data collection packet that the CP sends to HHSC for eligibility determination and processing.

If the CP interviewer fails to send a copy of the document used to verify identity, was unable to verify the identity of the applicant, or the advisor determines that verification is questionable, the advisor must pend the applicant for verification of identity and obtain the verification before certifying the SNAP application.

Pending Information

If HHSC needs information to complete the case, the advisor sends Form H1020, Request for Information or Action, to the household and allows at least 10 days for the household to provide the information, following regular policy.

Advisors must send Form H1020:

- to restate the same information requested by the CP; and
- to request additional information, if any, not noted by the CP.

The advisor must then dispose the application following regular policy for pended applications. See A-136, Eligibility Decision.

If the household does not provide the needed information and the 30-day SNAP processing time frame expires, or if the information is not provided by the last workday of the last benefit month for redeterminations, the advisor denies the request for benefits and notifies the individual about the denial action and the household's right to appeal the decision.

Advisors must:

- transfer all pertinent information gathered on Form H0920 to TIERS;
- document that CP staff conducted the interview; and
- document the specific food bank entity that conducted the interview.

Fair Hearings

HHSC staff represent the agency at all fair hearings. CP staff should refer individuals to the local HHSC eligibility office that serves them to submit a request for a fair hearing either by phone, in person, or by mail. If CP staff accepts a request for a fair hearing, they must send it to HHSC. The date of receipt for the fair hearing request is the date HHSC receives the request.

Scheduling a CP-Interviewed Appointment

Appropriate Office of Access and Eligibility Services (AES) staff must schedule appointments using the Portal Scheduler for cases interviewed by a CP. This allows for tracking via the Task List Manager (TLM). In many cases, the CP interview date will precede the date

the HHSC eligibility office actually receives the application; therefore, OES staff use the Select Appointment option to locate a past appointment slot that corresponds to the CP interview date. To make sure that the appointment task is routed to the proper location handling the application, staff must overwrite the individual's ZIP code, which automatically displays once the case number is entered into the Portal Scheduler, with the ZIP code of the office that is processing the application.

Interview slots must be published in order to use the Select Appointment option. If there are no appointment slots published for a past date, AES staff note the appointment date in TIERS on the Appointment Details page. If AES staff do not specify an appointment date, the SNAP Eligibility Determination Group (EDG) will be pended. The TLM will not track appointments that are not scheduled in the Portal Scheduler. **Note:** Assistance-only applications (applications not interviewed by a CP) should follow normal scheduling procedures.

Once the case is completed, send the supporting documents used for eligibility decisions to the vendor for Image-Only processing.

Related Policy
Application Processing, A-100

Electronic Benefit Transfer (EBT)

Each CP is assigned a specific local HHSC eligibility office to facilitate Lone Star Card distributions and security activities. A list of each local HHSC office assigned to a particular CP is part of the local office security plan, and each CP must comply with the HHSC security plan. Regional EBT coordinators must audit the HHSC eligibility offices and the offices' related community partners.

If it appears that the household could be eligible for benefits, the CP provides an EBT *Educational and Information Packet for Clients Applying for Supplemental Nutrition Assistance (SNAP)* to the household. The packet includes the Lone Star Card, information explaining the EBT process, and contact information. The household will not be able to register the card or select a PIN until an HHSC staff member enters a primary cardholder record for the individual and associates the correct card to the individual.

If it appears the household is not eligible, the CP interviewer does not give the household a Lone Star Card or related materials, but still must process the request for benefits and submit the application online at YourTexasBenefits.com or send securely to the HHSC Centralized Processing Unit for an eligibility determination.

The CP interviewer gives households that appear to be eligible:

- Form H1184, Here Is Your Lone Star Card; and
- Form H1185, Important Information About Your Lone Star Card.

The CP interviewer must discuss the issuance-related items as explained in B239.1, Advisor Interview Requirements for Client Training, with potentially eligible applicants during the interview, even if the application is pended. In addition, CP interviewers must also tell the applicant about the:

- benefits of keeping receipts to monitor one's SNAP EBT account balance;
- expunged benefits policy (benefits that are not accessed after a year are expunged – see B371, Expungement Policy); and
- procedures for using the Lone Star Card to access SNAP benefits in other states as explained in B351, Moves Out of State.

CP issuance staff give households that appear to be eligible a card sleeve.

The CP completes Form H1172, EBT Card, PIN and Data Entry Request, and the individual signs this form as acknowledgement of having received the EBT card. Form H0901, HHSC Enhanced Data Gathering Worksheet, also has a space to enter an existing cardholder's personal account number (PAN). CP interviewers must ask whether the household currently has a Lone Star Card. If the household says that there is an existing Lone Star Card, the CP interviewer must record the PAN on the last page of the data collection worksheet if the card is available. HHSC EBT staff must ensure that the card is linked to the proper case.

Form H1172 becomes part of the application package that the CP returns to the HHSC local office for eligibility determination. If HHSC determines the applicant is eligible, the advisor asks the EBT clerk (by sending Form H1172) to officially issue the card by linking the primary cardholder record with the card's PAN at the Administrative Terminal.

If applicants wish to add a secondary cardholder to their EBT card, applicants must contact the Lone Star Help Desk at 800-777-7328 (800-777-7EBT).

If the CP did not issue a Lone Star Card to a household eligible for SNAP benefits, the advisor must treat this situation like a certification following a telephone interview. The advisor must attempt to contact the household by telephone to give the household the choice of coming to the HHSC eligibility office to pick up the card or having the card mailed to the applicant's address.

Related Policy
Advisor Interview Requirements for Client Training, B239.1
Issuance Staff Requirements for Client Training, B239.2
Issuing Lone Star Cards for PCHs, B233.2
Applicants Interviewed by Phone, B233.2.2

A—116.5 Food Distribution Program on Indian Reservation (FDPIR)

Revision 11-3; Effective July 1, 2011

For application processing related to FDPIR, refer to the policy in B421, Food Distribution on Indian Reservation (FDPIR).

A—116.6 Joint SSI-SNAP Applications

Revision 11-3; Effective July 1, 2011

For application processing related to joint Supplemental Security Income (SSI)-SNAP applications, refer to the policy in B420, Joint SSI-SNAP Applications.

A—116.7 Types of Assistance Administered by Centralized Benefit Services (CBS)

Revision 11-3; Effective July 1, 2011

A—116.7.1 SNAP-CAP and SNAP-SSI

Revision 15-4; Effective October 1, 2015

For application processing related to SNAP-Combined Application Project (CAP) and SNAP-SSI, refer to the policy in B475, Supplemental Nutrition Assistance Program Combined Application Project (SNAP-CAP), and B474.1.1.1, SNAP-Supplemental Security Income (SSI) Caseload.

A—116.7.2 Applications for SNAP-CAP

Revision 15-4; Effective October 1, 2015

For application processing related to SNAP-CAP, refer to the policy in B475, Supplemental Nutrition Assistance Program Combined Application Project (SNAP-CAP).

A—116.7.3 Medicaid for Transitioning Foster Care Youth (MTFCY) (TP 70)

Revision 15-4; Effective October 1, 2015

For application processing related to MTFCY, staff should refer to policy in B474.1.2, Medical Programs, 2; and Other Medical Programs, Part M, Medicaid for Transitioning Foster Care Youth (MTFCY).

A—116.7.4 Medicaid Coverage for Children Placed in or Released from a Juvenile Facility

Revision 17-2; Effective April 1, 2017

For application processing related to Medicaid for children placed in the custody of or released from the Texas Juvenile Justice Department or Juvenile Probation Department, staff should refer to policy in B474.1.2.1, Child Placed in a Juvenile Facility, and B474.1.2.2, Child Released from a Juvenile Facility.

A—116.7.5 Medicaid for Breast and Cervical Cancer (MBCC)

Revision 15-4; Effective October 1, 2015

For application processing related to MBCC, staff should refer to policy in B474.1.2, Medical Programs, 4; and Other Medical Programs, Part X, Medicaid for Breast and Cervical Cancer (MBCC).

A—116.7.6 Refugee Medical Assistance (RMA)

Revision 15-4; Effective October 1, 2015

For application processing related to RMA, staff should refer to policy in B474.1.2, Medical Programs, 5; and Other Medical Programs, Part R, Refugee Medical Assistance.

A—116.7.7 Former Foster Care in Higher Education (FFCHE) (TA77)

Revision 11-3; Effective July 1, 2011

For application processing related to FFCHE, refer to policy in Other Medical Programs, Part F, Former Foster Care in Higher Education (FFCHE).

A—116.7.8 Former Foster Care Children (FFCC)

Revision 15-4; Effective October 1, 2015

For application processing related to FFCC, refer to policy in Other Medical Programs, Part E, Former Foster Care Children (FFCC).

A—117 Applications Filed Online through YourTexasBenefits.com

Revision 15-4; Effective October 1, 2015

When the household submits an application online, a process formats the information entered on the online application and imports certain data into TIERS. The process creates the PDF file of the application that is stored in the image repository and is viewable in the State Portal.

TIERS edits the data passed by YourTexasBenefits.com. The fields must contain valid characters and be valid values to be imported into TIERS. Dates must be in the correct format, fields that are numeric must contain only numbers and data must be in accepted ranges for fields with values such as Yes or No, or ZIP codes.

Applications that do not contain required data or have data that may be invalid may be rejected. When an application is rejected for electronic processing into TIERS, the system creates a non-SSP Application Registration Task List Manager (TLM) task.

Applications that are valid and accepted as electronic input into TIERS have an Application Registration TLM task created for them. The task is routed to the appropriate office based on Type of Assistance (TOA) and individual ZIP code for the clerk to perform the Application Registration process task.

A—117.1 Application Registration

Revision 15-4; Effective October 1, 2015

Clerks select the Application Registration task and review the application. Staff will perform Application Registration using certain pre-filled data from the online application that was entered by the individual. All online applications must have Application Registration processed even if the case is approved. It is important to associate the online application to the existing case.

A logical unit of work (LUW) is in Application Registration; Self-Service Application Search. Clerks search for the self-service application using any of the fields in the search area. The search results will be displayed by the head of household name even when the search was not on the head of household.

After successful Application Registration, an appointment or process task will be created for Data Collection, depending upon the programs requested on the online application.

The Application T number is changed to a case number upon clicking Submit in Application Registration.

A—117.2 Data Collection

Revision 15-4; Effective October 1, 2015

When performing Data Collection, the data entered in the online application is displayed for the advisor either as:

- pre-filled TIERS fields and a message at the top of the page stating that the fields are pre-filled from self-service data (for new applications); or
- YourTexasBenefits.com information that must be addressed, which displays in a comparison pop-up window (existing cases).

Click on the C icon in the Details page to access the comparison pop-up.

The comparison pop-up window displays the current data in TIERS and the data from the online application to allow the advisor to select the correct data to use in Data Collection.

The advisor may choose to:

- accept all TIERS data,
- accept all YourTexasBenefits.com data, or
- select each data element to be used individually from the comparison pop-up.

These comparison windows are displayed on most Data Collection pages through Resources. There is no YourTexasBenefits.com information or comparison windows in the Program, Income or Expenses pages. The advisor must complete the Data Collection driver flow.

A screen is added in the driver flow just before Run Eligibility. This screen is a summary screen that displays each LUW with YourTexasBenefits.com comparison data and the status of that data. Once the case is disposed, all YourTexasBenefits.com comparison data that was not resolved or processed will be marked completed by the system.

A—118 Coordination with the Federal Marketplace

Revision 15-4; Effective October 1, 2015

Medical Programs

HHSC and the federal Marketplace coordinate eligibility determinations for Texas Works Medicaid and CHIP. Information provided by the applicant or verified for the applicant is sent through an interface between the Marketplace and HHSC. The two systems — the Marketplace and HHSC — transfer an applicant's information from one system to the other. The transfer of application information is referred to as an account transfer. An account transfer is the way in which a client's information moves between the Marketplace and HHSC.

A—118.1 Applications Received from the Marketplace

Revision 15-4; Effective October 1, 2015

Medical Programs

The Marketplace sends the individual's or household's information electronically to HHSC via an account transfer when:

- the Marketplace determines the applicant is potentially eligible for Medical Programs available through HHSC; or
- the applicant requests a final eligibility determination for Texas Works Medicaid or CHIP from HHSC. This is referred to as a "full determination."

Applications sent via account transfers from the Marketplace are received by staff in the same manner as an application from YourTexasBenefits.com.

When an application is sent to HHSC via an account transfer, a PDF is populated with information provided by the applicant on the Marketplace application, along with a "Verifications" section that provides information on any verifications performed by the Marketplace. Advisors should enter the information provided on the PDF into TIERS.

Individuals cannot be required to provide the same information more than once, regardless of whether they apply through the Marketplace or through HHSC. This applies to any information provided on an application, as well as any verification materials provided by the applicant.

Related Policy
Verifications Provided by the Marketplace, A-118.1.2

A—118.1.1 Non-MAGI Account Transfers

Revision 15-4; Effective October 1, 2015

Medical Programs

A non-Modified Adjusted Gross Income (non-MAGI) account transfer is an account transfer that is sent from the Marketplace to HHSC when the Marketplace has identified that an applicant may be eligible for Medicaid for the Elderly and People with Disabilities (MEPD) because the applicant reported being age 65 or older, having a disability, or being blind. In order for an individual to apply for MEPD programs, they must submit an MEPD application, Form H1200, Application for Assistance — Your Texas Benefits.

Advisors must deny the application as “Filed in Error” and send the applicant Form H1200 if:

- the PDF included in the account transfer indicates “Medicaid Non-MAGI Eligibility” in the Referral Activity Eligibility Reason for an individual on the application;
- a “full determination” is not requested; and
- a determination for Texas Works Medicaid or CHIP is not listed for any other applicant on the application.

A—118.1.2 Verifications Provided by the Marketplace

Revision 15-4; Effective October 1, 2015

Medical Programs

For Marketplace account transfers, the PDF also includes a “Verifications” section. Advisors should use the verification section as follows:

- If the Marketplace has verified the applicant's Social Security number (SSN) or citizenship status using data from the Social Security Administration (SSA), advisors can identify that information in TIERS as "Verified by SSA."
- If the Marketplace has verified the applicant's alien status using data from the Department of Homeland Security (DHS), advisors can identify that information in TIERS as "Verified by DHS."
- All other applicant information, such as income, must be verified by an HHSC advisor according to HHSC procedures explained in C900, Verification and Documentation. If the Marketplace has verified the information according to HHSC procedures, then that data must be treated as verified.

A—118.2 Applications Sent to the Marketplace

Revision 15-4; Effective October 1, 2015

Medical Programs

When HHSC determines that a client is ineligible for Texas Works Medicaid or CHIP (due to Texas eligibility requirements), or that the client is only eligible for TP 56, Medically Needy with Spend Down; TP 32, Medically Needy with Spend Down-Emergency; or three months prior Medicaid, HHSC transfers that individual’s account information to the Marketplace to be assessed for eligibility for other health care coverage programs. Form TF0001, Notice of Case Action, informs the client that they have been transferred to the Marketplace.

A—119 Correspondence Options

Revision 15-4; Effective October 1, 2015

A—119.1 Electronic Correspondence

Revision 15-4; Effective October 1, 2015

All Programs

The head of household or authorized representative (AR) for a case may each choose at any time to receive most eligibility correspondence electronically rather than through the mail. By selecting this option, applicable forms and notices are posted to the client's or AR's YourTexasBenefits.com case account, and the client or AR receives a cell phone text message or email reminder each time a new form or notice has been posted to their account. Clients may print a copy of the correspondence from their account or request that a paper copy be mailed to them. Any forms or notices that are not available electronically will continue to be mailed to the client.

Once a head of household or AR has opted to receive electronic correspondence through their case account on YourTexasBenefits.com or by indicating that preference to staff through 2-1-1 (Option 2), a confirmation cell phone text message or email reminder will be sent to the client. The head of household or AR must enter the code provided in that confirmation message in their YourTexasBenefits.com case account in order to confirm their choice to receive electronic correspondence. Once confirmed, Form H1013, Electronic Correspondence Confirmation Letter, will automatically be mailed to the head of household or AR to further confirm the selection and to provide instructions about how to opt out of receiving electronic correspondence.

After a failed delivery of a text or email alert, the client is automatically unsubscribed from electronic correspondence. The eligibility system then automatically prints and mails to the client a paper copy of the correspondence that failed to reach the client with the original generation date, attached to Form H1015, Electronic Correspondence Failed Delivery. The client will receive future correspondence through the mail. However, the client may opt to subscribe again to receive electronic correspondence and start over the confirmation process.

A—119.2 Preferred Language for Correspondence

Revision 15-4; Effective October 1, 2015

All Programs

The head of household or AR for a case has the ability to choose the language in which certain forms and notices are generated from the eligibility system. The head of household or AR can select their primary household language from the following options:

- English
- Spanish
- Both English and Spanish
- Vietnamese*

* Clients who select Vietnamese as their primary household language will receive correspondence in English, and the eligibility system will automatically attach to the form or notice the Vietnamese Translation Interpreter Form, which directs clients to translation services.

Once a primary household language is selected, both the head of household and AR will receive correspondence in that language.

A—120 Office Procedures

Revision 08-1; Effective January 1, 2008

A—121 Receipt of Application

Revision 17-2; Effective April 1, 2017

All Programs

If the agency receives an application without a signature, follow the policy in A-122.1, Application Signature.

TANF

An application is valid as long as it contains the applicant's name, the applicant's address, and the signature of:

- the applicant; or
- an authorized representative (AR) if the applicant is incapacitated or incompetent.

SNAP

An application is valid as long as it contains the applicant's name, the applicant's address, and the signature of:

- the applicant;
- other responsible household member; or
- the AR of an applicant.

Medical Programs

An application is valid as long as it contains the applicant's name, the applicant's address, and the signature of:

- the applicant;
- the AR of an applicant;
- an individual age 19 or older who:
  - is included in the applicant's household composition; or
  - has a tax relationship with the applicant; or
- an individual who satisfies the definition of caretaker when the applicant is under age 19.

Note: Individuals are not required to live at the same physical address in order to apply for each other if they have a tax relationship as explained in A-240, Medical Programs. For example, a non-custodial parent may apply for Medicaid and CHIP on behalf of his or her child if the parent expects to claim the child as a tax dependent on his or her federal income tax return.

TP 43, TP 44 and TP 48

A new application is not required when an individual has an active Medicaid type program and requests to add another child for whom a new EDG is needed. Add the child to the case as explained in B-641, Additions to the Household. **Exception:** Staff must not add additional children/siblings to a case where a denied EDG was reinstated due to the release from a juvenile facility. The household must submit an application for the additional children/siblings. To identify these EDGs, view the Individual – Medicaid History page for the active child. If the Juvenile Placement History field has "Yes", the EDG has been reinstated.

This policy does not apply when there is no existing Children's Medicaid EDG. For example, advisors do not add a child when the only other child is certified for Medicaid because the certified child receives SSI. A separate application is required to initiate benefits for the

child being added. Also, advisors do not add an "other-related" child to an existing Medicaid case. This situation requires a separate application for Children's Medicaid.

Related Policy
Application Requests and Submissions, A-113
Filing the Application, A-122
Application Signature, A-122.1
Authorized Representatives (AR), A-170
Children's Medicaid Redetermination Expectations, B123.6
Denied EDGs, B-474.7

A—121.1 Receipt of Application from Residential Child Care Facility

Revision 15-4; Effective October 1, 2015

Medical Programs

When a representative from a licensed residential child care facility applies for an independent child who does not live in the county, staff should accept and process the application.

A—121.2 Receipt of Duplicate Application

Revision 15-4; Effective October 1, 2015

All Programs

A duplicate application:

- is an application filed after another application has already been filed;
- does not include a request for programs different from programs requested on the initial application submitted;
- does not include a request for programs different from programs currently received by the applicant; and
- is not needed for a redetermination of any active program.

Example: If a household submits an application for SNAP on January 2 and later submits one or more additional applications for SNAP that are different from the one the household filed on January 2, and are not needed for a redetermination of any active program, the additional application submitted is considered a duplicate application.

Duplicate Application Received While Original Application Is Being Processed

If an office receives a duplicate application while staff are in the process of making an eligibility determination (an application or redetermination) based on the original application submitted, staff must:

- treat the duplicate application as a report of change; and
- assign the duplicate application as a change to the advisor currently processing the case.

The advisor processing the original application must:

- review the duplicate application for reported changes;
- document the duplicate application was reviewed for changes;
- document the type of changes, if changes were reported on the duplicate application; and
- use information provided by the household on both the original application and the duplicate application when determining eligibility for the household.

Duplicate Application Received After Original Application Is Processed

If an office receives a duplicate application and the applicant has already been certified for assistance based on another application previously submitted, staff must review the duplicate application to determine if the household is applying for programs other than what the household is currently receiving and if any redeterminations are due.

If the household is applying for different types of programs, the application is not a duplicate application and must be processed as a new application for assistance.

If the household is not applying for a different type of program and there are no redeterminations, office staff must:

- treat the duplicate application as a report of change; and
- assign the duplicate application as a change indicating "duplicate application."

Staff are not required to create a T number for TIERS cases and/or dispose of a duplicate application as "filed in error." If staff erroneously create a T number, staff must deny/dispose the T number as filed in error, in addition to other required actions listed above.

Note: If the office that receives the duplicate application does not normally process reported changes, staff may mark the application form as a duplicate application and route it to appropriate staff following local office procedures.

Advisors who process the duplicate application as a reported change must review the application to determine if any changes are indicated and take the following action. If no change is indicated on the duplicate application, the advisor must:

- document receipt of the duplicate application in TIERS Case Comments;
- route the duplicate application to be imaged as part of the electronic case record;
- sustain the benefits for each Texas Works program the household receives; and
- send an individual notice to the household that eligibility for benefits has not changed.

If a change is indicated on the duplicate application, staff must follow the procedures outlined in B600, Changes, when processing changes reported on the duplicate application.

A—121.3 Receipt of Identical Application

Revision 15-4; Effective October 1, 2015

All Programs

An identical application is one or more exact copy of an application previously filed by an applicant.

Example: If a household faxes in an application on January 2 and later submits an exact copy of the same application, which includes the same signature and date of the application the household previously submitted, the newly submitted application is considered an identical application.

Required Action on Identical Application Received

If an identical application is received, staff must write "Identical Application" on the front page of the application and route the application for imaging. The vendor will image the identical application and add it to the electronic case record. No other action is needed.

A—122 Filing the Application

Revision 15-4; Effective October 1, 2015

All Programs

Staff should encourage households to file an application the same day the household or its representative contacts the office in person, by telephone, fax, or mail, and expresses interest in obtaining assistance. Staff should explain how to file an application. Application forms are also available at YourTexasBenefits.com and can be downloaded, printed, and electronically submitted.

The file date is the day HHSC receives an application form containing the applicant's name, address, and appropriate signature. This is day zero in the application process. Staff use this as the file date to determine eligibility for the programs the household requests upon filing the application through the time of the interview.

For electronically filed applications, the file date is the date the applicant clicks the “Submit Application” button in YourTexasBenefits.com.

Exception: For all applications received outside of business hours when HHSC is closed, including weekends and holidays, the file date is the next business day.

The household must file another application form to apply for additional programs after the interview is held, even if the case was pended and is not completed at the time of the request for a new program. **Exception:** If the household requests three months prior Medicaid coverage according to policies in A-831.2, Eligibility for Three Months Prior Coverage, staff use a previously filed application with a file date that corresponds with the three-month prior period as a basis for determining eligibility.

Once an application is filed, staff must take the following actions:

- enter the file date in the appropriate section on the application form, if received as a paper document;
- for SNAP and TP 40, screen the application for expedited service eligibility;
- upon request, give the household Form H1800, Receipt for Application/Medicaid Report/Verification/Report of Change;
- register the application when required; and
- schedule an interview appointment for the applicant when required as soon as possible.

See special procedures in this section to determine the file date for TP 40, TP 40 Continuous Coverage and TP 45 Retroactive Coverage.

Related Policy
Application Requests and Submissions, A-113
Receipt of Application, A-121
Documentation Requirements, A-190

TP 40 Continuous Coverage

The file date is the date the advisor determines eligibility, if an application form is not used.

Related Policy
Continuous Medicaid Coverage, A-832

TP 45 Retroactive Coverage

The file date is the date the advisor is notified about the child's unpaid medical bills.

Related Policy
TP 45 Retroactive Coverage, A-833

TP 33, TP 34, TP 35, TP 43, TP 44 and TP 48

The file date is the date a contracted facility accepts the application. If the application is not forwarded to HHSC within three business days, the file date is the date the HHSC office receives the application.

The file date is the date an individual submits an application to any HHSC office. The application must be faxed or mailed to the correct office the same day it is returned.

For electronically filed applications, the file date is the date the applicant clicks the “Submit Application” button in YourTexasBenefits.com. For applications received outside of business hours when HHSC is closed, including weekends and holidays, the file date is the next business day.

A—122.1 Application Signature

Revision 17-2; Effective April 1, 2017

All Programs

The applicant is required to provide a signed application form before being certified.

If the agency receives an application without a signature and the application has not been date stamped, the application is considered invalid. Staff must return the application with a letter and a self-addressed return envelope explaining that the application must be signed before the agency can establish a file date.

If the agency accepts an application without a signature and the application has been date stamped, the date the application is received is considered a valid file date. Staff must send Form H1020, Request for Information or Action, along with the signature page requesting a signature. If the applicant fails to provide a signed application by the final due date, staff must deny the application for failure to provide information.

Eligibility Support Vendor Action on Unsigned Applications

If the Eligibility Support vendor receives an unsigned application and takes action on that application within one business day, the application is invalid and is returned to the household with a letter and a self-addressed return envelope explaining that the application must be signed before a file date can be established.

If the Eligibility Support vendor accepts an application without a signature, and it is not identified as such before data entry or the data entry date is more than one business day after the receipt date of the application, the file date is protected. The file date is the receipt date of the application. The missing signature is treated as missing information.

Electronically Filed Applications

All Programs

For applications submitted online through YourTexasBenefits.com by the applicant or AR, staff must consider the application electronically signed.

Exception: Staff must not consider the application electronically signed when a non-client or non-AR completes and submits the online application for the household. In this situation, a pre-populated application is mailed to the household requesting a written signature from the applicant.

Applications Filed by Telephone

For certain programs, an applicant or AR may complete and sign an application by telephone:

Program	Complete Application by Telephone	Sign Application by Telephone
SNAP	No	No
TANF	Yes	No
Medical Programs	Yes	Yes

An applicant or AR who requests to apply for all programs by telephone is informed that the option to complete and sign an application for all programs by telephone is not available. The customer care representative directs the applicant or AR to submit an application online through YourTexasBenefits.com, by mail, by fax, or at a local office.

TANF

The applicant or AR completes an application over the telephone by providing their information to the customer care representative. However, the applicant or AR does not have the option to sign the application by telephone. The customer care representative enters the information provided by the applicant or AR through YourTexasBenefits.com and a pre-populated application is mailed to the household requesting a written signature from the applicant.

SNAP

The applicant or AR does not have the option to complete or sign the application by telephone.

Medical Programs

The applicant or AR may complete and sign an application over the telephone by:

- providing their information over the telephone to the customer care representative; and
- signing the application over the telephone by stating their name and agreeing to a penalty of perjury statement read by the customer care representative.

The customer care representative enters and submits the information provided by the applicant or AR through YourTexasBenefits.com.

Note: TW Advisors, MEPD Specialists, and other HHSC staff cannot accept telephonic signatures.

For applications signed and submitted over the telephone by the applicant or AR, staff must consider the application signed by telephone except in the following situation:

- the applicant or AR declines to sign the application by telephone; or
- a non-client or non-AR completes and signs the application by telephone for the household.

Correspondence is sent based on the following actions taken by the applicant or AR:

Action	**Correspondence**
Applicant or AR signs the application by telephone	• Form H1031, Telephonic Signatures Cover Letter, which notifies the individual they submitted a telephonically-signed application or renewal.
Applicant or AR declines to sign the application by telephone	• Form M5021A, Request for Missing Signature Cover Letter, which notifies the individual a signature is needed to complete the application process for TW medical programs; and • Form H1010, Texas Works Application for Assistance - Your Texas Benefits, the unsigned application for TW medical programs, which is populated with information provided over the phone. **OR** • Form M5021C, Cover Letter for Missing Signature Letter, which notifies the individual a signature is needed to complete the application process for TW medical and MEPD programs; • Form H1010, Texas Works Application for Assistance - Your Texas Benefits, the unsigned application for TW medical programs which is populated with information provided over the phone; and • Form H1200, Application for Assistance (Aged and Disabled), the unsigned application for MEPD, which is populated with information provided over the phone.

Notes:

- Individuals that sign a renewal by telephone receive the same correspondence, Form H1031, Telephonic Signatures Cover Letter, as individuals that sign an application by telephone.
- Individuals that decline to sign a renewal by telephone receive the following correspondence:
  - Form H1032, Cover Letter for Unsigned Your Texas Benefits Renewal Form, which notifies the individual a signature is needed to complete the renewal process; and
  - Form H2020-YTB, Your Texas Benefits Renewal Form, the unsigned renewal populated with information provided over the phone.

Related Policy

Application Requests and Submissions, A-113

Authorized Representatives (AR), A-170

Signatures Elsewhere

All Programs

If the applicant signs the first page of Form H1010, Texas Works Application for Assistance - Your Texas Benefits, but not the last page, the application can still be used to establish a file date. The applicant must still provide a signature for the last page to be certified.

If a signed first page of Form H1010 is received, staff must send Form H1020 requesting a signature on the last page of Form H1010 by the final due date. Applicants who fail to provide a signed last page of Form H1010 must be denied for failure to furnish information.

Note: If the applicant only provides a signed last page of Form H1010, staff does not require an additional signature for the first page of Form H1010.

Medical Programs

If an applicant only signs and returns Form H1010-MR, MAGI Renewal Addendum, without a corresponding application, the application is considered invalid.

If the applicant returns a signed application without Form H1010-MR, the application is considered incomplete. The advisor must send Form H1020, Request for Information or Action, with Form H1010-MR requesting the necessary information to make a determination based on Modified Adjusted Gross Income (MAGI) rules. If the applicant fails to provide a completed Form H1010-MR by the final due date, staff must deny the request for failure to provide information.

Related Policy
Application Requests and Submissions, A-113
Receipt of Application, A-121

A—122.2 Scheduling Appointments

Revision 15-4; Effective October 1, 2015

All Programs except TP 33, TP 34, TP 35, TP 36, TP 40, TP 43, TP 44, TP 45 and TP 48

Provide the individual with an appointment on Form H1830, Application/Review/Expiration/Appointment Notice, on the same day the individual submits an application unless the individual is interviewed on the same day. An appointment is required even if the application is filed with only a name, address and signature.

Exception: Staff sends Form H1830 no later than the next business day if the individual submits the application by mail or in an office drop box.

This policy applies to all new applications and untimely SNAP applications that are filed after the last day of the last benefit month.

Note: Staff should attempt to schedule the interview on a date and time that accommodates the needs of the household, such as after working hours if the only adult is working.

When scheduling a telephone interview, staff enters the individual's telephone number and the appropriate time, using one-hour increments. For example, a telephone interview will be conducted between 1 p.m. and 2 p.m. Local offices may choose to establish a shorter time increment.

TP 33, TP 34, TP 35, TP 36, TP 40, TP 43, TP 44, TP 45 and TP 48

There is no interview requirement for Children's Medicaid or Medicaid for Pregnant Women. Staff must process the application unless the individual requests an office appointment.

Exceptions:

- If the applicant was previously denied for failure to provide Form H1024, Subject: Self-Declaration Notice, or for missing an appointment related to Health Care Orientation (HCO) or THSteps, staff should schedule a telephone appointment and deliver the HCO, or remind the individual about the importance of the THSteps checkup at that time.
- Staff conducts a telephone interview for an initial application or renewal when HHSC receives conflicting information related to household composition or income that affects eligibility and the information cannot be verified through other means, such as an associated EDG.

Related Policy
Interviews, A-131
Explanation of Benefits, A-1531.4

A—122.3 Registering an Application

Revision 15-4; Effective October 1, 2015

All Programs

Staff must perform Application Registration (App Reg) within one workday after the file date when application registration is required.

To prevent overpayments or incorrectly providing benefits, staff must take the following action before registering an application:

- screen each application filed; and
- associate the old case number in File Clearance when appropriate.

Perform inquiry on all household members applying for benefits listed on the application for assistance. Use Social Security numbers (SSNs), case name search, and/or available case or EDG numbers to determine case status.

If inquiry shows …	then …
no record,	follow established local office procedures for processing applications.
an individual record,	check case/EDG status (active or denied). **If the case is active**, determine if the individual is currently active on another case in the same program. If the individual is: • not currently active in the same program, register the application. • entitled to dual SNAP participation as a resident of a shelter for battered persons, follow procedures in B454.1, Duplicate Participation Procedures. • currently active in the same program and is not entitled to dual benefits, take appropriate action to prevent duplicate participation. Process an overpayment, if applicable. **If the case is denied**, associate the old case number in File Clearance after determining that this is the same household.

If inquiry shows …	then …
a SNAP-CAP or SNAP-SSI case record,	check for CBS status in TIERS inquiry. SNAP-CAP will be listed as FS-SNAP under Current EDG Affiliations in case inquiry results and under Current Eligibility in individual inquiry results. SNAP-SSI will be listed as FS-SSI under Current EDG Affiliations in case inquiry results and under Current Eligibility in individual inquiry results. Follow established local office procedures applicable to the specific case situation.

SNAP

Staff must review the application for assistance to determine if the household is requesting a telephone interview due to a hardship.

Note: Staff use Form H1000-A, Notice of Application, to register applications and to obtain a unique EDG number when:

- TIERS is down for an extended period;
- the household is not known to TIERS;
- the household is eligible for expedited services; and
- the Administrative Terminal Application (ATA) must be used to assign the EDG number and issue benefits.

A—123 Withdrawal of an Application

Revision 15-4; Effective October 1, 2015

All Programs

The individual may voluntarily withdraw an application any time before certification.

SNAP

If someone other than the head of household, spouse, a responsible household member, or an AR requests a withdrawal, staff should contact the household to confirm the withdrawal.

Related Policy
The Texas Works Message, A-1527

A—124 Processing Presumptive Eligibility Applications

Revision 15-3; Effective July 1, 2015

TA 66, TA 74, TA 75, TA 76, TA 83, TA 86 and TP 42

Presumptive eligibility (PE) provides short-term medical coverage to pregnant women, MBCC applicants, children under age 19, parents and caretaker relatives of dependent children under age 19, and former foster care children. PE provides full fee-for-service Medicaid with the exception of pregnant women. Pregnant women receive ambulatory prenatal care only.

Qualified hospitals (QHs) determine PE for all groups except MBCC.

Qualified entities (QEs) determine PE for pregnant women and MBCC applicants. For MBCC applicants, only QEs that are also Texas Department of State Health Services (DSHS) Breast and Cervical Cancer Services contractors may make MBCC PE determinations, following the process outlined in X100, Application Processing.

A—124.1 Eligible Groups

Revision 15-3; Effective July 1, 2015

The following groups can receive presumptive eligibility coverage:

- Children:
  - MA-Children Under 1 Presumptive — TA 74
  - MA-Children 1–5 Presumptive — TA 75
  - MA-Children 6–18 Presumptive — TA 76
- Former Foster Care Children (MA-FFCC Presumptive — TA 83)
- Pregnant Women (MA-Pregnant Women Presumptive — TP 42)
- Parents and Other Caretaker Relatives (MA-Parents and Caretaker Relatives Presumptive — TA 86)

A—124.2 File Clearance

Revision 15-3; Effective July 1, 2015

TIERS performs automated file clearance for each individual determined presumptively eligible if the individual has a 100 percent match in TIERS or if there is no match for the individual in TIERS. For individuals for whom TIERS cannot perform automated file clearance, TIERS triggers an alert to create a TLM task for staff to manually do file clearance for the individual. TIERS routes manual file clearance tasks to the Out-stationed Worker Program (OWP) queue for assignment and processing.

A—124.3 Task List Manager

Revision 15-3; Effective July 1, 2015

When TIERS cannot automatically perform file clearance for an individual whom a QH/QE has determined to be presumptively eligible, an OWP advisor needs to take action. TIERS creates the task "Process a File Clearance Failure for Presumptive Eligibility" and sends it to an OWP advisor based on the applicant's ZIP code.

To complete the task, the advisor:

1. Selects the Work icon.
2. Selects the individual who needs file clearance from the **Presumptive Eligibility Individual — Summary page.**
3. Matches the PE individual to the TIERS individual on the **PE File Clearance — Results page.**
4. Selects **Auto Process PE** on the **File Clearance — Results page** to complete the task once the advisor has performed file clearance for all individuals on the case.

The advisor can also manually clear the task. When an advisor searches for an application on the **Self Service Application Search** page, the **SS Application Search Results section** displays a **Determine PE** link if a PE individual on the case requires manual file clearance. TIERS displays the **Presumptive Eligibility Individual — Summary page** when the advisor clicks the link.

Once the advisor completes file clearance, TIERS notifies TLM to close the QH/QE PE task.

A—124.4 Application Processing

Revision 15-3; Effective July 1, 2015

The TLM routes applications for regular Medicaid from individuals whom a QH/QE has determined to be presumptively eligible for Medicaid to an OWP advisor for processing. If the QH has an OWP advisor, the TLM assigns the application to that advisor for processing. If the QH does not have an OWP advisor or a QE submits the application, the TLM routes the application to the regional OWP queue.

Process the applications using current policy and application processing time frames. See B112, Deadlines. If both a PE task for file clearance and a regular Medicaid application exist for the same person, clear the PE task first.

A—124.5 Verifications

Revision 15-3; Effective July 1, 2015

Use standard verification requirements when processing an application for regular Medicaid from an individual determined presumptively eligible. See C900, Verification and Documentation.

Related Policy
Verifications, C1113.4

A—124.6 Medical Effective Date

Revision 15-4; Effective October 1, 2015

The medical effective date for PE is the date that the QH or QE determines the individual is presumptively eligible for Medicaid.

Note: An individual is not eligible for PE coverage if the individual is currently certified for Medicaid, CHIP or CHIP perinatal.

If the individual does not apply for regular Medicaid, PE coverage ends the last day of the month after the month of the PE determination (see scenario 1 below).

If the individual submits Form H1205, Texas Streamlined Application, or Form H1010, Texas Works Application for Assistance — Your Texas Benefits, HHSC determines whether the individual is eligible for regular Medicaid. If the person is not eligible for regular Medicaid, the individual's PE coverage ends the date that HHSC determines the individual is ineligible (see scenario 2 below). If the person is eligible for regular Medicaid, the person's PE coverage ends when HHSC makes the Medicaid eligibility determination, following cutoff rules.

If an individual is Medicaid-eligible during the application month, the individual receives Medicaid from the first of that month through the PE MED. Regular Medicaid coverage for the ongoing period starts once the PE period ends (see scenarios 3 and 4 below). **Exception**: Since PE for pregnant women provides only limited prenatal services, ongoing Medicaid coverage overlays the PE coverage (see scenario 5 below).

Examples:

PE Scenarios	
1. Individual does not apply for regular Medicaid	A child is determined eligible for MA-Children 6–18 Presumptive on February 2. Her mother does not submit an application for regular Medicaid. The child's PE coverage ends on March 31.
2. Individual is ineligible for regular Medicaid	A child is determined eligible for MA-Children Under 1 Presumptive on April 4. Her father submits an application for regular Medicaid on the same date. HHSC determines on April 20 that the child is not eligible for regular Medicaid. Her PE coverage ends on April 20.

3. Individual is eligible for regular Medicaid (HHSC makes eligibility determination before cutoff)	A child is determined eligible for MA-Children 1–5 Presumptive on March 6. His mother submits an application for regular Medicaid on the same date. HHSC determines on March 15 (before cutoff) that the child is eligible for regular Medicaid. His PE coverage ends March 31. He is certified for regular Medicaid effective March 1 to March 5 and April 1 through ongoing.
4. Individual is eligible for regular Medicaid (HHSC makes eligibility determination after cutoff)	A former foster care child is determined eligible for MA-FFCC Presumptive on May 9. He submits an application for regular Medicaid on the same date. HHSC determines on May 22 (after cutoff) that the individual is eligible for regular Medicaid. His PE coverage ends June 30. He is certified for regular Medicaid effective May 1 to May 8 and July 1 through ongoing.
5. Pregnant woman is eligible for regular Medicaid	A woman is determined eligible for MA-Pregnant Women Presumptive on June 4. She submits an application for regular Medicaid on the same date. HHSC determines on June 10 that the woman is eligible for regular Medicaid. Her PE coverage ends on June 30. Regular Medicaid overlays her PE coverage with an effective date of June 1.

A—124.7 Periods of Presumptive Eligibility

Revision 15-3; Effective July 1, 2015

Pregnant women are allowed one PE period per pregnancy.

For all other PE groups, an individual is allowed no more than one period of PE per two calendar years. **Example:** An individual receives PE for children ages 6–18 in June 2015. He cannot receive another period of PE until January 2017.

A—124.8 Fair Hearings

Revision 15-3; Effective July 1, 2015

Appeals and fair hearings do not apply to PE.

A—124.9 Questions About the Presumptive Eligibility Process

Revision 15-3; Effective July 1, 2015

Refer hospitals and entities that are interested in becoming qualified to make PE decisions to the PE website at www.TexasPresumptiveEligibility.com.

Refer individuals with questions about their PE coverage dates to the QH/QE that made the PE determination. For questions about services covered by Medicaid, tell the person to call the Medicaid help line at 1-800-335-9857.

A—124.10 Presumptive Eligibility Forms

Revision 15-3; Effective July 1, 2015

Qualified hospital/qualified entity staff use the following forms in the presumptive eligibility process:

- **Form H1265, Presumptive Eligibility (PE) Worksheet** — Completed by the QH/QE and used to determine if an applicant is presumptively eligible.
- **Form H1266, Short-term Medicaid Notice: Approved** — Completed by the QH/QE and given to an individual determined presumptively eligible. This form notifies the individual about PE coverage and lists the eligibility start and end dates. If an individual takes this form to a local eligibility determination office and requests a temporary Medicaid identification card, give the person Form H1027-A, Medicaid Eligibility Verification.
- **Form H1267, Short-term Medicaid Notice: Not Approved** — Completed by the QH/QE and given to an individual determined ineligible for PE coverage. This form explains the reason for ineligibility and how to apply for regular Medicaid.

Related Policy
Qualified Hospital/Qualified Entity Policy and Procedures for Presumptive Eligibility Determinations, C1113

A—125 TP 45 Provider Referral Process

Revision 16-3; Effective July 1, 2016

TP 45

State Office Data Integrity (SODI) uses the Provider Referral Process when a hospital, birthing center, or Federally Qualified Health Center (FQHC) submits a referral directly to SODI for a newborn whose mother is Medicaid eligible. The provider does not submit a claim for payment to the claims administrator for the child at this time.

SODI researches eligibility files. After verifying the mother's Medicaid coverage, which can be retroactive, SODI creates a TP 45 EDG for the newborn.

Coverage for the child begins with the child's date of birth (DOB). The last month of coverage is the month the child turns age one, unless one of the following situations occurs.

- The hospital notifies SODI using Texas Department of State Health Services Form 7484, Hospital Report (Newborn Child or Children), that the child's mother relinquishes her parental rights.
  - If Form 7484 indicates a relinquishment but the new caretaker's information is incomplete or is not provided, SODI provides newborn Medicaid coverage from the child's DOB through the end of the month the child is relinquished.
  - If Form 7484 indicates a relinquishment and the new caretaker's name and address are provided, SODI completes two case actions. The first action is to process an open and close newborn Medicaid EDG with the birth mother as the case name. The coverage begins with the child's DOB and continues through the end of the month the child was relinquished. The second action is to open a newborn Medicaid case/EDG with the new caretaker as the case name. The coverage begins the first of the month after the original newborn Medicaid coverage ended and continues through the month of the child's first birthday.
- The child's mother received TP 42 Pregnant Women Presumptive coverage at the time of the child's birth and the mother's application for regular Medicaid coverage is denied. SODI certifies the child through the birth month.

The computer generates and sends the following documents for each EDG:

- A notice of the newborn's individual number to the referring provider and other providers, if identified on the provider's referral;
- Your Texas Benefits Medicaid card to the newborn's mother; and
- A notice informing the newborn's mother/caretaker:
  - that the child is eligible to receive medical coverage through the month the child turns age one, as long as the Texas residence requirement is met, and to report any changes concerning these eligibility requirements;
  - to report if information on Form H1027-A, Medicaid Eligibility Verification, is incorrect;
  - to report if the newborn's siblings receive TANF; and
  - if the mother's Medicaid end date changes because the child was not born in the anticipated month.

A—125.1 Advisor Action in Provider Referral Process

Revision 15-4; Effective October 1, 2015

TP 45

A task is created when a TP 45 EDG is established and the TIERS case contains an active SNAP or TANF EDG. The advisor must take the following actions once the advisor claims the newborn alert task.

If ...	then ...
the newborn is a mandatory member of a TANF-certified group or SNAP household,	process to add the child to the TANF or SNAP EDG as explained in B641.1, Adding Newborns to the Case.
the child is **not** a mandatory member of a TANF-certified group, but the child's mother or caretaker provides additional information about the child (name, SSN, etc.),	add these changes to the TP 45 EDG.
the newborn's siblings are included in the MAGI household composition for a TP 43, 44, or 48,	take no action on the siblings' EDG until additional information is requested for the siblings. At that point, request verification of tax status and relationship for the newborn. If the mother provides verification of relationship for the newborn, add the newborn to the siblings' budget groups.
the child becomes ineligible for TP 45 before the child's first birthday,	deny TP 45 for the child, using the appropriate denial code.

A—125.2 Suspended Claim Process

Revision 15-4; Effective October 1, 2015

TP 45

The Medicaid provider sends a claim for a newborn child with the child's mother's claim to the claims administrator. If the claims administrator cannot find the child on HHSC's eligibility files, the claims administrator suspends the child's claim and sends an exception notice to State Office Data Integrity (SODI). SODI checks the child's mother's Medicaid eligibility. If the mother received Medicaid at the time of the child's birth, including a retroactive determination, SODI follows procedures in the Provider Referral Process to provide Medicaid coverage for the child.

A—125.3 Mandated TIERS Inquiry

Revision 15-4; Effective October 1, 2015

TP 45

Field staff must perform TIERS inquiry before providing coverage for a newborn when there is no evidence of SODI TP 45. Staff should inquire by the newborn's mother's individual number and look for a process date that is after the child's DOB.

A—126 Processing Children’s Insurance Applications

Revision 15-4; Effective October 1, 2015

See A-113, Application Requests and Submissions, for how to apply for Medical programs for children.

A—126.1 Front Desk Process

Revision 15-4; Effective October 1, 2015

CHIP and TP 43, TP 44 and TP 48

When individuals come to a local eligibility office to inquire about health insurance for their child(ren), the front desk clerk must:

- explain the ways to submit an application as outlined in A-113, Application Requests and Submissions; and
- explain that the Medicaid application process provides that if a child is found ineligible for Medicaid based on income, HHSC will test the child for CHIP and, if eligible, the Enrollment Broker will send an enrollment packet to the household.

A—126.2 Inquiry

Revision 15-4; Effective October 1, 2015

CHIP and TP 43, TP 44 and TP 48

Before certifying a child for any type of Medicaid program, advisors must perform an inquiry to determine whether the child applying for Medicaid is already enrolled or pending enrollment in Medicaid, CHIP, or CHIP perinatal.

A—126.3 Advisor Action for Determining Eligibility for Children

Revision 16-2; Effective April 1, 2016

CHIP and TP 43, TP 44 and TP 48

When taking action on an application, the following procedures must be applied:

If ...	then ...
The child applying is not active in CHIP or pending CHIP enrollment,	test for Medicaid eligibility. Follow the policy for assigning the MED*.
The child applying is active in CHIP and the CHIP end date is the application month or the following month,	test for Medicaid eligibility. If eligible, and it is: • before cutoff, begin Medicaid coverage the first day of the next month. • after cutoff, begin Medicaid coverage the first day of the month following the next month.

If ...	then ...
The child applying is active in CHIP and the CHIP end date is later than the month following the application month,	test for Medicaid eligibility. If eligible, and processing is: • before cutoff, begin Medicaid coverage the first day of the next month. • after cutoff, begin Medicaid coverage the first day of the month following the next month.
The child applying is pending CHIP enrollment with a start date the first day of the next month,	test for Medicaid eligibility for the three months prior, if the application indicates unpaid medical bills. Test for ongoing Medicaid eligibility. If eligible, and it is: • before cutoff, follow the policy for assigning the MED. • after cutoff, begin Medicaid coverage the first day of the month following the next month. Provide open/close coverage for the application month and/or prior months, if applicable.
The child applying is pending CHIP enrollment with a start date later than the first day of the next month,	test for Medicaid eligibility for the three months prior, if the application indicates unpaid medical bills. Test for ongoing Medicaid eligibility. Follow the policy for assigning the MED.
The child is active in CHIP, the application indicates she is pregnant, and the CHIP end date is in the application month,	test for Medicaid eligibility. If eligible, begin Medicaid coverage the first day of the month following the CHIP end date.
The child is active in CHIP, the application indicates she is pregnant, and the CHIP end date is in the month following the application month or later,	test for Medicaid eligibility. If eligible, and it is: • before cutoff, begin Medicaid coverage the first day of the next month. • after cutoff, begin Medicaid coverage the first day of the month following the next month.
One child in the family applying is active in CHIP and another is not,	test for Medicaid eligibility. If eligible, follow the applicable guidelines given in the preceding scenarios, for each child.

* See A-820, Regular Medicaid Coverage, to apply the MED.

After determining a child is ineligible for Medicaid, TIERS will test eligibility for CHIP.

When the head of household does not provide their date of birth (DOB) and/or Social Security number (SSN), the following steps are taken to obtain the information:

- Call the household to try to obtain the correct DOB and/or SSN. Let the household know this information is voluntary and is not required to make an eligibility determination for the child; however, it will help expedite the process.
- If unable to obtain the DOB and/or SSN by telephone, continue to process the child's application for Medicaid.
- Select a random DOB for the caretaker/second parent, with a year between 1965 and 1975. Using randomly selected DOBs reduces or eliminates the problem of duplicate individual numbers.
- The SSN field is left blank if the correct number is not available.
- Staff ensure that all other demographic information is correct and include the individual's middle name, when available.

A—126.3.1 Neonatal Intensive Care Unit (NICU) Newborn Process

Revision 15-4; Effective October 1, 2015

CHIP Perinatal, TP 36, TP 43 and TP 45

Income Above the Limit for Medicaid for Pregnant Women (TP 40)

When a CHIP perinatal mother whose household income is above the income limit for TP 40 applies for Medicaid for her newborn and HHSC hospital-based staff have information from the applicant or the hospital that the newborn is medically fragile and that the newborn is admitted into the NICU, HHSC hospital-based staff must certify the newborn using the following process:

- Upon receipt of an application for a Medicaid NICU newborn, HHSC hospital-based staff must perform inquiry to determine if the mother is on CHIP perinatal or whether the newborn has been assigned a TIERS individual identification (ID) number and is active on Medicaid.
- If the newborn is not active on Medicaid, staff must deny the CHIP perinatal and certify the eligible newborn for TP 43, if eligible, following existing policy.
- If not eligible, test the newborn for TP 56 and do not deny the newborn's CHIP perinatal coverage.
- If eligible, the newborn may receive TP 56 and CHIP perinatal coverage.

Income at or Below the Limit for Medicaid for Pregnant Women (TP 40)

When HHSC hospital-based staff have information from the applicant or the hospital that a newborn born to a CHIP perinatal mother whose household income is at or below the income limit for TP 40 is medically fragile and that the newborn is admitted into the NICU, HHSC hospital-based staff must certify the eligible mother for Emergency Medicaid and the newborn for TP 45, effective on the newborn's date of birth. The CHIP perinatal mother must submit Form H3038-P, CHIP Perinatal — Emergency Medical Services Certification, to the hospital. HHSC hospital-based staff must process Form H3038-P.

Upon receipt of Form H3038-P, HHSC hospital-based staff must:

- perform inquiry on the Newborn Perinatal Match Interface (Interfaces – TIERS Left Navigation) to verify the CHIP perinatal household's FPIL;
- use the date Form H3038-P is provided as the file date for both the Emergency Medicaid and Medicaid for the newborn child;
- certify the CHIP perinatal mother for Emergency Medicaid and deny the CHIP perinatal Eligibility Determination Group (EDG); and
- certify the eligible newborn for TP 45, effective on the newborn's date of birth.

Related Policy
Adding a New Child, D1433.1

A—126.4 CHIP Good Cause

Revision 15-4; Effective October 1, 2015

CHIP good cause is explained in D1723.6, Good Cause Exemptions for Children Subject to the 90-day Waiting Period.

A—126.4.1 Claiming Good Cause

Revision 15-4; Effective October 1, 2015

CHIP good cause is explained in D1723.6, Good Cause Exemptions for Children Subject to the 90-day Waiting Period.

A—127 Prior Medicaid Coverage

Revision 15-4; Effective October 1, 2015

Children's Medicaid and TP 33, TP 34 and TP 35

Staff use any valid application or renewal form to determine three months prior coverage for Children's Medicaid. Do not require Form H1113, Application for Prior Medicaid Coverage, if the family provides enough information to determine eligibility for prior months. If the family does not provide enough information and cannot be reached by telephone, staff sends Form H1113 with Form H1020, Request for

Information or Action, to request verification. **Note:** Three months prior coverage does not apply to CHIP. See D1723.5, Coverage Start Dates, to determine when CHIP coverage begins.

Staff must not delay certification of ongoing eligibility to determine if any child is eligible for prior coverage.

Related Policy
Medicaid Coverage for the Months Prior to the Month of Application, A-830

A—128 Processing Applications for Pregnant Women

Revision 15-4; Effective October 1, 2015

CHIP Perinatal, TP 40 and TP 36

A pregnant woman may apply for health care coverage using applications and ways to submit an application explained in A- 113, Application Requests and Submissions.

When a pregnant woman applies for health care coverage, she will first be tested for TP 40 coverage. If ineligible for TP 40, TIERS will determine whether the woman is eligible for CHIP or CHIP perinatal.

CHIP perinatal coverage provides services to unborn children of pregnant women, regardless of age, who are at or below the program income limit and are ineligible for:

- Medicaid because of immigration status or income; or
- CHIP because of age or immigration status.

CHIP perinatal households are exempt from the:

- 90-day waiting period;
- cost-sharing (enrollment fees and co-payments); and
- six-month income check.

A—128.1 Inquiry for Pregnant Women

Revision 15-4; Effective October 1, 2015

CHIP Perinatal, TP 40 and TP 36

Before certifying a pregnant woman for any type of health care coverage, advisors must perform inquiry to determine whether the pregnant woman is already certified for Medicaid or enrolled or pending enrollment in CHIP or CHIP perinatal.

Searching by the woman's last name and date of birth may increase the possibility for a match.

A—128.2 Advisor Action for Determining Eligibility for Pregnant Women

Revision 15-4; Effective October 1, 2015

CHIP Perinatal, TP 40 and TP 36

When taking action on an application, apply the following procedures.

If ...	then ...
The woman is active in CHIP perinatal and the application indicates she is due in the application month,	test for Medicaid eligibility.* If eligible, and she is: • not a U.S. citizen or alien with acceptable status, certify for Emergency Medicaid coverage for the birth. • certify the newborn for TP 45 Medicaid coverage.
The woman is active in CHIP perinatal and the application indicates she is due in the month following the application month or later,	test for Medicaid eligibility.* If eligible, and it is: • before cutoff, begin Medicaid coverage the first day of the next month. • after cutoff, begin Medicaid coverage the first day of the month following the next month.

* When an individual enrolled in CHIP perinatal submits a new application, they must be tested for Medicaid coverage. Otherwise, staff do not interrupt the continuous eligibility coverage.

A—128.3 CHIP Perinatal Application Process

Revision 15-4; Effective October 1, 2015

CHIP Perinatal, TP 36 and TP 45

Labor with delivery charges are covered by CHIP perinatal for households with income above the income limit for Medicaid for Pregnant Women (TP40), but not for households who qualify for Emergency Medicaid coverage (women who do not meet citizenship requirements and whose household income is at or below the income limit for Medicaid for Pregnant Women [TP40]). These Medicaid-eligible individuals must submit Form H3038-P, CHIP Perinatal — Emergency Medical Services Certification, to apply for Emergency Medicaid to pay for all these charges.

A child born to a CHIP perinatal mother whose household income is at or below the income limit for Medicaid for Pregnant Women (TP40) and who receives Emergency Medicaid to cover labor with delivery charges will be enrolled in Medicaid instead of CHIP perinatal. The Central Processing Center (CPC) processes both the Emergency Medicaid coverage for the mother and the TP 45 for the newborn when the newborn is not admitted to NICU. See A-126.3.1, Neonatal Intensive Care Unit (NICU) Process.

Thirty days prior to the due date, TIERS generates Form H3038-P with Form H1061, Birth Outcome Letter, for the individual. If the birth outcome has not been reported by 30 days after the due date, a second Form H3038-P is mailed along with a self-addressed postage-paid envelope and Form H1062, Birth Outcome Reminder Letter, which includes instructions for getting Form H3038-P completed and signed by the medical practitioner. The individual must return Form H3038-P to HHSC.

Upon receipt of Form H3038-P:

- the form is linked to the mother's case; and
- a task is created for CPC staff to certify the mother for Emergency Medicaid and the newborn for TP 45.

If Form H3038-P is not returned within 60 days from the date of the pregnancy due date, then CPC will not certify the mother for Emergency Medicaid or the baby for TP 45. See A-831.2.1, Reopening Three Months Prior Applications, for individuals who return Form H3038-P after 60 days from the pregnancy due date.

CPC Staff Process

CPC is assigned a task to process Form H3038-P. CPC staff must:

- perform an inquiry to determine whether mother and child are already active on Medicaid;
- if mother and child are not active on Medicaid, use all TP 40 eligibility policies and procedures to determine Emergency Medicaid eligibility with the exception of verifying income and citizenship/alien status;

- use the verified income provided to determine CHIP perinatal eligibility to determine Emergency Medicaid eligibility;
- verify all non-financial eligibility points prior to certification such as:
  - identity – see A-621, Verification Sources; and
  - residence – see A-761, Verification Sources;
- use the date Form H3038-P is received as the file date for the Emergency Medicaid and TP 45; and
- process Form H3038-P by the 45th date after the file date as explained in B112, Deadlines.

The file date for the TP 45 is usually the date Form H3038-P is received if it includes the newborn's information. Birth outcome information can also be received via an interface or from the individual by telephone or in writing. When this information is received after Form H3038-P has already been submitted to the CPC, a second task is assigned to CPC to process TP 45 for the newborn.

When CPC staff receive a task that includes Form H3038-P dated more than 60 days after the pregnancy due date, CPC will stamp "Received (Date) CPC" on Form H3038-P, which indicates the form was provided after the 60 days from the pregnancy due date. CPC staff return Form H3038-P to the individual along with an application and a letter informing the individual that she will be required to apply for Medicaid. Individuals are instructed to complete the application and return it to the nearest HHSC office or appropriate out-stationed worker if an out-stationed worker is housed at the hospital where the delivery took place.

Out-Stationed and HHSC Eligibility Office Staff Process

The chart below explains procedures staff must follow to determine appropriate action.

If an applicant …	then staff must:
provides Form H3038-P **only**, and was active on CHIP perinatal at the time of the delivery,	fax Form H3038-P to **1-877-236-4123**.
provides an application requesting Medicaid **only**, provides Form H3038-P, and was active on CHIP perinatal at the time of delivery,	follow policy as explained in A-121.2, Receipt of Duplicate Application, or A-121.3, Receipt of Identical Application, and fax Form H3038-P to 1-877-236-4123.
provides an application requesting Medicaid and other benefits (SNAP/Children's Medicaid/Medicaid/TANF), provides Form H3038-P, and was active on CHIP perinatal at the time of delivery,	• certify the TP 36 coverage when determining eligibility for the other requested programs (including TP 45) following existing policy, if eligible; or • fax only Form H3038-P to **1-877-236-4123** if the mother is ineligible for Emergency Medicaid based on the current information.
provides an application and provides Form H3038-P stamped with “Received (Date) CPC,”	process the request for Medicaid following normal application procedures.
was not active on CHIP perinatal at the time of delivery,	process the Emergency Medicaid request according to existing policy, and provide TP 45 if appropriate.

Notes:

- Staff fax the bar coded Form H3038-P to 1-877-236-4123. If Form H3038-P is not bar coded, staff must write the mother's CHIP perinatal case and EDG number on the top of the form.
- If the client requests the fax number for Form H3038-P, staff should instruct the client to fax the form to 1-877-447-2839.

A—129 Data Broker Requirements

Revision 15-4; Effective October 1, 2015

All Programs

Staff must request Data Broker reports as required in C-820, Data Broker.

Related Policy
Permissible Purpose, C-824

A—130 Interview Procedures

Revision 13-2; Effective April 1, 2013

A—131 Interviews

Revision 15-4; Effective October 1, 2015

TANF, SNAP, TP 08 and TA 31

Conducting Interviews for Applications and Redeterminations

Conduct the interview with the applicant or the applicant's spouse (if the spouse is a member of the household) to determine eligibility.

Exceptions:

- A household may designate an AR, who must also sign the application, as explained in A-170, Authorized Representatives (AR).
- For SNAP, another responsible household member may also be interviewed.
- For SNAP, a contracted Community Partner food bank participating in a pilot program with HHSC may conduct the interview and gather pertinent information and verification (see A-116.4, SNAP Applications from a Contracted Community Partner [CP]).
- For SNAP-SSI redeterminations conducted by CBS, no interview is required unless the household requests an interview, the case contains earned income or it appears the household is going to be denied (see B474.1.1, SNAP Programs, for more detailed information).

Note: The spouse (or other responsible household member for a SNAP interview) does not have to sign the application to be interviewed. Staff must not exempt the household from any program or verification requirements due to interviewing an AR or conducting a telephone interview.

SNAP and TANF

Staff must conduct a telephone interview if the household meets any of the following criteria:

- All adult members of the household are elderly or have a disability and have no earned income;
- The applicant resides in a family violence shelter and would be in danger if the individual left the shelter; or
- The household meets the telephone interview hardship criteria below and staff accepts the individual's statement regarding the hardship.

A household meets the hardship criteria if no responsible household member is able to come to the office for any of the following reasons:

- Residence is more than 30 miles away from the certification office (even if an itinerant office is less than 30 miles from the individual's home);
- Work or training schedule;
- Transportation difficulties;
- Prolonged severe weather;
- Illness;
- Care of a household member (the household member does not have to be part of the certified household); or
- Victims of family violence.

Advisors may conduct a telephone interview for all households who provide a contact telephone number (including households with a member disqualified for an intentional program violation [IPV]), unless the household requests a face-to-face interview.

TP 08 and TA 31

Applicants and clients are required to complete a telephone interview, unless the client requests a face-to-face interview. Clients cannot be required to complete a face-to-face interview.

TP 33, TP 34, TP 35, TP 43, TP 44 and TP 48

No interview is required to apply for or renew Children's Medicaid. Process the application or renewal form by mail or telephone. Schedule an office interview only if the individual requests a face-to-face interview.

When a family contacts HHSC to request an application for Children's Medicaid, offer the option to start the application process by phone. The family can complete the application process by phone, but must provide or return a signed Form H1205, Texas Streamlined Application, with any other required verification to complete the process.

Exceptions:

- If the applicant was previously denied for failure to provide Form H1024, Subject: Self-Declaration Notice, or for missing an appointment related to Health Care Orientation (HCO) or THSteps, schedule a face-to-face appointment. Deliver the HCO or remind the individual about the importance of the THSteps checkup at that time. See A-122.2, Scheduling Appointments, and B-123, Processing Children's Medicaid Redeterminations.
- Conduct a face-to-face interview for an initial application or renewal when HHSC receives conflicting information related to household composition, income or resources that affects eligibility and the information cannot be verified through other means, such as an associated case.

Related Policy
Scheduling Appointments, A-122.2
General Reminders, A-1510
Compliance Requirements, A-1531.5
Processing Children's Medicaid Redeterminations, B-123

TP 40 and TP 36

Interviews are not required at application for TP 40 or TP 36. Advisors should schedule an interview only if the household requests an interview.

Advisors must provide continuous coverage for a pregnant woman without Form H1010 or an interview if she meets the criteria in A-832, Continuous Medicaid Coverage.

Additional Policy Related to Telephone Interviews

If the office initially schedules a telephone interview and the individual subsequently requests a face-to-face interview before the telephone interview appointment time, staff must allow the household to receive a face-to-face interview and must not treat it as a missed appointment.

To avoid conflicts with an individual's work schedule, staff should be as flexible as possible when scheduling telephone interviews for households in which all adults are working. This could mean scheduling an appointment at a certain time of day or allowing the individual to call in from work at an appointed time for the interview. If a household does not have a home phone but prefers a telephone interview, staff should also attempt to schedule a telephone interview by allowing the individual to call in at an appointed time using someone else's telephone.

Staff must ensure that an interpreter or translation service is available if the applicant/recipient indicates the need for such services on an application.

When conducting a telephone interview, staff must offer the applicant reasonable assistance in obtaining any required verification.

Staff must indicate in TIERS, in the Voter Registration Information section of the Individual Demographics page, to mail Form H0025, HHSC Application for Voter Registration, to applicants who are interviewed by telephone, if a voter registration application is requested. If the request checkbox is marked Yes, TIERS automatically mails Form H0025 to the household.

If the individual declines to register to vote, staff must mail Form H1350, Opportunity to Register to Vote, and ask the individual to sign and return the form. Staff must also indicate in TIERS, in the Voter Registration Information section of the Individual Demographics page, that the client declined, and document that H1350 was mailed to the individual.

Related Policy
Joint TANF-SNAP Applications, A-160
Missed Appointment, B114
Processing Redeterminations, B122
Advisor Responsibility for Verifying Information, C932
Registering to Vote, A-1521

TP 45 Retroactive Coverage

Retroactive TP 45 coverage must be provided for the newborn child without Form H1010 or an interview with the child's mother if the household meets the criteria in A-833, TP 45 Retroactive Coverage.

A—131.1 Home Visits

Revision 15-4; Effective October 1, 2015

All Programs

Advisors must provide notice to the household before making any home visit. Application and redetermination interviews must be scheduled in writing. Notification of other home visits may be:

- verbal,
- given or mailed to the individual, or
- by telephone contact with a responsible household member.

The notification should include the time (at least whether morning or afternoon) and date of the visit. Advisors should route the notification for imaging to add to the electronic case record or document the specific information in TIERS Case Comments. If regions have specialized staff that conduct home visits, the documentation may be maintained in a separate location as long as it is accessible if needed.

Home visits to collateral sources do not have to be scheduled in advance.

No one should be denied for refusing to agree to a home visit unless there is no other sufficient and reliable verification available.

Related Policy
Advisor Responsibility for Verifying Information, C932

A—131.2 Requirement to Provide Interpreter or Translation Service

Revision 15-4; Effective October 1, 2015

All Programs

HHSC is required to provide interpreter and translation (written or verbal) services to applicants and recipients with Limited English Proficiency (LEP). Consider an individual with LEP even if they do not request an interpreter on the application if the individual indicates they would like to speak a language other than English during the interview. HHSC is also required to provide an effective method to communicate with applicants and recipients who indicate they are deaf or hearing impaired. Applicants and recipients may indicate on an application or during an interview that they need interpreter services.

A—131.2.1 Availability of Interpreters/Translation Services

Revision 17-4; Effective October 1, 2017

All Programs

Local offices must set up procedures to ensure that interpreters and translators are available for applicants or recipients who indicate the need for such services on an application.

To meet the requirement for applicants and recipients who indicate they are Limited English Proficiency (LEP), offices can use:

- Bilingual advisors – when it is reasonably possible to do so, schedule LEP applicant/recipient interviews with bilingual advisors.
- Bilingual clerical staff – use bilingual clerical staff as interpreters whenever possible.
- Local community interpreter providers.

Advisors use the following methods for interpretation only after exhausting all local and regional resources:

- Language Line Services – This service is available to all regions. Staff can access the service by calling 1-800-375-1184 and using their 11-digit employee identification number.
- Applicants/recipients may provide their own interpreter (only if they wish to do so). **Note:** Advisors may use minors, age 15 or older, as interpreters only at the individual's request and when the minor accompanies the individual to the interview. Advisors must not use a minor under age 15 as an interpreter.

To meet this requirement for applicants and recipients who indicate they are deaf or hearing impaired, offices can:

- Schedule a telephone interview if the applicant indicates the contact phone on the application is a TDD/TTY line, unless the applicant requests a face-to-face interview. **Note:** Relay Texas can be reached at these numbers:
  - 7-1-1, 1-800-RELAYTX (1-800-735-2989), Spanish to English (Spanish speaking callers to English speaking HHSC staff) at 1-888-777-5861;
  - and Spanish to Spanish at 1-800-662-4954.
- If unable to reach the applicant by phone, advisors must schedule a face-to-face interview and arrange for interpreter services at the interview location.

Note: In situations where an interpreter services vendor is not available, staff may use handwritten notes back and forth with the hearing-impaired individual as long as the notes are an effective means of communication with the individual.

A—131.2.2 Availability of Translated Written Material

Revision 15-4; Effective October 1, 2015

All Programs

Staff must inform applicants/recipients about the availability of translation (written or verbal) services regarding written materials HHSC sends to them by following the two processes below, when applicable.

When staff verbally communicate with LEP applicants/recipients at application, redetermination (including desk reviews) and change actions, staff must ensure that applicants/recipients understand the eligibility action (Form H1020, Request for Information or Action, and Form TF0001, Notice of Case Action) being taken and the requirements for the application process (including any missing information being requested). Providing a verbal explanation to all LEP applicants/recipients in their preferred language regarding the eligibility action being taken and/or missing information being requested meets this requirement.

Note: This requirement is not applicable for desk reviews and change actions when staff process the case action without talking with the applicants/recipients.

The Vietnamese Translation Interpreter Form is automatically attached to applicable eligibility notices when clients select Vietnamese as their primary household language.

A—131.3 Interview Requirements

Revision 15-4; Effective October 1, 2015

All Programs

During the interview, the interviewer must:

- protect the applicant's confidentiality and conduct the interview as a confidential discussion of household circumstances;
- review the application and resolve unclear and incomplete information with the household;
- advise the household of their rights and responsibilities, including the right to appeal;
- advise the household of the application processing time frames;
- advise the household of their responsibility to report changes;
- ensure that the address on TIERS reflects the individual's current address; and
- explain the various policies, rights, and responsibilities as required in A-1500, Reminders.

Advisors must take the following actions and provide the following referrals and information during the interview:

- Verify that the household agrees that the information is complete and correct on the application form and in the case documentation for household composition, income, and expenses;
- Verify that the income and expense information obtained for past periods (including self-employment) accurately reflect the amounts that can be anticipated for future income and expenses, according to policy in A-1355, How to Project Income. If the information is inaccurate, the advisor must determine why it is inaccurate;
- Determine whether households with questionable or negative management, as described in A-1710, General Policy, are able to explain how the household’s bills are paid;
- Determine whether households with other discrepancies in information that could affect eligibility are able to provide information to resolve those discrepancies;
- Determine whether there is a reason for households who have not provided all verification requested on Form H1020, Request for Information or Action, beyond the household's control that prevents the household from providing verifications. If the advisor designates a collateral source, the advisor should accept the individual statement or use other forms of verification for the missing verifications as required by policy in A-1370, Verification Requirements;
- Determine whether income verification may be calculated based on year-to-date information from other paychecks provided by the household when income verification is missing for a particular pay period(s), rather than requesting it on Form H1020; and
- Refer the household to other state or local resources for types of assistance the household requested on the application form, such as child care, child support, utilities, or rent, that are provided by other agencies.

TANF

- Determine whether any adult household member has received TANF cash assistance from another state since October 1999. Refer to A-1920, Determining the Number of FTL Months Used.
- Determine whether any member of the household has been disqualified in another state for a felony or drug conviction.
- Determine whether any member of the household has been disqualified from participating in TANF for an intentional program violation (IPV) in another state. See B942, Disqualifying a Household Member with a Current TANF Out-of-State IPV Disqualification, for policy regarding the IPV information the advisor must gather from the other state.
- Determine whether applicants must provide information on parent(s) living outside of the home to meet child and medical support requirements, or if applicants meet a good cause exemption, as explained in A-1130, Explanation of Good Cause.

SNAP

- Determine whether households qualifying for the standard medical expense want to claim actual expenses according to the policy in A-1428.3, Budgeting Options;
- Determine whether the household wants to prorate an expense or income according to policy in A-1428.3; A-1355.1, Budgeting Options for SNAP Households; and A-1358, How to Budget Expenses;
- Determine whether any household member claims an exemption to Employment and Training (E&T) work requirements;
- Provide reminders, including the household's change reporting requirement, regarding E&T requirements, able-bodied adult without dependents (ABAWD) time limit policy (if there is an ABAWD in the household), and how the household can obtain and use SNAP benefits issued via EBT;
- Determine whether an ABAWD received any countable months of benefits in another state; and
- Determine whether any member of the household has been disqualified from participating in SNAP for an IPV or a felony drug conviction in another state. **Note:** Data Broker displays current out-of-state IPV disqualification data.

Medical Programs

Determine whether applicants experiencing family violence are exempt from providing information about a member of their MAGI household composition because they fear physical or emotional harm by that person, as explained in A-241.4, Family Violence Exemption.

TP 08

Determine whether applicants must provide information on parent(s) living outside of the home to meet medical support requirements, or if applicants meet a good cause exemption, as explained in A-1130, Explanation of Good Cause.

A—132 Eligibility Factors

Revision 15-4; Effective October 1, 2015

All Programs

	TANF	SNAP	Medical Programs
Household Composition	X	X	All Medical Programs*
Citizenship	X	X	All Medical Programs*
Social Security number	X	X	TPs 08, 40, 43, 44, 48, 56
Age	X	-	TP 08, TA 31, TPs 32, 33, 34, 35, 43, 44, 45, 48, 56
Relationship	X	-	TP 08, TA 31, TPs 32, 33, 34, 35, 43, 44, 45, 48, 56
Identity	X	X	All Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36*
Residence	X	X	All Medical Programs*
Third-Party Resources	X	-	All Medical Programs*
Domicile	X	-	TP 08, TA 31
Deprivation	X	-	
Resources	X	X	TP 56 (children) or TP 32 (children)
Income/Deductions/Budgeting	X	X	All Medical Programs*
School attendance	X	-	TP 08
Work registration	X	X	
Management	X	X	TP 08, TA 31
Responsibility Agreement	X	-	

* TP 08, TA 31, TPs 32, 33, 34, 35, 36, 40, 43, 44, 45, 48 and 56.

Note: For medical programs, the eligibility factors noted above do not necessarily apply in all cases.

A—132.1 Medical Programs Hierarchy

Revision 18-1; Effective January 1, 2018

Medical Programs

Texas Works Medical Programs Hierarchy

Step	Eligible Persons	With Income	Type Program Code	Type Program
1	Individuals ages 18 through 25 who have aged out of foster care in Texas and were enrolled in Medicaid on their 18th birthday	Not Applicable	TP 82	MA	Former Foster Care Children (FFCC)
2	Individuals ages 18 through 20 who have aged out of foster care and: • are not eligible for FFCC (were not receiving federally funded Medicaid when they aged out of foster care); or • who aged out of foster care at age 18 or older, currently reside in Texas, and have had an Interstate Compact on the Placement of Children (ICPC) agreement	At or below program FPIL	TP 70	MA	Medicaid for Transitioning Foster Care Youth (MTFCY)
3	Pregnant Women	At or below program FPIL	TP 40	MA	Pregnant Women
4	Pregnant women who are nonimmigrants, undocumented aliens and certain legal permanent residents who have emergency medical conditions and who, except for alien status, would be Medicaid-eligible	At or below TP 40 FPIL	TP 36	MA	Pregnant Women - Emergency
5	Newborn children of Medicaid-eligible mothers up to age 1, including mothers receiving TP 36	Not Applicable	TP 45	MA	Newborn Children (Deemed)
6	Children under age 1	At or below program FPIL	TP 43	MA	Children Under Age One
7	Children ages 1 through 5	At or below program FPIL	TP 48	MA	Children 1–5
8	Children ages 6 through 18	At or below program FPIL	TP 44	MA	Children 6–18
9	Children ages 1 through 5 who are nonimmigrants, undocumented aliens and certain legal permanent residents who have emergency medical conditions and who, except for alien status, would be Medicaid-eligible	At or below TP 48 FPIL	TP 33	MA	Children 1–5 - Emergency
10	Children ages 6 through 18 who are nonimmigrants, undocumented aliens and certain legal permanent residents who have emergency medical conditions and who, except for alien status, would be Medicaid-eligible	At or below TP 44 FPIL	TP 34	MA	Children 6–18 - Emergency
11	Children under age 1 who are nonimmigrants, undocumented aliens and certain legal permanent residents who have emergency medical conditions and who, except for alien status, would be Medicaid-eligible	At or below TP 43 FPIL	TP 35	MA	Children Under Age One - Emergency
12	A parent or caretaker relative caring for a dependent child under age 18 or who meets school attendance requirements who receives Medicaid	At or below program FPIL	TP 08	MA	Parents and Caretaker Relatives Medicaid
13	Nonimmigrants, undocumented aliens and certain legal permanent residents who have emergency medical conditions and who, except for alien status, would be Medicaid-eligible as a parent or caretaker relative of a Medicaid-eligible child	At or below TP 08 FPIL	TA 31	MA	Parents and Caretaker Relatives - Emergency
14	Parents, caretaker relatives and children receiving Medicaid who receive denial due to new or increase in earnings	Above the limits for TP 08	TP 07	MA	Earnings Transitional
15	Parents, caretaker relatives and children receiving Medicaid who receive denial due to new or increase in spousal support income	Above the limits for TP 08	TP 20	MA	Child Support Transitional

Step	Eligible Persons	With Income	Type Program Code	Type	Program
16	Uninsured women ages 18 through 64 diagnosed with breast or cervical cancer and presumed eligible for Medicaid for Breast and Cervical Cancer (MBCC)	Not Applicable	TA 66	MA	MBCC Presumptive
17	Uninsured women ages 18 through 64 diagnosed with breast or cervical cancer	Not Applicable	TA 67	MA	MBCC
18	Children under age 19 and pregnant women	Above the limits for TPs 40, 43, 44, and 48 FPIL	TP 56	MA	Medically Needy with Spend Down
19	Nonimmigrants, undocumented aliens and certain legal permanent residents who have emergency medical conditions and who, except for alien status, would be Medicaid-eligible as a pregnant woman or child under age 19	Above the limits for TPs 40, 44, or 48 FPIL and at or below program limit	TP 32	MA	Medically Needy with Spend Down - Emergency
20	Children under age 19 ineligible for Medicaid due to income	Above the limits for TPs 43, 48, or 44 FPIL, and at or below program limit	TA 84	CI	CHIP
21	Unborn children whose mother is ineligible for Medicaid or CHIP due to income or immigration status	Above the limits for TPs 40 and 36, and at or below program limit	TA 85	CI	CHIP - Perinatal
22	Former foster care youth ages 21 through 22 attending school of higher education who: • are not eligible for FFCC; or • who aged out of foster care at age 18 or older, currently reside in Texas, and have had an ICPC agreement.	At or below program FPIL	TA 77	Health Care Benefits	Health Care - FFCHE
23	Children under age 1 presumed to be eligible for Medicaid as determined by a Qualified Hospital (QH)	At or below TP 43 FPIL	TP 74	MA	Children Under Age One - Presumptive
24	Children ages 1 through 5 presumed to be eligible for Medicaid as determined by a QH	At or below TP 44 FPIL	TP 75	MA	Children 1–5 - Presumptive
25	Children ages 6 through 18 presumed to be eligible for Medicaid as determined by a QH	At or below TP 48 FPIL	TP 76	MA	Children 6–18 - Presumptive
26	Parents and caretaker relatives presumed to be eligible for TP 08 by a QH	At or below TP 08 FPIL	TP 86	MA	Parents and Caretaker Relatives - Presumptive
27	Former Foster Care Children presumed to be eligible for Medicaid by a QH	Not Applicable	TP 83	MA	FFCC - Presumptive
28	Healthy Texas Women	At or below program FPIL	TA 41	MA	Healthy Texas Women
29	Pregnant women presumed to be eligible for TP 40 by a QH or Qualified Entity (QE)	At or below TP 40 FPIL	TP 42		Pregnant Women - Presumptive

Notes:

- TIERS will test for TP 56, Medically Needy with Spend Down, for prior coverage or coverage for the application month if medical expenses are indicated in data collection for:
  - Pregnant women who are ineligible for Medicaid because of income or alien status.
  - Children ages 0 to 18 who are ineligible for medical programs because of income will be tested for CHIP.
- Foster Care and Adoption Assistance Medicaid programs are above FFCC in the Medical Programs hierarchy.

Related Policy
Income Limits, C-131
Qualified Hospital/Qualified Entity Procedures for Presumptive Eligibility Determinations, C-1113
Guidelines for Providing Retroactive Coverage for Children and Medical Programs, C-1114
Type Programs (TP) and Type Assistance (TA), C-1150
Former Foster Care in Higher Education (FFCHE), Part F
Medicaid for Transitioning Foster Care Youth (MTFCY), Part M
Medicaid for Breast and Cervical Cancer (MBCC), Part X
Healthy Texas Women, Part W

A—132.2 Guidelines for Pregnant Women

Revision 15-4; Effective October 1, 2015

See A-240, Medical Programs.

A—133 Rights and Responsibilities

Revision 15-4; Effective October 1, 2015

All Programs except TP 33, TP 34, TP 35, TP 43, TP 44, TP 45 and TP 48

Before completing the interview, advisors must ensure that the applicant:

- provides all of the information requested on the application;
- reports any changes that occurred since filling the application; and
- reads and understands the individual's rights and responsibilities as explained on the application.

TANF and TP 08

Advisors must also ensure that:

- the applicant reads and understands the rights and responsibilities of the child support program explained on Form H1712, Explanation of Child/Medical Support, Family Violence and Good Cause;
- TANF applicants read and understand Form H2580, TANF Employment Services Notice, and receive a copy of the form; and
- TANF applicants read, understand and sign Form H1073, Personal Responsibility Agreement.

SNAP

Advisors must provide the applicant with Form H1805, SNAP Food Benefits: Your Rights and Program Rules.

TP 33, TP 34, TP 35, TP 43, TP 44 and TP 48

Before completing the interview, if requested, ensure the applicant:

- completes all sections of the application; and
- reads and understands an individual's and responsibilities as explained on Form H1010, Texas Works Application for Assistance — Your Texas Benefits, and Form H1205, Texas Streamlined Application.

A—134 Documentation Guidelines

Revision 13-2; Effective April 1, 2013

A complete list of documentation requirements for determining eligibility can be found at the conclusion of each eligibility section within the Texas *Works Handbook*. TIERS Data Collection pages handle a vast majority of the required documentation for case records. For the remaining small percentage of documentation still required by policy, staff must include the information in TIERS Case Comments. For documentation that is not captured within the Data Collection pages, a comprehensive guide, *The Texas Works Documentation Guide*, has been developed. This documentation guide outlines the requirements for documentation that must be entered in TIERS Case Comments.

A—135 Pending Information

Revision 15-4; Effective October 1, 2015

All Programs except TP 40

If the applicant cannot furnish all required proof during the interview or with the application, advisors must allow the household at least 10 days to provide the information. The due date must be a workday. Advisors must determine what sources of proof are readily available to the household and request that information first as sufficient proof. B-115, Pending Verification on Applications, includes more information on verification procedures.

Advisors must provide the applicant Form H1020, Request for Information or Action, explaining:

- what is needed,
- the due date for receipt of the information, and
- the date the advisor
- must deny the application if the advisor does not receive the information.

Advisors should attach to Form H1020 the page of Form H1020-A, Sources of Proof, that corresponds to the verification requested.

Medical Programs

The advisor must not request additional verification if verification is available through electronic data sources.

TP 40

Advisors should not allow 10 days for the applicant to provide verification if doing so exceeds the 15-workday processing time frame and verification can be postponed.

A—136 Eligibility Decision

Revision 15-4; Effective October 1, 2015

All Programs

After obtaining all required proof, the advisor must dispose the application and give the applicant Form TF0001, Notice of Case Action, detailing the decision.

Advisors must provide the individual with the HIPAA — Notice of Privacy Practices or HIPAA — Notice of Privacy Practices (Spanish) at initial certification and after breaks in certification of one or more months.

A—137 Prudent Person Principle

Revision 15-4; Effective October 1, 2015

All Programs

The policies and procedures included in the handbook are rules for determining eligibility. It is impossible to provide examples for all policy situations. When staff encounter rare and unusual situations, HHSC encourages them to use reason and apply good judgment in making eligibility decisions. The "prudent person" principle allows staff to make reasonable decisions based on the best available information using:

- common sense,
- program knowledge,
- experience, and
- expertise.

Staff should document the rationale used to make a decision and any applicable handbook references.

A—140 Expedited Service

Revision 16-2; Effective April 1, 2016

SNAP

All expedited applications are screened using the expedited screening questions on page 1 of the application. HHSC staff screen applications received in the local office. Vendor staff screen applications sent to Austin by fax or mail, and an automated system screens applications submitted online.

Applicants who meet the test for expedited service are entitled to:

- postpone all verification until after receiving the first month's benefit, except:
  - identity, and
  - proof they meet or are exempt from the SNAP ABAWD work requirement if they have already received the maximum number of benefit months without meeting the work requirement; and
- get benefits the same day they apply, if possible, but no later than the next workday.

  Exception: In the following situations, applicants may not get benefits in this time frame.
  - Applicants in drug and alcohol treatment/group living arrangement facilities. Staff must give benefits so the individual has an opportunity to participate by the seventh day after the application date.
  - Joint SNAP/SSI applicants released from public institutions. The CBS unit gives benefits so the individual can participate by the fifth day after release from the institution.
  - **Late determinations** for expedited service. These are households that:
    - the agency did not identify as entitled to expedited service when the household filed the application. Expedited processing begins on the day the office becomes aware the applicant is entitled to this service. Advisors cannot enter a late determination date if the agency failed to properly screen the application using the expedited screening questions on Form H1010, Texas Works Application for Assistance — Your Texas Benefits.

- meet expedited criteria and have an individual who served the minimum employment and training penalty, but have chosen to delay their certification until all disqualified individuals have signed Form H1808, SNAP Work Rules.
- qualify for a telephone interview, but HHSC must mail the application back to the household for signature. The late determination date is the date the applicant returns the signed application.
- mail or drop off Form H1010 or Form H1010-R, Your Texas Works Benefits: Renewal Form. Staff must contact the applicant and schedule an appointment the earliest day the applicant is available. If HHSC cannot contact the applicant by phone, staff must mail Form H1830-I, Interview Notice (Applications or Reviews), the same day the application is screened, notifying the applicant of possible eligibility for expedited service and instructing the applicant to contact the office. If the household also applies for TANF or Medicaid, staff should schedule a regular TANF/Medicaid appointment on the same notice. Expedited processing begins the day the applicant returns to the office for an interview.
- miss their expedited appointment. If the applicant subsequently contacts the office, staff must conduct an interview the earliest date the individual is available. Expedited processing begins the day the applicant returns to the office for an interview.
- do not provide acceptable proof of identity, or proof of meeting or being exempt from the SNAP ABAWD work requirement, as explained in the beginning of this section. Expedited processing begins when the applicant provides the required proof.
- are not eligible for expedited processing when screened for expedited services at the time of application, but meet expedited criteria later in the application month as a result of a change. The late determination date is the date the eligibility for expedited processing is met.
- submitted an application through the HHSC online system when the office was closed due to weather-related conditions, flooding or other similar situations. The late determination date is the first workday the office reopens following the office closure.

Notes:

- Staff can enter the late determination date in TIERS for late determinations caused by the applicant, resulting from a change in the household's circumstances, or due to office closures, as explained above.
- Except for delays in screening due to office closure, staff can enter the late determination date only if HHSC, the vendor or the automated system screened the application on the file date or no later than the next workday.
- The late determination date becomes day zero in determining timeliness on expedited applications.

TP 40

Expedite applications for Medicaid from women applying for current or ongoing coverage due to a pregnancy. These applicants are entitled to:

- have their eligibility determined no later than 15 workdays from the date HHSC receives the application; and
- postpone all verification, except identity, until the 30th calendar day from the application file date. **Note:** Postponing verification only applies to current and ongoing coverage. For prior coverage, take action no later than the 15th workday. Staff must deny the application if the applicant does not provide verification and reopen denied applications within two years at the applicant's request.

Note: An interview is not required when processing a TP 40 application.

Related Policy
Medicaid Coverage for the Months Prior to the Month of Application, A-830
ABAWD Referral Process, A-1831.1.2
Counting Months Toward Time-Limited Eligibility, A-1950
Regaining Eligibility, A-1960

A—141 Expedited Eligibility Criteria

Revision 15-4; Effective October 1, 2015

SNAP

Applicants are entitled to expedited service if they meet one of the following criteria:

- The household's:
  - liquid resources total $100 or less, and
  - countable gross monthly non-converted income totals less than $150. **Note:** When determining eligibility for expedited services, staff must count the actual amount of TANF the individual actually receives.
- The household's liquid resources plus actual, non-converted countable gross monthly income total less than the most recent monthly expenses for rent/mortgage and utilities. Staff should include the standard telephone allowance for households with a telephone

expense.
- The household includes a migrant or seasonal farmworker and meets the destitute criteria listed in A-146, Expedited Policy for Migrant or Seasonal Farmworkers.

An individual who reapplies within the last month of a current certification period is not eligible for expedited service.

TP 40

All applications for Medicaid from women applying for current or ongoing coverage due to a pregnancy are eligible for expedited processing.

A—142 Limit on Expedited Certification

Revision 15-4; Effective October 1, 2015

SNAP

A household may receive expedited certification any number of times if the household:

- completes the verification requirements postponed at the last expedited certification; or
- was certified under the usual 30-day processing standards since the last expedited certification.

Exceptions:

- If an expedited application with postponed verification is denied for failure to provide requested information/verification, the household may re-apply without submitting a new application until the 60th day after the file date, as explained in B-111, Reuse of an Application Form After Denial. If the household submits another application, staff must consider the second application a duplicate application. Staff must not allow SNAP expedited services.
- If a redetermination is denied for failure to provide requested information or for a missed appointment, the household may re-apply without submitting a new application until the 30th day following the last benefit month (see B-122.3, Delays Caused by Households). If the household submits another application, staff considers the application a duplicate application. Staff must not allow SNAP expedited services.

A—143 How to Determine Eligibility for Expedited Service

Revision 14-1; Effective January 1, 2014

SNAP

-	-	Yes	No
1.	Does the applicant's Form H1010, Texas Works Application for Assistance — Your Texas Benefits, and statement indicate eligibility for expedited service based on eligibility criteria in A-141, Expedited Eligibility Criteria?	Go to step 2.	Stop, use normal 30-day processing procedures.
2.	Did the applicant already receive SNAP this month?	Stop, use normal 30-day processing procedures.	Go to step 3.
3.	Did the applicant receive expedited service before?	Go to step 4.	Go to step 5.

-	-	Yes	No
4.	Did the applicant provide all postponed verifications from previous certification, or did HHSC certify the applicant under normal 30-day processing since the last expedited certification?	Go to step 5.	Stop, use normal 30-day processing procedures.
5.	Was the SNAP EDG denied at redetermination for a missed appointment or for failure to provide requested information, and is it still within 30 days of the last benefit month?	Stop, this application is a duplicate application. Follow reuse of application policy.	Go to step 6
6.	Does the applicant or AR being interviewed have proof of identity?	Go to step 7.	Not eligible for expedited service until he provides proof.
7.	If an applicant age 18 to 50 has already received the maximum number of benefit months without meeting the work requirement, did the applicant verify that the applicant is exempt from or meets the 20-hour-per-week work requirement (even if the AR applies)?	Go to step 8.	Not eligible for expedited service until he provides proof.
8.	Issue benefits today. Postpone all other verification that is: • not provided at the interview, or • not acceptable.		

TP 40

All applications for Medicaid from women applying for current or ongoing coverage due to pregnancy are eligible for expedited processing.

Related Policy
Receipt of Duplicate Application, A-121.2
Reuse of an Application Form After Denial, B111
Delays Caused by Households, B122.3
Denied for Missed Appointments, B122.3.1
Denied for Failure to Provide Information/Verification, B122.3.2

A—144 Expedited Verifications

Revision 15-4; Effective October 1, 2015

SNAP and TP 40

See A-140, Expedited Service.

A—144.1 Social Security Numbers (SSNs)

Revision 15-4; Effective October 1, 2015

SNAP

Staff must include household members for the initial month, or initial two months if receiving a combined allotment, even if they fail to provide or apply for an SSN at the interview.

Staff must disqualify individuals who fail to provide or apply for an SSN without good cause before the next monthly issuance. See A-410, General Policy, for rules for children age six months or younger and good cause.

A—144.2 Work Registration

Revision 15-4; Effective October 1, 2015

SNAP

Advisors should register the applicant being interviewed for work unless:

- the applicant is exempt from work registration, or
- an AR is applying for the household.

Advisors should register other household members if possible. Advisors should postpone registration for the initial month if it cannot be completed within the expedited time frames.

A—144.3 Citizenship

Revision 16-2; Effective April 1, 2016

SNAP

Household members whose citizenship/eligible alien status is questionable can receive expedited benefits with the household. These household members must provide verification of citizenship/eligible alien status before the next month's benefits are issued or be disqualified.

TP 40

Citizenship/eligible alien status must be verified using policy in A-350, Verification Requirements, for pregnant women who declare to be a U.S. citizen or declare to have an eligible alien status. If a pregnant woman does not provide proof of citizenship or alien status and:

- no other information is required to determine eligibility, she is provided a period of reasonable opportunity as explained in A-351.1, Reasonable Opportunity.
- other information is required to determine eligibilty, she is allowed to postpone verification (except identity) until the 30th calendar day from the application file date, as explained in A-145.1, Postponed Verification Procedures. If during that time she returns the other information, but not proof of citizenship or alien status, she is certified, sent Form TF0001, Notice of Case Action, and provided a period of reasonable opportunity at that time.

Related Policy
Reasonable Opportunity, A-351.1

A—144.4 Reserved

Revision 12-1; Effective January 1, 2012

A—144.5 Pregnancy

Revision 18-1; Effective January 1, 2018

TP 40

Accept the individual's (pregnant woman's, case name's or AR's) verbal or written statement of pregnancy as verification, unless questionable. The woman's statement would be questionable if the information provided regarding the due date is discrepant, such as the pregnancy start month and pregnancy end month are less than or more than nine months apart or if the woman reports a pregnancy with overlapping start and end months.

The individual's statement of pregnancy must provide the following information:

- Name of woman who is pregnant
- Pregnancy start month and/or anticipated date of delivery
- Number of expected children

If questionable, advisors must verify pregnancy by using:

- Form H3037, Report of Pregnancy; or
- other documentation containing the same information as Form H3037.

The verification must be from an acceptable source such as:

- a physician;
- a hospital;
- a family planning agency; or
- a social service agency.

A physician, nurse, advanced nurse practitioner or other medical professional must sign Form H3037 or another document for it to be considered verification from a medical source. If another medical professional completes the form, the advisor must ensure that information about the supervising physician is provided.

Staff must use the following procedures when certain information regarding pregnancy is not provided on an application for benefits.

- If the only item missing on the application form is the pregnancy start month, staff must count nine months back from the pregnancy end month to determine the pregnancy start month. The pregnancy end month is month zero.
- If the only item missing on the application form is the pregnancy end month, staff must count nine months from the pregnancy start month to determine the anticipated date of delivery. The pregnancy start month is month zero.
- If both the pregnancy start and end months are missing, attempt to obtain the information by phone. If unable to obtain the information by phone, send Form H1020, Request for Information or Action, to request the information.

Related Policy
Verification Requirements, A-870

A—145 Expedited Certification Procedures

Revision 15-4; Effective October 1, 2015

SNAP

Advisors must assign usual certification periods even if staff postpones verifications. See A-2324, Length of Certification, for certification period policy.

Advisors must issue the second month's benefits as a combined allotment as explained in A-150, Combined Allotment Policy, if the household applies after the 15th of the month and benefits are prorated.

TP 40

If an applicant provides the minimum information required to process the application, the advisor may certify the application before the 15th workday and allow postponed verification.

Advisors must deny the application no later than 15 workdays if:

- the information provided indicates the applicant is not eligible, or
- not enough information was provided to determine eligibility.

Advisors must reopen applications denied because there was not enough information provided if the information is received within 60 days of the file date.

Advisors must use the date the information is provided as the new file date, and follow the expedited processing guidelines.

Note: An interview is not required when processing a TP 40 application.

A—145.1 Postponed Verification Procedures

Revision 15-4; Effective October 1, 2015

SNAP

Advisors must provide Form TF0001, Notice of Case Action, stating:

- what information is needed;
- the date it is needed; and
- that the individual must provide the information before the issuance of benefits for the:
  - second month; or
  - third month, if the applicant received a combined allotment.

TIERS identifies and holds benefits for the second month for households not issued a combined allotment or the third month for combined allotment households. See A-150, Combined Allotment Policy.

If the household furnishes the postponed verification and the ...	then ...
second month is on hold,	enter the information and dispose the SNAP EDG within five days or by the first workday of the second month, whichever is later.
third month is on hold (for combined allotment situations),	enter the information and dispose the SNAP EDG.

If the household provides postponed verification that results in lowered or denied benefits, see B116.1, Information Received During Expedited Application Processing.

If the household does not provide postponed verifications within 30 days of the application date, advisors must:

- disqualify the individual when appropriate, or
- deny the SNAP EDG for failing to provide postponed information and send the individual adequate notice using Form TF0001.

A household denied for failure to provide postponed verification must submit a new application to receive benefits if the household does not provide the postponed verification by the 60th day from the file date. If the household provides the verification by the 60th day, advisors must reopen the application using the date the household provided the verification as the new file date.

An individual receiving adequate notice of adverse action as noted above cannot receive continued benefits pending appeal.

TP 40

Advisors must provide Form TF0001, stating the:

- eligibility start and end date,
- postponed verifications, and
- date the verifications are due.

If the individual does not provide verification by the 30th day following the file date, the advisor must initiate adverse action. Advance notice is required. The individual must reapply if the verification is not provided by the expiration of the adverse action.

If the individual provides verification by the 30th day following the file date but does not meet eligibility requirements, the advisor must provide advance notice of adverse action and deny ongoing coverage.

Note: Advisors must not deny the EDG if the individual is eligible in the application month or one of the three prior months.

A—146 Expedited Policy for Migrant or Seasonal Farmworkers

Revision 15-4; Effective October 1, 2015

SNAP

The expedited processing procedures apply to migrant or seasonal farmworkers except for the following:

- If verifying something other than identity and the source of verification is out of state, the advisor postpones verification until after the household receives the second month's benefit. Advisors should use this procedure for only one two-month postponement during one round-trip from home.
- Households with a migrant or seasonal farmworker are **destitute** if they have $100 or less countable liquid resources and meet **any** of the following:
  - The household's only income for the application month is from a terminated source, and the household will not receive any more payments from that source after the application date.

    Advisors should consider terminated income if it is usually received:
    - monthly or more often but will not be received from that source the following month, or
    - at intervals of more than one month but will not be received from that source in the next usual payment period.

    Advisors should not consider terminated income in the following situations:
    - Someone changes jobs while working for the same employer;
    - A self-employed person changes contracts or has different customers without having a break in normal income cycle; or
    - Someone receives regular contributions, but the contributions are from different sources.

  - **Note:** When determining destitute status, advisors do not consider terminated income if a payment from the same source will be received after the file date in the month of application.
  - All household income in the application month is from a new source, and the household will receive income of $25 or less from the first of the month up to and including the 10th day after the application date (or the end of the month if there are not 10 days left in the month).

    Income received monthly or more frequently is from a new source if the household did not receive $25 or more from that new source in the 30 days up to and including the application date.

    Income received at intervals of more than one month is new income if the household has not received more than $25 from that source between the last usual payment month and the application date.

    Advisors count new income received after the application date to determine whether the individual is destitute, but disregard it in determining eligibility and benefits for the month of application.

- The household has a combination of terminated income through the application date and new income after the application date if:
  - there is no other income from the terminated source that month, and
  - the household will receive income of $25 or less from the new source from the first of the month through the 10th day after the application date (or the end of the month if there are not 10 days left in the month).

  At recertification, advisors disregard income from a new source in the first month of the certification period if that income will not exceed $25 within 10 days after the individual's usual issuance cycle.

  Notes:

  - Advisors count an advance of wages for travel expenses as income unless it is a reimbursement.
  - Advisors do not consider the advance in determining whether the household is destitute or in determining whether later payments from the employer are from a new source.
  - Self-employed farmworkers whose income is annualized are not destitute if they do not receive income each month of the year.
  - The grower, not the crew chief, is the farmworker's source of income. An individual who follows a crew chief to a new grower is leaving a terminated source for a new source.

The policies in this section apply to income determinations for destitute applicants at initial and later certifications but only in the first month of any certification period.

A—147 Expedited Eligibility and Enrollment of Active Duty Military Members and Their Dependents

Revision 15-4; Effective October 1, 2015

Medical Programs – All Except Emergency Medicaid and TP 56

All applications for Medicaid from active duty military members and their dependents applying for coverage are eligible for expedited processing.

Active duty refers to military members who currently are serving full time in their military capacity. A military member is defined as someone in the:

- U.S. Armed Forces/Reserves
  - Army
  - Marine Corps
  - Navy
  - Air Force
  - Coast Guard
- National Guard
  - Army
  - Marine Corps
  - Navy
  - Air Force
  - Coast Guard
  - Reserve/Guard
- Army National Guard
- Air National Guard
- State Military Forces/Texas State Guard
  - Texas State GuarD – Unless **activated** by the governor and placed on paid state active duty, these personnel receive no compensation for their time.
  - Texas Army National Guard
  - Texas Air National Guard

When an application for Texas Works medical assistance is received and includes an active duty military member, staff should take the following action on or before the 15th workday of the application file date:

- Provide an interview if requested or required;
- Send/provide Form H1020, Request for Information or Action, to request missing information if no interview was requested or required and the household did not provide information with the application; and

- Send/provide Form TF0001, Notice of Case Action, if the household provided all verification with the application and no interview was requested or required.

Military status is self-declared. Additional verification is not required.

Advisors should use processing time frames stated in B-112, Deadlines, if the household did not provide all required information and verification with the application.

The expedited processing requirement does not apply to TP 56 (Medically Needy with Spend Down) or to Emergency Medicaid for ineligible aliens, and only applies to applications and untimely reviews/renewals.

A household is not eligible for expedited processing if the military member is on active duty because of training as a member of the Reserves, National Guard, or State Military Forces.

When an application consists of a pregnant member and an active duty member, advisors use TP 40 expedited application processing time frames.

Advisors provide expedited processing for a Medicaid application if the budget group includes the needs of an active duty member even if the active duty member is not included in the certified group.

Advisors must not pend an application if the household:

- fails to answer the **Yes/No** question and **name/designation**. Advisors must not process the application using expedited time frames. If the Yes/No question is left blank, advisors enter **No** in the system.
- fails to answer the **Yes/No** question but provides a name or information that can be used to determine who the active military member is. Advisors should assume that the answer is **Yes** and process the application using expedited time frames.
- answers **Yes** to the question but does not provide a name or information that can be used to determine who the active military member is. Advisors must not process the application using expedited time frames.

When an interview is scheduled timely within 15 workdays, but the applicant requests to reschedule the interview, staff should attempt to accommodate the rescheduled appointment within the 15-workday time frame. If, at the household's request, the interview is rescheduled after the 15-workday time frame, staff should document the reason for not scheduling the appointment within the required time frame.

Note: For requested interviews, if the applicant requests to be rescheduled, staff should inform the household that an interview is not required and that the processing of the application can begin without an interview. Staff must not deny an application if the household fails to show for the appointment when an interview is not required.

A—150 Combined Allotment Policy

Revision 15-4; Effective October 1, 2015

SNAP

Advisors must issue benefits for the month of application and the following month at the same time if:

- an applicant files the application after the 15th of the month (including reapplications filed after the 15th of the month following the last benefit month);
- the household is eligible for the application month and the following month (including applicants eligible but not receiving an allotment for the application month because benefits prorate to less than $10); and
- advisors must prorate the initial month's benefits.

Note: For applicants who meet expedited criteria, advisors issue a combined allotment within expedited time frames, even if postponing verification.

Inform households receiving combined allotments:

- when the benefits will be available;
- that no additional benefits will be available until the third month; and
- that the third month's benefits will be available on the regular issuance schedule.

TIERS identifies and issues benefits to households eligible for a combined allotment and holds the third month's benefits if the combined allotment certification has postponed verification.

A—160 Joint TANF-SNAP Applications

Revision 13-2; Effective April 1, 2013

TANF, SNAP and TP 08

A household in which all members are applying for or receiving TANF and/or TP 08 may apply for SNAP at the same time the household applies for TANF and/or TP 08. The advisor then conducts a single interview.

Exception: Conduct the unfinished TANF and/or TP 08 interview later if necessary to meet the SNAP expedited processing time limits.

A—161 When Receipt of TANF Is Uncertain

Revision 15-4; Effective October 1, 2015

TANF and SNAP

When TANF eligibility is uncertain, advisors must:

- certify the household for Non-Public Assistance (NPA) SNAP benefits if eligible. **Note:** If the TANF members have resources, advisors do not exclude the resources for SNAP until the household's TANF EDG is certified (see A-1248, Resources of TANF and SSI Recipients); and
- assign an NPA certification period (see A-2324, Length of Certification).

If TANF is approved later, advisors should process it as a reported change and add the TANF benefit to the SNAP budget as soon as possible. (See A-1324.18, Temporary Assistance for Needy Families [TANF].) Advisors should adjust the certification period to expire when the next TANF periodic review is due. Advisors should send or give the applicant Form TF0001, Notice of Case Action, with the new certification period stated. **Exception:** One-Time Temporary Assistance for Needy Families (OTTANF), A-1324.11.

If the TANF application is denied later, the advisor should continue SNAP eligibility based on the original application.

A—170 Authorized Representatives (AR)

Revision 15-4; Effective October 1, 2015

All Programs

An applicant, head of household, or someone with legal authority to act for the individual (i.e., legal guardian or power of attorney) may designate an individual or organization as an AR.

An AR must be verified using one of the following:

- Client's signature on one of the following HHSC applications for benefits containing the AR designation:
  - Form H1010, Texas Works Application for Assistance — Your Texas Benefits
  - Form H1010-R, Your Texas Works Benefits: Renewal Form
  - Form H1014-R, Renewing Children's Health-care Benefits

    - Form H1034, Medicaid for Breast and Cervical Cancer
    - Form H1200, Application for Assistance — Your Texas Benefits
    - Form H1200-MBI, Application for Benefits — Medicaid Buy-In
    - Form H1200-MBIC, Application for Benefits — Medicaid Buy-In for Children
    - Form H1205, Texas Streamlined Application
    - Form H1206, Health Care Benefits Renewal
    - Form H1840, SNAP Food Benefits Renewal Form
    - Form H1841, SNAP-CAP Application
    - Form H1842, SNAP-CAP Renewal Application
    - Form H2340, Medicaid for Breast and Cervical Cancer Renewal
    - Form H2340-OS, Medicaid for Breast and Cervical Cancer
- Client's signature on a Marketplace application for health care benefits that is transferred to HHSC.
- Legal documentation that the AR has authority to act on behalf of the client under state law (i.e., legal guardianship or power of attorney).
- Letter from a client designating AR authority and containing the client's signature, in addition to the name, address, and signature of the AR.
- Completed Form H1003, Appointment of an Authorized Representative.
- Client's electronic signature designating the AR through their case account on an application, renewal, or reported change submitted through YourTexasBenefits.com.

If a person or organization has submitted an application on behalf of a client and indicates that they wish to be the client's AR, and the client has not signed the application, then the AR must be verified before the client's eligibility for benefits can be determined. Correspondence will be sent to both the unverified AR and the head of household on the case to request the verification.

- The head of household for the case will be sent:
    - Form H1020, Request for Information or Action, listing what missing information is needed before eligibility can be determined.
    - Form H1003, to capture the client's and AR's signatures designating the AR.
- The AR will be sent:
    - Form H1004, Cover Letter: Authorized Representative Not Verified, to describe what is needed to verify the AR.
    - Form H1003, to capture the client's and AR's signatures designating the AR.

In order for the AR to be verified, either the AR or the head of household will need to return the completed Form H1003 within 10 days (or 30 days from the file date) in order for the application to be considered valid. If other missing information was listed on the Form H1020 that was sent to the client, that information must also be returned timely. If the AR verification is not received by the due date, then the application is denied.

Note: During the interview, the advisor must obtain the AR's complete mailing address, if the AR's address is not included on the application form. The advisor must record the AR's address on the corresponding TIERS Data Collection page, **Household - Authorized Representative**. If the individual cannot provide a complete mailing address for the AR or no interview is required for the program type, the advisor should not pend the case. The advisor must record the household's mailing address as the AR's address in TIERS.

The AR designation is effective from the date the AR is verified until:

- the client notifies HHSC that the AR is no longer authorized to act on his or her behalf;
- the AR notifies HHSC that they no longer wish to act as the client's AR;

  Note: The AR will not be able to do this during the redetermination process if the AR is completing the redetermination.
- there is a change in the legal authority (i.e., legal guardianship or power of attorney) on which the AR's designation is based; or
- the client designates a new AR to act on their behalf. If there is an existing AR designated on a case, the person or organization that the client most recently designated as the AR will replace the existing AR on the case.

Notices ending the designation of the AR must include the client's or AR's signature as appropriate.

Note: An AR is not automatically a personal representative (PR).

An AR is designated at the case level to have access to all benefit information for that case. A verified AR may:

- sign an application on an applicant's behalf;
- complete and submit a renewal form;
- receive copies of an applicant's/client's notices in the preferred language selected on the application, and other communications from HHSC;
- designate a health plan; and
- act on an applicant's/client's behalf in all other matters with HHSC.

The client or AR may also request that the AR receive the client's Medicaid or CHIP ID card and enrollment-related agency correspondence.

Related Policy
Identifying Applicants Interviewed by Phone and Prevention of Duplicate Participation, A-2000

Personal Representatives, B-1212
Establishing Identity for Contact Outside the Interview Process, B-1213
Telephone Contact, B-1213.1

SNAP

People disqualified for SNAP benefits because of an administrative disqualification hearing or a nonmember living with the household may serve as an AR only if:

- no other responsible household member is reasonably able to be an AR, or
- that person is the only adult living in the household.

HHSC employees involved in certification or issuance and retailers authorized to accept SNAP benefits may serve as an AR only if the unit supervisor gives written approval.

A—171 Protective Payee

Revision 15-4; Effective October 1, 2015

TANF

A grandparent (including great- or great-great- grandparent) may represent the household in the application and review process upon the grandparent's request and when the advisor determines that the incompetent or incapacitated individual is not using TANF for the child's benefit. In these situations, the individual's signature and designation of the grandparent as AR in writing is not required on Form H1010, Texas Works Application for Assistance — Your Texas Benefits. If the grandparent is designated AR, the grandparent is also designated protective payee.

Related Policy
Receipt of Application, A-121
Receipt of Application from Residential Child Care Facility , A-121.1
Verification Requirements, A-180
Documentation Requirements, A-190
Children Residing in General Residential Operations Facilities, A-923

A—172 AR Applying for Household

Revision 15-4; Effective October 1, 2015

All Programs

The AR must be informed about the household circumstances. The individual is liable for any overissuance resulting from inaccurate information that the AR gives, except in situations when drug/alcohol treatment centers or group living facilities act as AR for a SNAP household.

The AR must be an adult.

A—173 AR for Residents of Drug and Alcohol Treatment/Group Living Arrangement (GLA) Facilities

Revision 15-4; Effective October 1, 2015

SNAP

For these residents, a facility employee must serve as an AR to apply for the household and to use the benefits. See B-440, Drug and Alcohol Treatment (D&A)/Group Living Arrangement (GLA) Facilities. The AR designated to use SNAP benefits may be a different person from the AR who applies for the household.

A—174 Abuse by AR

Revision 15-4; Effective October 1, 2015

SNAP

An advisor who suspects an AR of acting against the household's interests must report the circumstances to the advisor's program manager.

A—180 Verification Requirements

Revision 15-4; Effective October 1, 2015

All Programs

When an eligibility determination has been requested for multiple programs and the programs allow the same verification sources, the advisor must use the same verifications for all applicable programs. For example, if an individual is applying for SNAP, TANF, and Medical Programs, and the advisor accepts a wage verification for SNAP, the advisor must not request additional verification of the wage for TANF or Medical Programs if the source used was an acceptable form of verification for TANF or Medical Programs.

Advisors make the eligibility decision in each program when all verifications are received for that program.

Related Policy
Data Broker, C-820
Questionable Information, C-920
Providing Verification, C-930

TANF

Staff must verify that the caretaker is not using TANF benefits for the child's needs when the grandparent requests to be designated AR. If the caretaker requests the grandparent's removal as AR, staff must verify that the caretaker intends to use TANF benefits for the child's needs.

SNAP

Staff must verify the nonprofit status of homeless shelters, if questionable. See IRS documentation that proves the nonprofit status under Section 501(c)(3) of IRS regulations.

A—181 Verification Sources

Revision 15-4; Effective October 1, 2015

TANF

Advisors use the following sources to verify when a grandparent requests to be designated as an AR or when the caretaker requests that the grandparent be removed as AR:

- non-related landlord,
- non-related neighbor,
- school officials,
- Child Protective Services worker, and
- a person without vested interest in outcome of decision.

A—190 Documentation Requirements

Revision 15-4; Effective October 1, 2015

All Programs

Advisors must document the date and method by which advance notice of a home visit was provided and the date and time of the visit. An imaged copy of the appointment notice provided to the individual is sufficient.

Advisors must document why a certain file date was used to determine eligibility when:

- the file date used differs from the received date on the application; or
- the application has two received dates.

When a household requests additional programs after filing an application, advisors must document the requested program and the date of the request.

Advisors must document the rationale used to make a prudent person principle decision and any applicable handbook references.

Advisors must document that Form H0025, HHSC Application for Voter Registration, was given to the applicant, AR, or representative payee under the Agency Use Only section of the application.

Advisors must document on the application and on Form H1350, Opportunity to Register to Vote, in the Agency Use Only section the actions taken when an applicant or individual notifies the local office of the decision to decline the opportunity to register to vote after receipt of Form H0025.

Advisors must document information to support the eligibility decision in enough detail that others can understand all computations and advisor decisions explained in C940, Documentation.

All Programs except TP 33, TP 34, TP 35, TP 43, TP 44, TP 45 and TP 48

For all interviews, staff must document:

- whether the individual met telephone interview criteria and a telephone interview was not done for TANF and SNAP;
- how interpreter services were provided when the application indicates the individual requested these services, including when the advisor conducted the interview and acted as an interpreter.

Medical Programs

Advisors must document when a designated Texas Works advisor requests that a child born to a woman in prison be certified for TP 43.

TANF

Advisors must document the specific reason for designating an AR.

When the grandparent requests to be the AR, the following information must be documented:

- information the grandparent gives to support the claim that the parent is not using the TANF benefit for the child's needs;
- information obtained from collateral contacts and/or documents; and
- decision whether or not to designate the grandparent as the AR and protective payee.

SNAP

The following information must be documented:

- the name and address of the AR;
- that no one else is available, if a person disqualified for IPV or a nonmember living with the household is appointed as AR;
- the tax-exempt status [Section 501(c)(3)] for public or private homeless shelters, if applicable;
- expedited service eligibility by marking the appropriate box on Form H1010 and explain if eligibility is questionable;
- the decision on the length of certification and reporting requirements for expedited service EDG;
- whether a migrant is in or out of the workforce;
- the reason for entering a late determination date; and
- the reason why an appointment for an expedited applicant is not scheduled for an interview within the expedited time frame.

Related Policy
Documentation, C-940
Registering to Vote, A-1521
The Texas Works Documentation Guide

TWH, A-200, Household Composition

Revision 18-1; Effective January 1, 2018

A—210 General Policy

Revision 15-4; Effective October 1, 2015

TANF

The composition of a Temporary Assistance for Needy Families (TANF) certified group:

- is a person or group of relatives whose needs are included in one Eligibility Determination Group (EDG).
- must include an eligible child, unless the eligible relative cares for a child who receives:
  - Supplemental Security Income (SSI), Foster Care with Cash or Adoption Assistance with Cash; or
  - ME - SSI Medicaid (TP 19) and the relative chooses not to apply for TANF for the child.

Some persons are required members of the TANF certified group. The individual may not choose to exclude a required member from the certified group. If the individual fails to provide available verifications for a required member, assistance is denied for the entire certified group.

A TANF-State Program (SP) certified group must contain both an eligible:

- caretaker/parent; and
- second parent.

Note: Households are eligible for TANF-SP if the budget group contains:

- two parents who are eligible and certified for TANF;
- one parent who is certified for TANF and the other parent is disqualified for one of the reasons listed in A-222, Who Is Not Included, No. 4, Disqualified Members, unless that disqualification is due to not meeting citizenship requirements; or

- two parents who are disqualified for one of the reasons listed in A-222, No. 4, unless that disqualification is due to not meeting citizenship requirements.

Related Policy
Alien Sponsor's Income, A-1361
A Household with Members on TANF, TANF-State Program (SP), TP 07, TP 08 and TP 20, B-480

SNAP

A Supplemental Nutrition Assistance Program (SNAP) unit is one person or a group of people who live:

- together and who usually purchase and prepare their food together; or
- with others and intend to purchase and prepare food separately after certification.

Exception: A separate household status is allowed to a person (along with the person's spouse) age 60 or over who lives with others but cannot purchase and prepare food separately because of permanent incapacity, provided that required household members are not excluded. To allow separate household status, the gross income of the other household members (without the elderly person and spouse) must be less than 165 percent of the Federal Poverty Income Limit for the number of other persons.

The elderly person must:

- prove that he or she meets the Social Security disability criteria in B-432, Definition of Disability, if questionable; and
- provide verification of the other household member's income.

Note: All required members are always included, as described in A-231, Who Is Included, in the elderly person's household. For example, the elderly person's spouse or children under age 22 are always included in the same household unless elderly members have their own SNAP Combined Application Project (SNAP-CAP) EDGs.

Related Policy
Who Is Included, A-231
Noncommercial Roomer/Boarder Payments, A-1323.4.3
Disqualified Members, A-1362
Alien Sponsor's Income, A-1361
Students in Higher Education, B-410
Joint Supplemental Security Income (SSI)-SNAP Applications, B-476
Categorically Eligible Households, B-470

Medical Programs

Modified Adjusted Gross Income (MAGI) household composition is used to determine whose needs, income, and expenses are considered in determining an individual's eligibility for medical programs. Each MAGI household composition is determined on the individual level. Individuals living at the same physical address may have a different MAGI household composition. MAGI household composition is based on federal income tax rules.

Exception: Medically Needy with Spend Down has certain exceptions for determining MAGI household composition and income explained in A-1359, How to Determine Spend Down.

An individual does not have to file a federal income tax return to apply for Medical Programs.

A—211 Relationships Resulting from Termination of Parental Rights

Revision 15-4; Effective October 1, 2015

All Programs

When a court terminates the relationship between a biological or adoptive parent and child, a legal parent/child relationship does not exist between the two individuals.

If a biological or adoptive parent's parental rights to a child are terminated, that parent no longer has a legal parent/child relationship to that child, nor to any of the child's children who are born after the date the parental rights were terminated.

Example: Amy's parental rights to her child Julie are terminated when Julie is 16. Julie already has one child, Jill, at the time Amy's parental rights are terminated. Subsequently, Julie has a second child, Bill. As a result, Amy no longer has a legal relationship with Julie or Bill, but she retains her grandparent relationship to Jill.

Note: A parent whose parental rights have been terminated is not considered the natural parent of their biological child.

Relationships that existed between the child and other relatives of the biological parent are not interrupted or terminated. The only relationship terminated is that of the parent that relinquished his or her parental rights. **Example:** The child's biological or adoptive grandparents, siblings, aunts, uncles, and cousins still have the same relationship to the child they had before the parental rights were terminated.

Related Policy
Child Support and Medical Support Referrals, A-1122.2

A—212 Relationships Resulting from Adoption Procedures

Revision 15-4; Effective October 1, 2015

All Programs

A legal parent/child relationship is created when an individual adopts a child. The adoptive parent/child relationship creates the same relationships with the adoptive parent's relatives that are created with a biological parent/child relationship. **Example:** When a grandparent adopts a biological grandchild, the:

- grandparent becomes the child's adoptive parent, and
- the biological parent becomes the child's adoptive sibling.

A—213 Adoption Household Composition Situations

Revision 15-4; Effective October 1, 2015

TANF

Adoption household composition is determined by the advisor using the following steps:

Step 1	Identify all eligible children for the applicant/recipient.
Step 2	Include all eligible children in the certified group.
Step 3	Include all siblings of the children included in Step 2 if they are eligible children and cannot be certified separately from their sibling. Include a minor's child at the caretaker/payee's request.

Example 1

If a household consists of the applicant, the applicant's two biological children, ages 15 and 17, the 15-year-old's baby (age 1) that the applicant has adopted, and the 17-year-old's 2-year-old baby, the advisor must:

Step 1 Identify eligible children:

- 15-year-old (daughter of applicant)

- 17-year-old (daughter of applicant)
- 1-year-old (adopted daughter)
- 2-year-old (applicant's grandchild – include at applicant's request)

Step 2

Include in certified group:

- applicant
- 15-year-old
- 17-year-old
- 1-year-old

Step 3

Include in certified group at the applicant's request:

- 2-year-old

Example 2

If a household consists of the applicant, adopted child (biological grandchild), and the adopted child's half-sibling, not related to the applicant, the advisor must:

Step 1

Identify eligible children:

- adopted child

Step 2

Include in certified group:

- applicant
- adopted child

Step 3 N/A – there are no optional eligible children.

Note: For TP 32, TP 33, TP 34, TP 35, TP 43, TP 44, TP 48 or TP 56, the half-sibling can be considered an independent child when determining the child's eligibility for Medicaid. See A-910, General Policy.

A—220 TANF

Revision 08-1; Effective January 1, 2008

A—221 Who Is Included

Revision 18-1; Effective January 1, 2018

TANF

The following are always included in the TANF certified group:

1. **Eligible Child**

   An eligible child is a person who meets TANF requirements, is not married according to Texas state law, and is:
   - under age 18; or
   - age 18 and:

- is a full-time student (as defined by the school) in high school, attends an accredited general equivalency diploma (GED) class, or regularly attends vocational or technical training as an equivalent to high school attendance; and
- expects to graduate before or during the month of the child's 19th birthday.

Notes:

- GED is approved only if the class is administered by an accredited institution.
- When removing a child age 18 or 19 from the grant, A-1424, Diversions, Alimony, and Payments to Dependents Outside the Home, is used to determine whether to divert for the child's needs.
- A child certified for foster care Medicaid only or adoption assistance Medicaid only is a potentially eligible child.

An emancipated minor is an eligible child if the:

- child meets the TANF age criteria;
- child is not married in accordance with Texas state law; and
- caretaker/payee exercises parental control of the child.

2. **Eligible Legal Parent**

An eligible legal parent is a legal parent who meets TANF requirements and lives with an eligible child. This includes a parent who is absent solely because of employment or active duty in the U.S. military. See A-1040, Deprivation Based on Absence from the Home. This includes parents receiving foster care or adoption assistance services for themselves, but not the child(ren).

Exception: See No. 6, Minor Parents, below.

3. **Siblings**

A sibling is a brother or sister of an eligible child, including legally adopted and half-brothers and sisters. Siblings must be certified together if they meet all TANF requirements. If an unborn child will be a required member of the certified group, a special review is set for the first day of the month after the expected delivery month.

Note: Half-brothers/sisters who do not meet the degree of relationship to the caretaker are not eligible to receive TANF benefits but can be certified as an independent child on a separate Medicaid EDG. See A-910, General Policy.

Example: The household consists of a grandparent, two grandchildren and a half-sibling to the grandchildren. The two grandchildren can be certified for TANF and Medicaid because they meet the required degree of relationship to the caretaker. The half-sibling does not meet the required degree of relationship to the caretaker and cannot be certified for TANF. The half-sibling can be certified as an independent child on a separate Medicaid EDG.

Exception: See No. 6, Minor Parent, below.

4. **Caretaker**

A caretaker is any specified relative who:

- is present in the home; and
- supervises and cares for the TANF child(ren).

A caretaker must be the child's:

- father or mother;
- grandfather or grandmother;
- brother or sister;
- uncle or aunt;
- first cousin;
- nephew or niece;
- stepfather or stepmother;
- stepbrother or stepsister; or
- first cousin once removed.

Relationship extends to the:

- Spouse of the listed relatives, even after the marriage has ended in death or divorce, regardless of when the child's birth occurred.
- Degree of "great-great" for uncles/aunts and nephews/nieces.
- Degree of "great-great-great" for grandparents.

A caretaker meets the relationship requirement even if a court has jurisdiction over the child or an agency is the child's managing conservator. If a child lives with a managing conservator, the conservator must meet the relationship requirement.

If a child lives with a married relative (not a parent) who wants to be considered the caretaker, eligibility and benefits are determined using:

- normal budgeting procedures for the applicant's income, and
- stepparent budgeting for the income of the applicant's spouse.

Note: See A-1366, Stepparent EDGs, for budgeting.

If the person applying for the child cannot qualify to receive TANF, the individual's needs are not included in the certified group. If no one qualifies as caretaker, only the needs of the eligible children are included.

No one else is included as caretaker if the legal parent is:
- in the home; and
- physically and mentally able to provide care.

Exception: The stepparent may be certified as caretaker if the stepparent wants to be included and the legal parent has a disability. The stepparent and legal parent who has a disability are certified for TANF-SP when the stepparent is included in the certified group.

Related Policy
Relationship, A-520
Relationship Charts, C-1440

5. **Second Parent**

When a child lives with both legal parents, both parents are included in the certified group. The parent who is not the caretaker is the second parent. The second parent must meet all TANF requirements.

The household may be certified for TANF-SP when:
- both parents are eligible and certified for TANF;
- one parent is eligible and certified for TANF and the other parent is disqualified for one of the reasons listed in A-222, Who Is Not Included, No. 4, Disqualified Members, unless that disqualification is due to not meeting citizenship requirements; or
- both parents are disqualified for one of the reasons listed in A-222, No. 4, unless that disqualification is due to not meeting citizenship requirements.

Related Policy
General Policy, A-1310

6. **Minor Parent**

A minor parent and child(ren) living with the minor parent's parent(s) and/or siblings may:
- be certified separately if the:
  - minor parent's parent(s)/sibling(s) is not a TANF applicant/recipient; or
  - minor parent cannot be included in his parent(s)'/sibling(s)' TANF EDG because he is not an eligible child; or
- continue to receive TANF on a separate EDG if the minor parent's EDG was certified before the:
  - month the parent(s)/sibling(s) applied for TANF; or
  - day the minor parent moved into the home with the parent(s)/sibling(s).

Otherwise, the minor parent must be included as a child with the:
- legal parent(s) who receives TANF/TANF-SP; or
- sibling certified for TANF/TANF-SP as a child.

If the caretaker or payee in the EDG requests TANF for the minor parent's child, the child is included in the EDG with the caretaker/payee and the minor parent.

Exception: A married minor parent is an eligible legal parent and must be certified separately from the minor parent's parents. See No. 1, Eligible Child, above.

Related Policy
Requirement for Unmarried Minor Parents to Live with an Adult or in an Adult-Supervised Setting, A-930
Unmarried Minor Parent Income, A-1365
Stepparent Budgeting Procedures, A-1366.2

7. **Stepparents**

A stepparent is not a child's legal parent but is the legal parent's spouse. Stepchildren are deprived of parental support because one legal parent is absent.

Include the stepparent in the certified group only if the stepparent wants to be included and:
- the stepparent is the only parent in the home; or
- both the legal parent and the stepparent are in the home and the legal parent has a disability according to policy in A-1051, Determining Incapacity.

Certify the stepparent and legal parent with disabilities for TANF-SP when the stepparent is included in the certified group.

If the legal parent and stepparent live in the home and have mutual children, they must all be included in the same certified group.

Related Policies
Resources of Stepparents, A-1247
Stepparent EDGs, A-1366
A Household with Members on TANF, TANF-State Program (SP), TP 07, TP 08 and TP 20, B-480

8. **People in Nursing Homes**

   If a member of the TANF-certified group temporarily enters a nursing facility, the individual's needs are left in the TANF budget during the nursing facility stay or until the individual is certified for Supplemental Security Income (SSI). The individual should be referred to the Social Security Office for an SSI eligibility determination.

A—222 Who Is Not Included

Revision 15-4; Effective October 1, 2015

TANF

The following are not included in the TANF-certified group:

1. **Payee**

   A payee is a relative who meets relationship requirements in A-220, TANF, and lives with, supervises and cares for an eligible child. The payee is authorized to receive the TANF benefits for an eligible child but is not a member of the certified group because the individual is a:

   - legal parent who would be a caretaker but is ineligible due to receipt of SSI.
   - relative other than the legal parent who qualifies as a caretaker except the individual:
     - chooses not to be included as caretaker;
     - receives SSI, Foster Care with Cash or Adoption Assistance with Cash payments;
     - is disqualified for an intentional program violation (IPV); or
     - fails to comply with a program requirement that would disqualify a legal parent. See No. 4, Disqualified Members, below.

   Note: A payee who chooses not to be included as a caretaker on one EDG may be a caretaker on another TANF EDG for other related children.

2. **Protective Payee**

   A protective payee must be selected to receive and manage the TANF benefit if the caretaker is not using the TANF payments for the children's benefit. See A-1553, Use of TANF Benefits.

   The protective payee must be someone who can help the individual spend the household'sTANF benefits properly. The individual must agree to the person designated as the protective payee unless the:

   - Texas Department of Family and Protective Services (DFPS) designates a protective payee, or
   - advisor designates the grandparent (including great- or great-great-grandparent) as authorized representative and protective payee, because the parent is not using the TANF payments for the child's benefit. See A-170, Authorized Representatives (AR).

   The protective payee cannot be a:

   - Texas Health and Human Services Commission (HHSC) employee, or
   - person who provides HHSC services to the family.

   The protective payee situation must be re-evaluated at each complete redetermination. For EDGs with a:

- DFPS-requested protective payee, DFPS must be contacted at each complete redetermination to determine whether the protective payee should continue; and
- grandparent designated as protective payee and authorized representative, any reports alleging that the grandparent is not using TANF for the child's benefit must be investigated.

When designating or continuing a protective payee, the individual is notified and allowed an opportunity to appeal.

3. **Representative Payee**

A representative payee is designated if an individual is unable to receive and manage the household's TANF or Medicaid benefits because of incapacity or incompetence. The representative payee must be knowledgeable about the family members and interested in the family's welfare. The individual must designate this representative in writing if physically or mentally capable of doing so.

The representative payee may be the authorized representative who assisted in the eligibility process.

4. **Disqualified Members**

A legal parent is disqualified from the certified group if the individual:

- does not meet citizenship requirements;
- refuses to comply with Medicaid third-party resource (TPR) requirements;
- does not comply with Social Security number requirements;
- is found guilty of an intentional program violation;
- fails to timely report the temporary absence of a certified child (see A-920, Temporary Absence from the Home, for disqualification procedures);
- is a fugitive fleeing to avoid prosecution of or confinement for a felony criminal conviction, or found by a court to be violating federal or state probation or parole;
- is convicted of a felony drug offense (not deferred adjudication) for the possession, use or distribution of a controlled substance as defined in 102(6) of the Controlled Substances Act [U.S. Code (USC) 802(6)] that was committed on or after April 1, 2002, in Texas or another state;
- has received benefits for the total months allowed by the state time limit;
- is a minor parent who fails to comply with the unmarried minor parent domicile requirement; or
- is denied for refusal to cooperate with the program integrity assessment (that is, quality control) process.

Note: A legal parent is permanently disqualified for a felony drug conviction (not deferred adjudication) for an offense that was committed on or after April 1, 2002.

A child is disqualified from the certified group if the child:

- is a fugitive;
- fails to comply with Social Security number requirements;
- is a minor parent and fails to report the temporary absence of the minor parent's child; or
- is convicted of a felony drug offense that was committed on or after April 1, 2002.

Notes:

- If the disqualified member wishes to apply for Medicaid, the advisor must determine which medical program applies to the disqualified household member. If all eligibility requirements are met, the member is certified on the appropriate medical program.
- When the criminal history report in the Data Broker system indicates the individual has been convicted of an offense involving a controlled substance, the situation should be discussed with the individual. If the individual claims not to be the individual indicated on the criminal history report but the identifying information on the report (name, date of birth, physical description) leads the advisor to believe the report is correct, or the individual is in disagreement with other information provided in the report (for example, the type of conviction or whether it was a felony or misdemeanor), the advisor must:
  - document the client's response in Case Comments;
  - proceed with the appropriate EDG action without acting on the criminal history report;
  - contact the Office of Inspector General (OIG) by emailing the OIG General Investigations Policy and Quality Control Unit at oig_gi@hhsc.state.tx.us; and
  - document the reason for contacting OIG in Case Comments. Once OIG obtains information to clear the discrepancy, the assigned OIG investigator provides the response/finding by creating a task within the Task List Manager (TLM) system. The assigned advisor clearing this task documents the results of the OIG's findings in case comments and, if applicable, enters information in the Data Collection-Individual Demographic-Conviction/Rehabilitation page. Make an overpayment referral if appropriate. (See B-770, Filing an Overpayment Referral.)

Related Policies
Disqualified Members, A-1362
General Policy, A-1210
When the Client Signs Form H1073, A-2128.1

5. **SSI Recipients**

A TANF family member is removed from the grant when the person is certified for SSI. The Social Security Administration notifies HHSC via an interface when a TANF recipient is determined eligible for SSI.

Exception: Children whose SSI financial benefits were denied because of changes in the SSI disability definition in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 receive TP 19, SSI Denied Children. Individuals may choose to include or exclude these children from the TANF certified group.

6. **Residents in State Supported Living Centers for Individuals with Intellectual Disabilities**

   If a TANF recipient enters a state supported living center for individuals with intellectual disabilities, the individual's needs are removed from the TANF grant. If the recipient is the caretaker or payee, the grant continues for the remaining eligible children in another eligible person's name.

7. **Strikers**

   A household's application or ongoing benefits are denied for any month in which a certified or disqualified legal parent is participating in a strike.

8. **Foster Care with Cash Payment, Adoption Assistance with Cash Payment, and Permanency Care Assistance (PCA) with Cash Payment recipients.**

A person receiving these cash benefits is not included in the TANF EDG.

Note: An individual potentially may receive Texas Department of Family and Protective Services foster care through the individual's 22nd birthday month. Adoption assistance and PCA are only received through the 18th birthday month unless the family signs an agreement after the youth turns age 16. When this occurs, the youth may receive adoption assistance or PCA through their 22nd birthday month.

9. A child who is ineligible, such as an ineligible alien child or a child who is not within the required degree of relationship to the adult caretaker/payee, is not included.

A—223 Certifying Children on Non-Parent Caretaker EDGs

Revision 16-3; Effective July 1, 2016

TANF

When an eligible child lives with a relative other than the legal parent, the child is certified on:

- a separate EDG when the relative receives TANF for children who are not the child's natural, adopted, or half siblings (designate the relative as a payee); or
- the same EDG with the non-parent caretaker when the relative:
  - requests it and is not receiving TANF for any other children; or
  - is receiving TANF for children who are the child's natural, adopted, or half siblings.

Each other-related child (other than siblings) is certified on a separate EDG.

Exception: Other-related children are certified on the same EDG if:

- at least one EDG is ineligible separately;
- the members would be eligible if the EDGs were combined; and
- the relative requests that they be combined.

A child's TANF must not be denied because of the income or resources of a:

- child who is not the child's natural, adopted, or half sibling; or
- caretaker who is not the child's parent (see A-1366.2, Stepparent Budgeting Procedures).

When an EDG is denied because of the income or resources of a non-parent relative caretaker:

- process the denial for the EDG including the caretaker's request for aid; and
- process a separate EDG to determine the child's eligibility without the caretaker.

Note: Households that include a non-parent caretaker are not eligible for TANF-SP.
See B-480, A Household with Members on TANF, TANF-State Program (SP), TP 07, TP 08 and TP 20, for more information on the action to take when some members must be denied while others remain eligible.

Related Policy OTTANF, A-2411 Grandparent Payments, A-2412 Documentation Requirements, A-2470

A—224 Special Household Composition Situations

Revision 02-8; Effective October 1, 2002

A—224.1 TANF-SP EDGs with Stepchildren or a Parent's Child from a Previous Relationship

Revision 15-4; Effective October 1, 2015

TANF

The following must be included in the TANF-SP EDG:

- a child who lives with a natural/adoptive parent, a stepparent, and a sibling who is the parent and stepparent's mutual child.
- parents and all children, when:
  - the legal parents of a mutual child are not married to each other, and
  - one or both have a child living in the home who is not a mutual child.

If the household is ineligible for TANF-SP because they do not meet other TANF eligibility requirements such as income or resources, the family unit must remain as one filing unit even when stepchildren are included. In this situation, the advisor must determine whether the household meets eligibility requirements for the Medical Programs.

If an active TANF-SP EDG is denied because of earnings or the removal of the 90 percent earned income deduction and the household is receiving TP 08, the Texas Integrated Eligibility Redesign System (TIERS) will deny both the TANF-SP and TP 08 EDGs and create:

- a transitional Medicaid EDG if the certified group meets the eligibility criteria; or
- another Medical Program type of assistance EDG for eligible members if they are not eligible for transitional Medicaid and are otherwise eligible for medical coverage.

Related Policy
Transitional Medicaid Coverage, A-840
General Eligibility Information, A-841
TP 07 Transitional Medicaid, A-842

A—224.2 TANF-SP EDGs with an Other-Related Child

Revision 15-4; Effective October 1, 2015

TANF

Each other-related child living in the family (see A-223, Certifying Children on Non-Parent Caretaker EDGs) is certified on a separate EDG unless the child or other members are ineligible separately. If the child or other members are ineligible separately, the other-related child in the TANF-SP EDG is included. The advisor must ensure that the other-related child has the opportunity to continue receiving TANF when the TANF-SP EDG is denied.

A—230 Supplemental Nutrition Assistance Program (SNAP)

Revision 08-1; Effective January 1, 2008

A—231 Who Is Included

Revision 16-4; Effective October 1, 2016

SNAP

The following people must be certified as a Supplemental Nutrition Assistance Program (SNAP) household if they live together:

1. **Parents and children** (natural, adopted or step) **age 21 or younger**. Parents and children living together when the parent or child is away from home for employment or educational purposes only, and returns home at least one day a month are considered. This includes college students who are eligible for SNAP, as explained in B-410, Students in Higher Education.

   Notes:
   - Consider the individual's age as 22 beginning the month they turn age 22.
   - Do not consider a parent whose parental rights were terminated as the natural parent of a child.
   - The relationship between a stepparent and stepchild terminates when the marriage between the parent and stepparent terminates, either by death or divorce.
   - When DFPS places a child in foster care, the foster child is considered under parental control of the foster parent. If the foster child's parent moves into the home, the parent, child and foster parent must all be included in the SNAP household.
   - If the parents of a child do not live together and the child lives with each parent part of the month, the child can be certified with either parent as long as both parents do not apply. If both parents apply, then certify the parent who provides the majority of meals for the child.
2. **A child under age 18 and any nonparent adult household member** with parental control over the child. A child not under parental control may apply separately if the child purchases and prepares food separately. Individuals age 18 are considered beginning the month they turn age 18.

   Exceptions: Even if under parental control of a nonparent household member:

   - A foster parent or caregiver has the option to include or exclude a foster/Permanency Care Assistance (PCA) child/adult as a household member in the SNAP-certified group. Households with more than one child/adult can opt to include some foster/PCA children/adults while excluding others, even if the foster/PCA children/adults are related to each other or related to the foster parent or caregiver. A foster/PCA child/adult who is excluded from the foster/PCA family's SNAP-certified group is not eligible to participate in SNAP alone as a separate household or as a certified member on another household's SNAP EDG. See A-1326.4, Foster Care and Permanency Care Assistance (PCA) Payments, for information on how to budget foster care/PCA payments.
   - The household may consider a foster child as a boarder instead of a household member. See A-1323.4.3, Noncommercial Roomer/Boarder Payments.
   - A child under age 18 who purchases and prepares food separately can apply separately if the child is:
     - married and living with the spouse; or
     - the parent of a minor child living in the home.
   - A child under age 18 residing with a SNAP-CAP participant can apply separately. The minor child is certified as the SNAP head of household. See B-475.3, Household Composition.
3. **Spouses.** Spouses are people who:
   - are married to each other; or
   - live together and represent themselves to the community as married. This definition may differ from state laws governing common-law marriage.
     - A same-sex marriage that occurred before June 26, 2015, is considered valid effective June 26, 2015.
     - A same-sex marriage that occurred on or after June 26, 2015, is considered valid on the date it occurred.

Note: Spouses are considered to be living together even when one spouse:

- is away from home for employment or educational purposes only; and
- returns home at least one day a month.

Exception: SNAP-CAP participants are certified on separate EDGs.

A—232 Who Is Not Included

Revision 15-4; Effective October 1, 2015

A—232.1 Nonmembers

Revision 16-3; Effective July 1, 2016

SNAP

The following are not included in a Supplemental Nutrition Assistance Program (SNAP)-certified group:

1. **Roomers —** A roomer who pays for lodging but not food as a separate household is certified unless the individual meets one of the three categories in A-231, Who Is Included.
2. **Live-in attendants —** A live-in attendant is certified as a separate household unless the individual meets one of the three categories in A-231.
3. **Boarders —** Boarders in noncommercial boarding houses cannot receive SNAP separate from the household they are living with. Boarders who live in a commercial boarding house cannot participate in SNAP. See A-1323.4.3, Noncommercial Roomer/Boarder Payments.

   Note: The household has the option to include or exclude a foster child/adult as a household member in the SNAP-certified group.

4. **Ineligible students —** These are students who do not meet the student criteria in B-410,Students in Higher Education.
5. **Institutional residents —** Residents who are offered more than half their meals from an institution that is not an approved institution. (See examples of approved institutions in the note below).

   Common examples of institutions are hospitals, nursing homes, public or private homes for persons with a disability, establishments for delinquents and young offenders, group homes for children, penal and correctional institutions, jails, homeless shelters, and students living in a school dormitory where the majority of meals are provided.

   Some foster children/adults are placed by foster placement agencies in homes or facilities other than a foster parent home and are cared for by individuals who are employees of, or contract with, placement agencies. There usually are multiple foster children/adults residing in such facilities. Foster children/adults who reside at these facilities or locations instead of at the foster parent's home address are considered institutionalized and cannot receive SNAP.

   Note: Residents of approved institutions can receive SNAP as explained in A-116.2, Applications from Residents of a Homeless Shelter; B-440, Drug and Alcohol Treatment (D&A)/Group Living Arrangement (GLA) Facilities; B-450, Residents in Family Violence Shelters.

   Residents of a homeless shelter, drug and alcohol treatment center, or a shelter for battered persons can apply and be certified separately, regardless of how they purchase and prepare meals with other residents. The SNAP household would consist of the mandatory household members found in A-231, Who Is Included.

6. **New household members** who are certified in another household. These people are not added to the new EDG until they are removed from the old one. **Exception:** Residents in shelters for battered persons may receive two allotments in one month if the original benefits were issued to the former household that included the woman and children and the abusive person. See B-454, Participation Twice in Same Month.
7. **Supplemental Nutrition Assistance Program Combined Application Project (SNAP-CAP) participants.** Household members are certified separately from an active SNAP-CAP participant. See B-475.3, Household Composition.

Related Policy
Foster Care and Permanency Care Assistance (PCA) Payments, A-1326.4
Prepared Meal Services, B-460
Determining Whether an Individual Who Receives Residential Assistance Is Institutionalized, B-490

A—232.2 Disqualified Persons

Revision 16-3; Effective July 1, 2016

SNAP

These are people who would be required SNAP household members but are disqualified. They cannot participate during their period of disqualification. The disqualified individual's circumstances, however, including income and resources, do affect the household's benefits.

1. **Fugitives** are people who are fleeing to avoid prosecution of or confinement for a felony criminal conviction, or are found by a court to be violating federal or state probation or parole. The individual's statement is accepted as verification and the individual is treated as a disqualified person for the period they remain a fugitive.
2. **Individuals with a felony conviction.** An individual with a felony drug conviction (not deferred adjudication) in Texas or another state occurring on or after September 1, 2015, for the possession, use or distribution of a controlled substance as defined in 102(6) of the Controlled Substance Act [21 USC 802(6)]:

- incurs a two-year SNAP disqualification if the individual violates a condition of parole or community supervision: or
- incurs a permanent disqualification if the individual has a subsequent felony drug conviction while receiving SNAP.

The individual's statement is accepted as verification of a felony drug conviction.

When the criminal history report in the Data Broker System indicates the individual has been convicted on or after September 1, 2015 of an offense involving a controlled substance, discuss the situation with the individual. If the individual claims not to be the individual indicated on the criminal history report but the identifying information on the report (name, date of birth, physical description) leads the advisor to believe the report is correct, or the individual disagrees with other information provided in the report (such as the type of conviction or whether it was a felony or misdemeanor), the advisor must:

- document the individual's response in Case Comments;
- proceed with the appropriate EDG action without acting on the criminal history report;
- contact the OIG by emailing the OIG General Investigations Policy and Quality Control Unit at oig_gi@hhsc.state.tx.us; and
- document the reason for contacting OIG in Case Comments. Once OIG obtains information to clear the discrepancy, the assigned OIG investigator provides the response/finding by creating a task within the Task List Manager (TLM) system. The assigned advisor clearing this task documents the results of the OIG's findings in Case Comments and, if applicable, enters information in the Data Collection-Individual Demographic-Conviction/Rehabilitation page. Make an overpayment referral if appropriate. (See B-770, Filing an Overpayment Referral.)

3. **IPV.** These are people disqualified for an intentional program violation in Texas or another state.
4. **Noncooperation with SNAP Employment and Training (E&T).** These are people disqualified for failing to cooperate with E&T requirements.
5. **Noncooperation with Social Security number (SSN) requirements.** These are people disqualified for failing to cooperate with SSN requirements.
6. **Ineligible Alien.** These are people who do not have eligible alien status to receive benefits.
7. **SNAP ABAWD Work Requirement.** These are people who are age 18 up to age 50 who have received their initial three months of SNAP benefits and who do not meet the work requirement.

Related Policy Disqualified Members, A-1362

A—240 Medical Programs

Revision 16-4; Effective October 1, 2016

Medical Programs

The following individuals may be certified for medical coverage if they meet all eligibility criteria:

- children under age 19;
- other-related children under age 19;
- independent children under age 19;
- pregnant women;
- legal parent(s);
- caretaker relatives; or
- spouse of caretaker relatives.

MAGI rules are used to determine financial eligibility for certain Medical Programs. MAGI rules are based on Internal Revenue Service tax rules.

The following criteria are considered when determining the MAGI household composition for Medical Programs:

- tax status;
- tax relationships;
- living arrangements; and

- family relationships.

Tax Status

An individual's tax status must be designated before their MAGI household composition can be determined.

Tax status is based on the individual's self-declaration for what he or she plans to report on his or her federal income tax return for the taxable year in which eligibility for Medical Programs is requested.

Individuals must be designated as one of the following:

- A taxpayer – an individual who plans to file a federal income tax return for the taxable year in which eligibility for Medical Programs is requested and who is not claimed by another taxpayer. Spouses who plan to file a joint or separate federal income tax return are both considered taxpayers.

Note: For MAGI household composition purposes, an unmarried individual who intends to file a joint tax return is considered a taxpayer filing separately. An individual who is unmarried is not considered a taxpayer filing jointly.

- A tax dependent – an individual who plans to be claimed as a tax dependent by a taxpayer.

Note: An individual who is both a taxpayer and tax dependent is considered a tax dependent. **Example:** A college student who plans to file his or her own federal income tax return and expects to be claimed by his or her parents will be considered a tax dependent.

- A non-taxpayer/non-tax dependent – an individual who does not plan to file a federal income tax return in the taxable year in which eligibility for Medical Programs is requested and does not plan to be claimed by a taxpayer.

Tax Relationships

Individuals have a tax relationship to one another if they:

- plan to file a joint federal income tax return;
- are the taxpayer that plans to claim specific tax dependent(s); or
- are a tax dependent of a specific taxpayer.

Individuals do not have a tax relationship to anyone if they:

- do not plan to file a federal income tax return;
- are not the taxpayer planning to claim the specified tax dependent(s); or
- are not a tax dependent of a specified taxpayer.

Living Arrangements

Individuals are not required to live at the same physical address in order to apply for each other if they have a tax relationship, as explained in A-121, Receipt of Application.

Domicile requirements explained in A-900, Domicile, apply to TP 08, Parents and Caretaker Relatives Medicaid. A parent/caretaker relative must reside with a dependent child to receive TP 08 benefits.

A child entering a state hospital may qualify as an independent child. The child may qualify even if ordered by the court into a state hospital. A child is considered an independent child if court ordered into a state hospital because the parent/caretaker relative no longer has care and control. If the parent/caretaker relative admitted the child voluntarily into a state hospital, verification of whether the parent/caretaker relative still has care and control to determine independent child status is required.

An inquiry should be performed prior to certifying an independent child. The child is certified as an independent child if all eligibility criteria are met. The coverage continues for 12 months, even if the child is released from the state hospital. If a child is released from the facility prior to the end of the 12-month period, the address change is processed and coverage is continued.

Determining Custodial Parent

A custodial parent is established based on physical custody and who has legal authority to claim a child as a tax dependent specified in a court order, binding separation agreement, divorce agreement, or custody agreement.

- If there is no order or agreement, or in the event of a shared custody agreement without specifications for filing federal income tax returns, the custodial parent is the parent with whom the child spends most nights. In the event that the child spends an equal amount of nights with both parents, the advisor must make a prudent person decision regarding which parent should be considered the custodial parent.

- If both a custodial parent and a non-custodial parent declare that they plan to claim the same child as a tax dependent on their federal income tax return, the advisor should build the child's MAGI household composition as a tax dependent of the custodial parent.

Family Relationships

Family relationships that impact household composition include:

- marriage;
- parents of children under age 19; and
- siblings under age 19 or a child under age 19.

The tax status of the individual impacts how the family relationship is used in determining MAGI household composition.

Notes:

- For MAGI only applications and renewals, a relationship and tax status of unmarried and intending to file jointly is not an indication that the individual is currently married or that there is a discrepancy in the individual's marital status.
- For integrated applications and renewals that include SNAP or TANF, a relationship and tax status of unmarried and intending to file jointly should be treated as a case clue if marital status is questionable.
- For all applications and renewals, if the client provides a tax document with an indication of marital status that is inconsistent with the marital status that was reported on an application, the discrepancy in the marital status must be resolved.

A household cannot choose to exclude a child from the budget group when determining eligibility for Medical Programs.

The policy in A-241, Budget Group, and A-242, Certified Group, is used to determine whom to include in the budget and certified group.

Related Policy
Children Admitted into State Hospitals, A-922
Verification Requirements, A-940
Documentation Requirements, A-950
Applications for Babies Born to Women in Prison, A-116.3
Eligibility Requirements, A-521

A—241 Budget Group

Revision 12-1; Effective January 1, 2012

A—241.1 Who Is Included

Revision 15-4; Effective October 1, 2015

A—241.1.1 Taxpayer's MAGI Household Composition

Revision 15-4; Effective October 1, 2015

Medical Programs

The following individuals are included in the taxpayer's MAGI household composition:

- The taxpayer;
- The taxpayer's spouse, if the taxpayer and the spouse live together;
- The taxpayer's spouse, if the taxpayer and spouse file a joint federal income tax return; and
- Any individual the taxpayer plans to claim as a tax dependent.

A—241.1.2 Tax Dependent Exceptions

Revision 15-4; Effective October 1, 2015

Medical Programs

If a tax dependent meets any one of the following exceptions, staff must use the non-taxpayer/non-tax dependent rules explained in A-241.1.4, Non-Taxpayer/Non-Tax Dependent's or Tax Dependent with an Exception MAGI Household Composition, (not the tax dependent rules) to build the tax dependent's MAGI household composition:

- The tax dependent is not the taxpayer's spouse or the taxpayer's child under age 19;
- The tax dependent is a child under age 19 who lives with both parents who do not plan to file a joint federal income tax return and the child was claimed by one parent; or
- The tax dependent is a child under age 19 who is claimed as a tax dependent only by a non-custodial parent.

For a child claimed as a tax dependent by both parents who are filing jointly, with one parent living outside the home, the child does not meet the third tax dependent exception. Staff must build the child's MAGI household composition using the tax dependent rules explained in A-241.1.3, Tax Dependent's MAGI Household Composition.

A—241.1.3 Tax Dependent's MAGI Household Composition

Revision 15-4; Effective October 1, 2015

Medical Programs

If an individual is a tax dependent and does not meet a tax dependent exception previously listed, the following individuals must be included in the tax dependent's MAGI household composition:

- The tax dependent;
- The individuals in the MAGI household composition of the taxpayer who is planning to claim the tax dependent; and
- The tax dependent's spouse, if the tax dependent and the spouse live together.

A—241.1.4 Non-Taxpayer/Non-Tax Dependent's or Tax Dependent with an Exception MAGI Household Composition

Revision 15-4; Effective October 1, 2015

Medical Programs

If an individual does not plan to file a tax return nor plans to be claimed as a tax dependent, the individual is considered a non-taxpayer/non-tax dependent. All tax dependents who meet an exception – Tax Dependent Exceptions – will build his or her MAGI household composition using the non-taxpayer/non-tax dependent rules.

The following individuals must be included in the non-taxpayer/non-tax dependent's or tax dependent with exception's MAGI household composition **if living together**:

- The individual,
- The individual's spouse,
- The individual's children under age 19, and
- If the individual is a child under age 19:
  - The individual's parents, and
  - The individual's siblings under age 19.

A—241.1.5 Inclusion of the Unborn

Revision 16-4; Effective October 1, 2016

Medical Programs

The expected number of unborn children are included in the MAGI household composition of:

- a pregnant woman; and
- any individual whose MAGI household composition includes a pregnant woman.

Note: When including the expected number of unborn children in the MAGI household composition, the pregnant woman is not required to be certified on a medical program.

Related Policy
General Policy, A-910
Income Limits and Eligibility Tests, A-1341
Who Is Included, D-321
Who Is Not Included, D-322

A—241.2 Who Is Not Included

Revision 15-4; Effective October 1, 2015

Advisors must use the MAGI household composition policy explained in A-241.1, Who Is Included, when determining eligibility for Medical Programs.

A—241.3 Household Composition Situations (Minor Parents, Independent Children, Etc.)

Revision 15-4; Effective October 1, 2015

Advisors must use MAGI household composition policy explained in A-241.1, Who Is Included, when determining eligibility for Medical Programs.

A—241.3.1 Children's Living Arrangements

Revision 18-1; Effective January 1, 2018

Medical Programs

A child is considered institutionalized if the child is residing in a facility:

- that is an organizational part of a governmental entity, such as a county holding facility for juveniles; or
- over which a government unit exercises final administrative control.

A child is not considered institutionalized if the child is residing in a facility that is a:

- publicly operated community residence that serves no more than 16 residents, such as a county emergency shelter;
- non-public facility, such as a group or foster home or a general residential operations facility;
- state hospital; or

- halfway house operated by the Texas Juvenile Justice Department or Juvenile Probation Department that meets the following federally required criteria:
  - the halfway house must operate in such a way that individuals living there have freedom of movement and association according to the following tenets;
  - residents are not precluded from working outside the facility in employment available to individuals who are not under justice system supervision;
  - residents can use community resources at will; and
  - residents can seek health care treatment in the community to the same or similar extent as other Medicaid enrollees.

Related Policy

Children Placed in a Non-Secure Facility, B-474.1.2.1.1

A—241.4 Family Violence Exemption

Revision 15-4; Effective October 1, 2015

Medical Programs

Individuals may not be able to or may not want to provide information about a member of their MAGI household composition because they fear physical or emotional harm by that person. Individuals who are pended for missing information about a MAGI household composition member who may be a family violence offender can contact HHSC to request the family violence exemption by calling 2-1-1 or visiting a local office.

Advisors must ask the individual requesting the family violence exemption, at the time the exemption is requested, if they want to be designated as the head of household for the case. Advisors must also confirm the address that should be used for agency correspondence and offer to set up an alternate address if needed. Individuals experiencing family violence must be allowed to provide an address for agency correspondence other than the address on the case with the offender.

If the individual wants to pursue the family violence exemption, advisors must determine whether the individual has existing approved Office of the Attorney General (OAG) good cause for TANF or TP 08 as explained in A-1130, Explanation of Good Cause.

- If the individual has existing OAG good cause, no further action is required for the individual. The advisor must select “OAG Good Cause” as the verification source in TIERS.
- If the individual does not have existing OAG good cause, the advisor must make a referral to a family violence specialist at a nearby family violence service provider, following the process explained in A-241.4.1, Referral to a Family Violence Specialist.

A—241.4.1 Referral to a Family Violence Specialist

Revision 15-4; Effective October 1, 2015

Advisors must send the contact information for the nearest family violence shelter to the individual pursuing the family violence exemption using Form H1071, Family Violence Exemption for Medicaid and CHIP. Form H1071 informs the individual how they can claim the family violence exemption and is sent along with Form H1020, Request for Information or Action.

The individual must contact the family violence specialist and explain the need to claim the family violence exemption. After the family violence specialist makes the recommendation, the family violence specialist completes Form H1706, Good Cause Recommendation and Family Violence Exemption, and may mail or fax the form to HHSC, or send the form back with the individual to HHSC. Only a family violence specialist can recommend the exemption using Form H1706. Form H1706 is due 10 days from the date Form H1020 was sent (or 30 days from the file date, whichever is later).

- If the family violence specialist recommends the family violence exemption, the exemption is granted and will affect all MAGI EDGs on the case by removing the offender from their MAGI household composition.
- If the family violence specialist does not recommend the family violence exemption, the exemption is denied. The advisor must re-pend the MAGI EDGs to give the individual additional time to provide the information that was originally requested for the MAGI household member.
- If Form H1706 is not returned by the due date, the exemption is denied. All pending MAGI EDGs are denied for failure to provide information that was originally requested for the MAGI household member.
- If the client withdraws the request for the family violence exemption, the client must provide the information that was originally requested for the MAGI household member by the due date, or the pending MAGI EDGs are denied.

Once the family violence exemption has been established by a family violence specialist, advisors do not need to re-evaluate the exemption. If the individual contacts HHSC to indicate that they no longer wish to receive the family violence exemption, advisors should update the page by indicating that the exemption has been withdrawn by the client.

The individual continues to receive the family violence exemption until there is a break in eligibility for all MAGI EDGs on the case. If an individual wants to pursue the family violence exemption again after a break in eligibility, advisors must follow the referral process explained in this section.

A—242 Certified Group

Revision 17-1; Effective January 1, 2017

Medical Programs

Each EDG will have one individual in the certified group.

TP 08

Parents and caretaker relatives caring for a dependent child who receives Medicaid.

TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Pregnant women, children under age 19, and parents and caretaker relatives who are ineligible for ongoing Medicaid because they are non-immigrants, undocumented aliens, or certain legal permanent resident aliens who do not meet the citizenship eligibility requirement but meet all other eligibility requirements. Only a person with an emergency medical condition is certified.

TP 40

Minor or adult pregnant woman unless disqualified from Medical Programs for not complying with TPR or SSN requirements.

TP 43

Children under age 1.

If the child is hospitalized on the child's first birthday, eligibility is continued through the month the hospitalization ends. See A-825, Medicaid Termination, for additional information.

TP 44

Children age 6 to 18. Children are eligible through the month of their 19th birthday.

Note: A child should be certified for TP 48 rather than TP 44 the month of the child's sixth birthday.

If the child is hospitalized on his 19th birthday, eligibility is continued through the month the hospitalization ends. See A-825, Medicaid Termination, for additional information.

TP 45

Children under 12 months old whose mother was eligible for and receiving Medicaid at the time of the child's birth. The mother's eligibility for the child's birth month can be determined retroactively.

TP 48

Children age 1 to 5. Children are eligible through the month of their sixth birthday.

Note: A child should be certified for TP 45 (or 43) rather than TP 48 the month of the child's first birthday.

If the child is hospitalized on the child's sixth birthday, eligibility continues through the month the hospitalization ends. See A-825, Medicaid Termination, for additional information.

TP 56

The following individuals should be certified for TP 56 if they meet all other eligibility criteria:

1. A pregnant woman with household income that exceeds the income limits for TP 40 unless disqualified from Medical Programs for not complying with:

    - TPR requirements; or
    - SSN requirements.
2. Children under age 19 with household income that exceeds the income limits for TP 43, TP 44 and TP 48 unless disqualified from Medical Programs for not complying with:
    - TPR requirements; or
    - SSN requirements.

A—250 Verification Requirements

Revision 16-3; Effective July 1, 2016

TANF

There are no verification requirements for household determination. See A-500, Age/Relationship; A-900, Domicile; and A-1000, Deprivation.

Out-of-state disqualifications for felony drug convictions must be verified.

SNAP

The following must be verified:

- household size, if questionable, or if a regional requirement;
- out-of-state disqualifications for intentional program violations;
- out-of-state disqualifications for felony drug convictions;
- compliance with parole or community supervision for individuals with a felony drug conviction on or after September 1, 2015 at each application, renewal, and when adding a new individual with a felony drug conviction at a change; and
- whether a felony drug conviction is:
    - subsequent to another felony drug conviction on or after September 1, 2015; and
    - received while the individual was receiving SNAP.

The individual's statement is acceptable about who buys and prepares meals, unless questionable.

An elderly and person with disabilities claiming separate household status must provide verification of:

- meeting criteria in B-432.1, Social Security's Criteria for Disability, if questionable; and
- other household members' income.

Medical Programs

In order for an advisor to determine an individual’s MAGI household composition, each individual on the application must provide his or her tax status, which will identify the individual as a taxpayer, tax dependent, or a non-taxpayer/non-tax dependent. Additionally, applicants must provide the following information on their tax relationships to one another:

- a taxpayer who plans to claim one or more dependents must provide the name(s) of the dependent(s);
- a taxpayer who plans to file a joint federal income tax return with a spouse must provide the spouse’s name;
- a taxpayer who plans to file a separate federal income tax return from his or her spouse must provide the name and filing status of the spouse; and
- a tax dependent must provide the name of the taxpayer(s) who expects to claim him or her.

Note: For a pregnant woman, if tax status information is not available and the client cannot be reached, the advisor can create a Medicaid for Pregnant Women (TP 40) EDG and certify the pregnant woman by postponing verification of tax status, as explained in A-145.1, Postponed Verification Procedures. TIERS will use the non-tax payer/non-tax dependent household rules to build and pend the TP 40 EDG for the tax status information. Advisors must verify tax status for a TP 40 EDG after certification if the tax status was not verified by the client during the eligibility determination.

A—251 Verification Sources

Revision 17-2; Effective April 1, 2017

SNAP and TANF

- Current school record showing the same address as the specified relative
- Visual observation of the child
- Statement from non-relative landlord
- Statement from non-relative neighbor
- Hospital, clinic, health department or private doctor's record
- Statement from clergy
- Court child support order
- Juvenile court records
- Child welfare records
- Marriage license/certificate
- Juvenile Medicaid Tracker (only for those placed or released by the Texas Juvenile Justice Department/Juvenile Probation Department)

An out-of-state human services agency can verify intentional program violations and felony drug convictions.

TANF

An out-of-state human services agency can verify time limits.

SNAP

Compliance with parole or community supervision for individuals with a felony drug conviction on or after September 1, 2015 can be verified using:

- Form H1806, Parole/Community Supervision Report; or
- answers to the parole or community supervision compliance questions submitted online through YourTexasBenefits.com or the Your Texas Benefits Mobile App when the individual who has the felony drug conviction is the same individual who:
  - signed the online application;
  - signed the renewal; or
  - submitted the change.

Subsequent felony drug convictions while receiving SNAP can be verified using:

- Criminal history in Data Broker
- Out-of-state human services agency
- TIERS inquiry

Medical Programs

The client's statement is an acceptable verification source for MAGI household composition, including an individual's tax status and tax relationships.

Related Policy
Questionable Information, C-920
Providing Verification, C-930

A—260 Documentation Requirements

Revision 16-3; Effective July 1, 2016

TANF and TP 08

An explanation of persons living in the home who are not included on the EDG must be documented for TANF and TP 08. See A-540, Documentation Requirements; A-950, Documentation Requirements; and A-1080, Disability Verification, for documentation requirements for relationship, domicile and deprivation.

TANF

The following must be documented:

- specific reason for designating a representative payee;
- basis for giving separate household status to married minors;
- name and telephone number of the out-of-state human services employee;
- months of TANF cash assistance received in other states since October 1999 by an adult household member;
- that the household was informed of the one-time payment at application and whether the caretaker requested it or declined it; and
- that a grandparent was informed of the one-time grandparent payment at application or periodic review if the grandparent is potentially eligible and whether they requested it or declined it.

SNAP

The following must be documented:

- explanation of the household composition;
- basis of granting separate household status;
- individual's response to Data Broker information if the individual disagrees with the information;
- reason for an OIG referral resulting from the Data Broker criminal history record for a felony drug conviction;
- the result of OIG's findings;
- disqualification status of any disqualified household member;
- name and telephone number of the out-of-state human services employee who provides verification;
- name of the household member currently disqualified for an intentional program violation in another state (see B-941, Disqualifying a Household Member with a Current SNAP Out-of-State IPV Disqualification, for additional documentation requirements); and
- number of any countable months of benefits received in another state as an able bodied adult without dependents (ABAWD).

Related Policy
The Texas Works Documentation Guide

TWH, A-300, Citizenship

Revision 18-1; Effective January 1, 2018

A-310 General Policy

Revision 13-2; Effective April 1, 2013

All Programs

U.S. citizens and certain legally-admitted alien residents are eligible for benefits if they meet all other eligibility criteria.

A person born in the 50 states, District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, America Samoa, Swain's Island or Northern Marianna Islands is considered a U.S. citizen.

A person born abroad to at least one U.S. citizen parent may claim derivative citizenship. See How to Verify Citizenship, A-351.4.

Exception: Undocumented aliens applying for Emergency Medicaid do not have to meet citizenship status eligibility requirements.

A—311 Alien Status Policies

Revision 18-1; Effective January 1, 2018

All Programs

Before certifying any alien resident, the advisor must ensure that the individual is legally admitted by the U.S. Citizenship and Immigration Services (USCIS) to reside in the United States and meets the definition of a "qualified immigrant" as specified in A-311.1, Definition of Qualified Immigrant. See A-352, Verification of Alien Status.

The advisor must use the alien's USCIS document(s) and the charts in A-340, Qualified Alien Status Eligibility Charts, to determine the programs for which the alien is potentially eligible. The advisor may check USCIS documents for expiration dates. An expired document is not acceptable. Advisors must disqualify aliens who do not have acceptable alien status.

Exception: If the individual's USCIS document is expired and the Systematic Alien Verifications for Entitlements (SAVE) response shows the individual is a Lawful Permanent Resident – Employment Authorized and the Date Admitted To response is Indefinite, the individual meets alien status criteria. These individuals must not be disqualified.

Notes:

- See A-342, TANF and Medical Programs Alien Status Eligibility Charts, for Emergency Medicaid eligibility for aliens who do not have acceptable status.
- Before disqualifying an alien with an expired document, check the expiration date of the document on the SAVE Program.USCIS automatically extends certain I-766s, Employment Authorization Documents, for up to 180 days when USCIS receives a renewal application for the document. When this occurs, SAVE will display the new expiration date.Do not disqualify the individual if SAVE shows that the I-766 is current.

Related Policy
Verifying Alien's USCIS Documents, A-355

A—311.1 Definition of Qualified Immigrant

Revision 13-2; Effective April 1, 2013

All Programs

The USCIS defines a qualified immigrant as an alien in one of the following categories:

Lawful Permanent Resident (LPR) — lawfully admitted for legal permanent residence in the U.S. This category also includes Amerasians admitted under Section 584 of the Foreign Operations, Export Financing and Related Programs Appropriation Act of 1988.

Asylee — granted asylum under Section 208 of the Immigration and Nationality Act (INA).

Refugee — admitted to the U.S. under Section 207 of the INA.

Parolee — paroled into the U.S. under Section 212(d)(5) of the INA for at least one year.

Deportation (or Removal) Withheld — deportation is being withheld under Section 243(h) of the INA, or removal is withheld under Section 241(b)(3) of the INA.

Conditional Entrant — granted conditional entry under Section 203(a)(7) of the INA as in effect before April 1, 1980.

Battered Alien — a battered spouse, battered child or parent, or child of a battered person with a petition pending; (See A-343, How to Determine Eligibility for Battered Aliens).

Cuban or Haitian Entrant — admitted under Section 501(e) of the Refugee Education Assistance Act of 1980.

Trafficking Victims – victims admitted under the Trafficking Victims Protection Act of 2000.

Iraqi and Afghan Special Immigrants (SIV) – special immigrant status under 101(a)(27) of the INA may be granted to Iraqi and Afghan nations who have worked on behalf of the U.S. government in Iraq or Afghanistan. The Department of Defense Appropriations Act of 2010, PL 111-118, 120 enacted on December 19, 2009, provides that SIV are eligible for all benefits to the same extent and the same period of time as refugees.

Note: All of the above are listed in A-340, Qualified Alien Status Eligibility Charts.

A—312 Contact with the U.S. Citizenship and Immigration Services (USCIS)

Revision 15-4; Effective October 1, 2015

TANF and SNAP

An illegal alien is one who has received a final deportation order. Advisors must report applicants who are illegal aliens to USCIS in writing. The supervisor must sign a written notification and send it to the nearest USCIS office, which can be found at https://egov.uscis.gov/crisgwi/go?action=offices.type&OfficeLocator.office_type=LO.

Except for using the SAVE Verification Information System (VIS), advisors may contact USCIS on behalf of an alien only at the individual's written request. If the alien does not wish to contact USCIS or give the advisor permission, the advisor must advise the household that the household may be certified without the alien (that is, disqualify the alien).

A—313 Absence of Proof of Alien Status

Revision 15-4; Effective October 1, 2015

SNAP and TANF

Advisors must disqualify a household member from the certified group if the member does not have or refuses to provide proof of alien status. The remaining members of the group are certified if they meet all eligibility requirements.

Related Policy

TANF — Budgeting for a Legal Parent Disqualified for Alien Status, Failure to Prove Citizenship, Noncompliance with the Unmarried Minor Parent Domicile Requirement or State Time Limits, A-1362.1

SNAP — Budgeting for Members Disqualified for Citizenship, 18-50 Work Requirement or Noncompliance with Social Security Number Requirements, A-1362.3

TANF

If the applicant cannot provide proof of eligible alien status for a child, the child is considered ineligible rather than disqualified.

Medical Programs

If the applicant cannot provide proof of eligible alien status after the period of reasonable opportunity explained in A-351.1, Reasonable Opportunity, the applicant is ineligible for benefits.

Household members are included in the budget group even if the member does not have proof of alien status. See A-241.1, Who Is Included.

A—314 Re-verification of Alien Status Due to a USCIS Document's Expiration Date

Revision 18-1; Effective January 1, 2018

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Advisors must re-verify the alien's USCIS card if the:

- USCIS document has expired; and
- alien wants to continue receiving or reapplies for benefits.

Advisors must allow an alien 10 days to update the card with the USCIS. If the individual cannot provide an updated document or proof within 10 days, the alien is disqualified until the individual provides a valid USCIS card or proof of application for a new card.

Exception: If the individual's USCIS document is expired and the SAVE response shows the individual is a Lawful Permanent Resident - Employment Authorized and the Date Admitted To response is Indefinite, the individual meets alien status criteria. These individuals must not be disqualified.

TANF and Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

When a certified alien's USCIS document expires before the periodic review date, the advisor must schedule a special review the month the document expires.

SNAP

Advisors must set the certification period to end the same month the USCIS document expires or schedule a special review for the month the document expires.

For streamlined reporting (SR) households, the advisor must not set a special review for the month the document expires. A document that expires during the SR certification period does not cause an individual to lose eligibility. The advisor may assume that the household will renew the document upon expiration and re-evaluate at the next certification.

Related Policy
Alien Status Policy, A-311

A—315 Definition of Public Charge

Revision 15-4; Effective October 1, 2015

All Programs

A public charge is defined by law as an alien who has applied for and received public cash assistance for income maintenance, such as Temporary Assistance for Needy Families (TANF) cash assistance, Supplemental Security Income (SSI) or institutionalization for long-term care at government expense, such as nursing home care.

A—315.1 Providing Information to Immigrants Regarding Public Charge

Revision 15-4; Effective October 1, 2015

TANF

If an immigrant inquires, staff must inform the individual that receipt of TANF cash benefits places the immigrant at risk of being considered a public charge and the individual may lose his or her immigrant status.

Exception: According to USCIS, the following individuals are exempt from public charge:

- refugees,
- asylees,
- asylum applicants,
- refugees and asylees applying for adjustment of permanent resident status,
- Cuban/Haitian entrants and parolees,
- Special Immigrant Visa holders from Iraq and Afghanistan,
- Amerasian immigrants (for their initial admission),
- individuals granted relief under the Cuban Adjustment Act (CAA),
- individuals granted relief under the Nicaraguan and Central American Relief Act (NACARA),
- individuals granted relief under the Haitian Refugee Immigration Fairness Act (HRIFA),
- individuals applying for a T Visa,
- individuals applying for a U Visa,
- individuals who possess a T Visa and are trying to become a permanent resident,
- individuals who possess a U Visa and are trying to become a permanent resident,
- individuals who have been certified by the Office of Refugee Resettlement as a victim of trafficking (prior to being issued a T Visa by USCIS),
- applications for Temporary Protected Status (TPS), and

- certain applicants under the LIFE Act Provisions.

SNAP and Medical Programs

If an immigrant inquires, the advisor must assure the individual that receipt of Supplemental Nutrition Assistance Program (SNAP) and/or medical program benefits does not place the immigrant at risk of becoming a public charge.

A—315.2 Receiving Other Benefits

Revision 15-4; Effective October 1, 2015

All Programs

There are other public assistance programs that immigrants may apply for that do not result in public charge considerations. These programs include: Special Supplemental Nutrition Program for Women, Infants and Children (WIC), immunizations, prenatal care, testing and treatment of communicable diseases, emergency medical assistance, emergency disaster relief, housing assistance, and child care.

A—316 Sponsored Alien

Revision 15-4; Effective October 1, 2015

All Programs

A sponsored alien is an individual who has been sponsored by a person who signed an affidavit of support (USCIS Form I-864 or I-864-A)on or after December 19, 1997, agreeing to support the alien as a condition of the alien's entry into the U.S.

A sponsor is someone who brings family-based or certain employment-based immigrants to the U.S. and demonstrates that he or she can provide enough financial support to the immigrant so that the individual does not rely on public benefits.

If necessary, advisors use the SAVE system to verify whether an alien has a sponsor. The SAVE system, through additional verification, can provide the sponsor's name and address.

A—316.1 Providing Verification of the Alien's Sponsor Income and Resources

Revision 16-2; Effective April 1, 2016

TANF, SNAP, TP 08, TP 43, TP 44, TP 48, TP 40, TP 07, TP 20, TP 56, TP 70, TA 84 and TA 85

For cases involving aliens and their sponsors, the alien is responsible for getting all verification from the sponsor and sponsor's spouse.

Request the following information from the alien if not otherwise available through Systematic Alien Verification for Entitlement (SAVE) or Texas Integrated Eligibility Redesign System (TIERS) inquiry or case documentation:

- Alien sponsor name,
- Alien sponsor date of birth,
- Alien sponsor Social Security number,
- Alien sponsor earned income,
- Alien sponsor unearned income,
- Alien sponsor self-employment income,
- Alien sponsor resources (if applicable, as explained in A-1245, Resources of an Alien’s Sponsor), and

- Alien sponsor citizenship status or alien number if the sponsor is a lawful permanent resident.

The income and resources (if applicable) of an alien's sponsor (and the sponsor's spouse if the spouse also signed an affidavit of support, USCIS Form I-864) must be counted (deemed) as belonging to the sponsored alien, regardless of actual availability when determining the sponsored alien's eligibility and benefit amounts.

Deeming of the sponsor's income and resources (if applicable) to the sponsored alien lasts until the:

- sponsored alien becomes a naturalized citizen,
- sponsored alien can be credited with 40 qualifying quarters of work, or
- sponsor dies.

Sponsored aliens not subject to sponsor deeming are:

- children under age 18;
- sponsored aliens who are ineligible for benefits (examples include those who are disqualified from getting benefits or those considered non-members, such as students who do not meet SNAP student eligibility criteria);
- battered spouses or children;
- refugees, parolees, asylees, people granted withholding of deportation, Amerasians, trafficking victims, and Iraqi and Afghan special immigrants;
- aliens whose sponsor has not signed an affidavit of support;
- aliens whose sponsor is in the same household/Modified Adjusted Gross Income (MAGI) household composition; and
- indigent aliens.

TANF, TP 08, TP 43, TP 44, TP 48, TP 40, TP 07, TP 20, TP 56, TP 70, TA 84 and TA 85

If the sponsored alien fails to provide sponsor verification by the required date in B-115, Pending Verification on Applications, the alien's application is denied.

Note: Resources of an alien sponsor must only be verified if resources are counted for that program, as explained in A-1245.

SNAP

If the sponsored alien fails to provide sponsor verification by the required date in B-115, the sponsored alien is disqualified until the alien provides the proof. If eligible, remaining household members may participate while the alien is disqualified. If the disqualified alien later provides the proof, the advisor processes it as a reported change. The Eligibility Determination Group (EDG) is denied if the household fails to provide proof of the disqualified alien's own income.

Related Policy

Resources of an Alien's Sponsor, A-1245
Alien Sponsor's Income, A-1361

A—320 Definitions of Military Connection

Revision 12-4; Effective October 1, 2012

A—321 Veteran

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

A veteran is eligible for benefits because of a military connection if the veteran is:

- "honorably discharged" from the armed service, and
- meets the minimum active duty requirement of:
  - 24 months of continuous active duty, or
  - the full period the person was called or ordered to active duty.

Individuals who served in the Philippine Commonwealth Army during World War II, or as Philippine scouts following the war, are veterans for purposes of eligibility.

Related Policy

Verification of Veteran Status, A-353.1

A—322 Active Duty Military Member

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

An active duty military member is eligible for benefits because of a military connection if currently on full-time duty in the U.S. Army, Navy, Air Force, Marine Corps or Coast Guard. It does not include full-time National Guard duty.

Active duty training as a member of the Reserves, Army National Guard, or Air National Guard does not establish eligibility for the individual. The advisor must determine that training is not the reason the reserve member is on active duty.

Related Policy

Verification of Active Duty Military, A-353.2

A—323 Spouse or Minor Unmarried Dependent Child of Veteran or Active Duty Military Member

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

A spouse is eligible for benefits because of a military connection if the individual is currently married to a veteran or active duty military member. A minor unmarried dependent child under age 18 is eligible.

Related Policy

Verification of a Spouse or Minor Unmarried Dependent Child of a Veteran or Active Duty Military Member or Unmarried Surviving Spouse of a Deceased Veteran or Active Duty Military Member, A-353.3

A—324 Unmarried Surviving Spouse of a Deceased Veteran or Active Duty Military Member

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

To meet the alien eligibility status as a surviving spouse of a deceased veteran or an active-duty military member, the spouse must not have remarried, and the marriage to the veteran or active duty military member must fulfill one of the following requirements:

- lasted at least one year;

- occurred within 15 years after the period of service in which the injury or disease that resulted in the death of the veteran or active duty member ended; or
- a child was born between the surviving spouse and the veteran or active duty member, either during or before the marriage.

Related Policy

Verification of a Spouse or Minor Unmarried Dependent Child of a Veteran or Active Duty Military Member or Unmarried Surviving Spouse of a Deceased Veteran or Active Duty Military Member, A-353.3

SNAP

If a currently certified surviving spouse remarries, the spouse retains eligible alien status through the end of the current certification period.

A—330 Lawful Permanent Resident (LPR) and 40 Qualifying Quarters of Social Security Coverage

Revision 18-1; Effective January 1, 2018

TANF and Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

LPRs admitted prior to Aug. 22, 1996, meet the alien eligibility requirement by having 40 qualifying quarters of social security coverage. LPRs admitted on or after Aug. 22, 1996, meet the alien eligibility requirement by having 40 countable qualifying quarters of social security coverage, **if five years** have passed since the legal date of entry. An LPR does not have to meet the 40-quarter requirement, including the five-year wait, if any of the following apply.

The alien:

- has a military connection;
- entered the U.S. with a status described in Chart C of A-342, TANF and Medical Programs Alien Status Eligibility Charts, and meets the eligibility criteria for refugees, asylees, etc., or meets the criteria in A-343, How to Determine Eligibility for Battered Aliens; and
- is a qualified immigrant or non-immigrant child age 18 and under who lawfully resides in the U.S. with a status described in Chart D of A-342, TANF and Medical Programs Alien Status Eligibility Charts.

SNAP

LPRs with 40 qualifying quarters meet the alien eligibility requirement. An LPR does not have to meet the 40-quarter requirement if the alien:

- lawfully resided in the U.S. as a qualified immigrant for five years from the date of entry;
- was admitted to the U.S. on or before Aug. 22, 1996, and was age 65 or older on Aug. 22, 1996;
- meets the definition of disability in B-432, Definition of Disability (regardless of when the alien acquired a disability or entered the U.S.);
- is currently under age 18 (regardless of when the alien entered the U.S.);
- has a military connection; or
- qualifies as a refugee, asylee, etc., as shown in Chart A of A-341, SNAP Alien Status Eligibility Charts.

Related Policy
Verifying 40 "Qualifying Quarters," A-354

A—331 Whose Quarters Can Be Considered

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

For purposes of establishing eligibility through the use of the 40 "qualifying quarters" requirement, LPRs are credited with quarters of earnings for the:

- LPR,
- LPR's current spouse or deceased spouse regardless if the spouse is an LPR or a U.S. citizen, and
- LPR's parent before the LPR turned age 18. This includes adoptive parents or stepparents.

Note: All of the quarters earned by the LPR's parents through the quarter the LPR turns age 18 are counted.

When determining whether to credit the quarters to an individual's spouse, the advisor must count quarters earned:

- beginning with the quarter from the date of marriage, and
- by a deceased spouse only if the marriage was not terminated before the spouse died.

Quarters earned by divorced spouses for either ex-spouses do not count. LPRs who divorce after certification retain their eligible alien status through the end of the current certification period. This also applies to stepchildren.

Until the quarter a child turns age 18, to meet the 40-quarter requirement, a child may use quarters earned by:

- natural or adoptive parents;
- stepparents from the date of marriage to the legal parent; and
- deceased parents.

Related Policy

Verifying 40 "Qualifying Quarters," A-354

A—340 Qualified Alien Status Eligibility Charts

Revision 18-1; Effective January 1, 2018

An alien's eligibility is based on the USCIS status and other criteria as shown in A-341, SNAP Alien Status Eligibility Charts, and A-342, TANF and Medical Programs Alien Status Eligibility Charts.

A—341 SNAP Alien Status Eligibility Charts

Revision 18-1; Effective January 1, 2018

Chart A

Advisors use the following chart to determine if a qualified alien meets the eligibility requirements to receive SNAP benefits. These aliens are eligible for benefits indefinitely, except a victim of severe trafficking.

If the qualified alien was admitted as a/an …	and the USCIS document provided is a/an …	then the alien is …
Refugee	• ***I-551**, Permanent Resident Card, annotated with R8-6, RE-1 thru RE-9 • **I-94**, Arrival/Departure Record, annotated with INA Section 207 or Refugee • Original certification letter from the Office of Refugee Resettlement (ORR) • **I-766**, Employment Authorization Document, annotated with Code A3	**eligible from date of entry.**

Asylee	• ***I-551**, Permanent Resident Card, annotated with AS-6 thru AS-8 • **I-94**, Arrival/Departure Record, annotated with INA Section 208 or Asylee • **I-766**, Employment Authorization Document, annotated with Code A5 • USCIS letter from Asylum Office • Order from an immigration judge granting asylum	**eligible from date of entry.**
Deportation Withheld	• **I-94**, Arrival/Departure Record, annotated with INA Section 243(h) or 241(b)(3) • **I-766**, Employment Authorization Document, annotated with Code A10 • Order from an immigration judge showing deportation withheld under INA Section 243(h) or 241(b)(3). Consider the date of entry as the date the status was assigned.	**eligible from date of entry.**
Cuban/Haitian Entrant	• ***I-551**, Permanent Resident Card, annotated with R8-6, CH-6, CU-6, CU-7 • **I-94**, Arrival/Departure Record, annotated with INA Section 212(d)(5) or Cuba/Haitian Entrant • **I-94**, Arrival/Departure Record, annotated with INA Section 240, Pending Hearing – Cuban granted parole for one year • **I-94**, Arrival/Departure Record, annotated as Public Interest Parole • **I-766**, Employment Authorization Document, annotated with Code C8 • Receipt from INS Asylum Office indicating filing of Form I-589, Application for Asylum	**eligible from date of entry.**
Haitian Orphan	• **I-94**, Arrival/Departure Record, indicating the person has humanitarian "parole" status admitted after January 12, 2010 • **Immigrant visa** indicating the person was lawfully admitted for permanent residence • ***I-551**, Permanent Resident Card, annotated with Status Code CH-6	**eligible from date of entry.**
Amerasian	***I-551**, Permanent Resident Card, annotated with one of the following Status Codes: **AM-1, AM-2, AM-3, AM-6, AM-7** or **AM-8**	**eligible from date of entry.**
Victim of Severe Trafficking	• Derivative T Visa annotated with **T-1** • Derivative T Visa annotated with **T-2, T-3, T-4, T-5** (family members of a victim of severe trafficking)	**eligible up to four years from date of entry or until the law enforcement extension expires.**
Afghani or Iraqi Special Immigrant	Passport with a stamp noting that the individual has been admitted under a special immigrant visa category **IV** with one of the following codes: • **SI-1** or **SQ-1** for the principal applicant; • **SI-2** or **SQ-2** for the spouse of the principal applicant; • **SI-3** or **SQ-3** for the unmarried child under age 21 of the principal applicant; and a • Department of Homeland Security (DHS) stamp or notation on passport or **I-94**, showing date of entry. For those special immigrants who are adjusting their status to LPR status in the U.S.: ***I-551,** Permanent Resident Card, annotated with one of the following status codes:	**eligible from date of entry.**

	• **SI-6** or **SQ-6** for the principal applicant, • **SI-7** or **SQ-7** for the spouse of the principal applicant, or • **SI-9** or **SQ-9** for the unmarried child under age 21 of the principal applicant. These special immigrants also may demonstrate nationality with an Afghani or Iraqi passport. **Note:** The entry date for an Afghani special immigrant must be Dec. 26, 2007, or later. An Iraqi special immigrant's entry date must be Jan. 26, 2008, or later.	

*An I-551, Permanent Resident Card, does not always include the holder's signature. See A-355, Verifying Alien's USCIS Documents.

Note: The category of aliens listed in Chart A are eligible for SNAP benefits from the date they adjust to any of the specific statuses listed in the chart. For example, once an alien is granted asylee status, the immigrant is potentially eligible for SNAP benefits.

Chart B

Advisors use the following chart to determine the eligibility of these particular qualified aliens. Their eligibility is indefinite regardless of their date of entry into the U.S.

If the alien was admitted as a …	and the USCIS document provided is an …	then the alien is eligible if the alien …
Parolee	• **I-94**, Arrival/Departure Record, showing admission for at least one year under INA Section 212(d)(5) or Parolee • **I-766**, Employment Authorization Document, annotated with A-4 or C-11	• has lawfully resided as a qualified immigrant in the U.S. for five years; • meets the SNAP definition of disability in B-432, Definition of Disability (regardless of when the alien acquired a disability or when the alien entered the U.S.); • is currently under age 18 (regardless of when the alien entered the U.S.); or • is the spouse, unmarried surviving spouse or minor unmarried dependent child of an honorably discharged veteran or is an active duty military member.
Conditional Entrant	• **I-94**, Arrival/Departure Record, annotated with INA Section 203(a)(7) • **I-766**, Employment Authorization Document, annotated with A3	• has lawfully resided as a qualified immigrant in the U.S. for five years; • meets the SNAP definition of disability in B-432 (regardless of when the alien acquired a disability or when the alien entered the U.S.); • is currently under age 18 (regardless of when the alien entered the U.S.); or • is the spouse, unmarried surviving spouse or minor unmarried dependent child of an honorably discharged veteran or is an active duty military member.

Chart C

Use the chart below to determine eligibility for Legal Permanent Residents.

If the qualified alien was admitted as a …	and the USCIS document provide is an …	then the alien is eligible if the alien …

If the qualified alien was admitted as a …	and the USCIS document provide is an …	then the alien is eligible if the alien …

Legal Permanent Resident	• **I-151**, Alien Registration Receipt Card (also known as a Green Card)
	• **I-551**, Resident Alien Card
	• ***I-551**, Permanent Resident Card (introduced December 1997)
		• has lawfully resided as a qualified immigrant in the U.S. for five years;
		• meets the SNAP definition of disability in B-432 (regardless of when the alien acquired a disability or when the alien entered the U.S);
		• is currently under age 18 (regardless of when the alien entered the U.S.);
		• meets the 40 qualifying quarters requirement in A-354, Verifying 40 "Qualifying Quarters";
		• is an honorably discharged veteran who met the minimum active duty requirements for:
		  ◦ 24 months; or
		  ◦ the period for which the person was called to active duty; or
		• is an active duty military member; or
		• is the spouse, unmarried surviving spouse or minor dependent child of an honorably discharged veteran or active duty military member.
		
		Note: To qualify for SNAP as a surviving spouse of a deceased veteran or an active duty military member, the surviving spouse must not have remarried.

*An I-551, Permanent Resident Card, does not always include the holder's signature. See A-355, Verifying Alien's USCIS Documents.

Chart D

If the alien was admitted as a …	and the USCIS document provided is an …	then the alien is …
• **Native American born in Canada who is entitled by treaty to reside in the U.S.**	• ***I-551**, Permanent Resident Card, annotated with KIP – Kickapoo Indian Pass • ***I-551** annotated with S13 – American Indian born in Canada • A letter or other tribal document certifying at least 50 percent American Indian blood, as required by INA Section 289, combined with a birth certificate or other satisfactory evidence of birth in Canada	eligible.
• **Hmong or Highland Lao tribe member when the tribe assisted the U.S. Armed Forces during the Vietnam War, or their spouses, unmarried dependent children and the unremarried widow(er)s of those who are deceased**	**I-94** or ***I-551**	eligible if the immigrant: • is from Laos, Vietnam or Cambodia; and • claims to be a member of a Hmong or Highland Laotian tribe.

*An I-551, Permanent Resident Card, does not always include the holder's signature. See A-355, Verifying Alien's USCIS Documents.

A—342 TANF and Medical Programs Alien Status Eligibility Charts

Revision 18-1; Effective January 1, 2018

Chart A

Staff should use the following chart to determine eligibility for qualified aliens who were admitted into the U.S. before August 22, 1996.

If the qualified alien was admitted as a/an …	and the USCIS document is a/an …	then the alien is …

Refugee	• ***I-551**, Permanent Resident Card, annotated with R8-6, RE1 thru RE9
	• **I-94**, Arrival/Departure Record, annotated with INA Section 207 or Refugee
	• **I-766**, Employment Authorization Document, annotated with Code **A-3**
		• eligible for TANF; and
		• eligible for Medicaid if the alien meets one of the following requirements:
		  ○ honorably discharged veteran or active duty member of the U.S. armed forces;
		  ○ spouse (including unmarried surviving spouse) of honorably discharged veterans or active duty members;
		  ○ dependent child of honorably discharged veteran or active duty member;
		  ○ American Indian born in Canada;
		  ○ member of a federally recognized Indian tribe;
		  ○ received SSI and/or Medicaid on 8/22/96 and lawfully resided in the U.S. on or before 8/22/96; or
		  ○ LPR credited with 40 qualifying quarters of Social Security coverage.
		• **Note:** Permanently Residing Under Color of Law (PRUCOL) aliens are not eligible.

Asylee	• ***I-551**, Permanent Resident Card, annotated with AS-6 thru AS-9
	• **I-94**, Arrival/Departure Record, annotated with INA Section 208 or Asylee
	• **I-766**, Employment Authorization Document, annotated with Code A5
	• USCIS Asylum Office letter
	• Order from an immigration judge granting asylum
		• eligible for TANF; and
		• eligible for Medicaid if the alien meets one of the following requirements:
		  ○ honorably discharged veteran or active duty member of the U.S. armed forces;
		  ○ spouse (including unmarried surviving spouse) of honorably discharged veterans or active duty members;
		  ○ dependent child of honorably discharged veteran or active duty member;
		  ○ American Indian born in Canada;
		  ○ member of a federally recognized Indian tribe;
		  ○ received SSI and/or Medicaid on 8/22/96 and lawfully resided in the U.S. on or before 8/22/96; or
		  ○ LPR credited with 40 qualifying quarters of Social Security coverage.
		• **Note:** Permanently Residing Under Color of Law (PRUCOL) aliens are not eligible.

If the qualified alien was admitted as a/an …	and the USCIS document is a/an …	then the alien is …

Deportation Withheld	• **I-94**, Arrival/Departure Record, annotated with INA Section 243(h) or 241(b)(3)
	• **I-766**, Employment Authorization Document, annotated with code A10
	• Order from an immigration judge showing deportation withheld under INA Section 243(h) or Section 241(b)(3). Consider the date of entry as the date the status was assigned.
		• eligible for TANF; and
		• eligible for Medicaid if the alien meets one of the following requirements:
		  ○ honorably discharged veteran or active duty member of the U.S. armed forces;
		  ○ spouse (including unmarried surviving spouse) of honorably discharged veterans or active duty members;
		  ○ dependent child of honorably discharged veteran or active duty member;
		  ○ American Indian born in Canada;
		  ○ member of a federally recognized Indian tribe;
		  ○ received SSI and/or Medicaid on 8/22/96 and lawfully resided in the U.S. on or before 8/22/96; or
		  ○ LPR credited with 40 qualifying quarters of Social Security coverage.
		• **Note:** Permanently Residing Under Color of Law (PRUCOL) aliens are not eligible.

Cuban/Haitian Entrant	• ***I-551**, Permanent Resident Card, annotated with R8-6, CH-6, CU-6 or CU-7
	• **I-94**, Arrival/Departure Record, annotated with INA Section 212(d)(5) or Cuban/Haitian Entrant
	• **I-94**, Arrival/Departure Record, annotated with INA Section 240 Pending Hearing – Cuban granted parole for one year
	• **I-94**, Arrival/Departure Record, annotated with Public Interest Parolee
		• eligible for TANF; and
		• eligible for Medicaid if the alien meets one of the following requirements:
		  ○ honorably discharged veteran or active duty member of the U.S. armed forces;
		  ○ spouse (including unmarried surviving spouse) of honorably discharged veterans or active duty members;
		  ○ dependent child of honorably discharged veteran or active duty member;
		  ○ American Indian born in Canada;
		  ○ member of a federally recognized Indian tribe;
		  ○ received SSI and/or Medicaid on 8/22/96 and lawfully resided in the U.S. on or before 8/22/96; or
		  ○ LPR credited with 40 qualifying quarters of Social Security coverage.
		• **Note:** Permanently Residing Under Color of Law (PRUCOL) aliens are not eligible.

If the qualified alien was admitted as a/an …	and the USCIS document is a/an …	then the alien is …

Haitian Orphan	• **I-94**, Arrival/Departure Record, indicating person has humanitarian "parole" status admitted on or after January 12, 2010
	• **Immigrant visa** indicating the person was lawfully admitted for permanent residence
	• ***I-551**, Permanent Resident Card, annotated with status code **CH-5**
		• eligible for TANF; and
		• eligible for Medicaid if the alien meets one of the following requirements:
		  ○ honorably discharged veteran or active duty member of the U.S. armed forces;
		  ○ spouse (including unmarried surviving spouse) of honorably discharged veterans or active duty members;
		  ○ dependent child of honorably discharged veteran or active duty member;
		  ○ American Indian born in Canada;
		  ○ member of a federally recognized Indian tribe;
		  ○ received SSI and/or Medicaid on 8/22/96 and lawfully resided in the U.S. on or before 8/22/96; or
		  ○ LPR credited with 40 qualifying quarters of Social Security coverage.
		• **Note:** Permanently Residing Under Color of Law (PRUCOL) aliens are not eligible.

Amerasian	• ***I-551**, Permanent Resident Card, annotated with one of the following status codes: **AM-1, AM-2, AM-3, AM-6, AM-7 or AM-8**	• eligible for TANF; and
		• eligible for Medicaid if the alien meets one of the following requirements:
		  ○ honorably discharged veteran or active duty member of the U.S. armed forces;
		  ○ spouse (including unmarried surviving spouse) of honorably discharged veterans or active duty members;
		  ○ dependent child of honorably discharged veteran or active duty member;
		  ○ American Indian born in Canada;
		  ○ member of a federally recognized Indian tribe;
		  ○ received SSI and/or Medicaid on 8/22/96 and lawfully resided in the U.S. on or before 8/22/96; or
		  ○ LPR credited with 40 qualifying quarters of Social Security coverage.
		• **Note:** Permanently Residing Under Color of Law (PRUCOL) aliens are not eligible.

If the qualified alien was admitted as a/an …	and the USCIS document is a/an …	then the alien is …

Parolee	• **I-94**, Arrival/Departure Record, annotated with INA Section 212(d)(5) showing admission for at least one year
	
	Note: This does not include Cuban/Haitian entrants.
		• eligible for TANF; and
		• eligible for Medicaid if the alien meets one of the following requirements:
		  ○ honorably discharged veteran or active duty member of the U.S. armed forces;
		  ○ spouse (including unmarried surviving spouse) of honorably discharged veterans or active duty members;
		  ○ dependent child of honorably discharged veteran or active duty member;
		  ○ American Indian born in Canada;
		  ○ member of a federally recognized Indian tribe;
		  ○ received SSI and/or Medicaid on 8/22/96 and lawfully resided in the U.S. on or before 8/22/96; or
		  ○ LPR credited with 40 qualifying quarters of Social Security coverage.
		• **Note:** Permanently Residing Under Color of Law (PRUCOL) aliens are not eligible.

Conditional Entrant	• **I-94**, Arrival/Departure Record, annotated with INA Section 203(a)(7)
	• **I-766**, Employment Authorization Document, annotated with status code **A-3**
		• eligible for TANF; and
		• eligible for Medicaid if the alien meets one of the following requirements:
		  ○ honorably discharged veteran or active duty member of the U.S. armed forces;
		  ○ spouse (including unmarried surviving spouse) of honorably discharged veterans or active duty members;
		  ○ dependent child of honorably discharged veteran or active duty member;
		  ○ American Indian born in Canada;
		  ○ member of a federally recognized Indian tribe;
		  ○ received SSI and/or Medicaid on 8/22/96 and lawfully resided in the U.S. on or before 8/22/96; or
		  ○ LPR credited with 40 qualifying quarters of Social Security coverage.
		• **Note:** Permanently Residing Under Color of Law (PRUCOL) aliens are not eligible.

If the qualified alien was admitted as a/an …	and the USCIS document is a/an …	then the alien is …

Legal Permanent Resident	• **I-151**, Alien Registration Receipt Card – commonly referred to as Green Card
	• **I-551**, Resident Alien Card
	• ***I-551**, Permanent Resident Card
		• eligible for TANF; and
		• eligible for Medicaid if the alien meets one of the following requirements:
		  ○ honorably discharged veteran or active duty member of the U.S. armed forces;
		  ○ spouse (including unmarried surviving spouse) of honorably discharged veterans or active duty members;
		  ○ dependent child of honorably discharged veteran or active duty member;
		  ○ American Indian born in Canada;
		  ○ member of a federally recognized Indian tribe;
		  ○ received SSI and/or Medicaid on 8/22/96 and lawfully resided in the U.S. on or before 8/22/96; or
		  ○ LPR credited with 40 qualifying quarters of Social Security coverage.
		• **Note:** Permanently Residing Under Color of Law (PRUCOL) aliens are not eligible.

Native American born in Canada who is entitled by treaty to reside in the U.S.	• ***I-551** annotated with KIC – Kickapoo Indian Citizen
	• ***I-551** annotated with KIP – Kickapoo Indian Pass
	• ***I-551** annotated with S13 – American Indian born in Canada
	• **Letter —** A letter or other tribal document certifying at least 50 percent American Indian blood, as required by INA Section 289, combined with a birth certificate or other satisfactory evidence of birth in Canada
		• eligible for TANF; and
		• eligible for Medicaid if the alien meets one of the following requirements:
		  ○ honorably discharged veteran or active duty member of the U.S. armed forces;
		  ○ spouse (including unmarried surviving spouse) of honorably discharged veterans or active duty members;
		  ○ dependent child of honorably discharged veteran or active duty member;
		  ○ American Indian born in Canada;
		  ○ member of a federally recognized Indian tribe;
		  ○ received SSI and/or Medicaid on 8/22/96 and lawfully resided in the U.S. on or before 8/22/96; or
		  ○ LPR credited with 40 qualifying quarters of Social Security coverage.
		• **Note:** Permanently Residing Under Color of Law (PRUCOL) aliens are not eligible.

*An I-551, Permanent Resident Card, does not always include the holder's signature. See A-355, Verifying Alien's USCIS Documents.

Chart B

Staff should use the following chart to determine eligibility for TANF and Medicaid for qualified aliens admitted into the U.S. on or after August 22, 1996.

If the qualified alien was admitted as a/an …	and the USCIS document provided is a/an …	then the alien is …
Refugee	• ***I-551**, Permanent Resident Card, annotated with R8-6, RE1 thru RE9 • **I-94**, Arrival/Departure Record, annotated with INA Section 207 or Refugee • An original certification letter from the Office of Refugee Resettlement (ORR) • **I-766**, Employment Authorization Document, annotated with Code A-3	• eligible for TANF for the first five years after the legal date of entry; and • eligible for Medicaid (including Parents and Caretaker Relatives Medicaid) for the first seven years after the legal date of entry. **Notes:** • Qualified aliens retain this eligibility even if they have adjusted to LPR status. • LPRs must have 40 qualifying quarters of Social Security coverage.
Asylee	• ***I-551**, Permanent Resident Card, annotated with R8-6, AS6 thru AS-9 • **I-94**, Arrival/Departure Record, annotated with INA Section 208 or Asylee • **I-766**, Employment Authorization Document, annotated with Code A-5 • USCIS letter from Asylum office • Order from an immigration judge granting asylum	• eligible for TANF for the first five years after the legal date of entry; and • eligible for Medicaid (including Parents and Caretaker Relatives Medicaid) for the first seven years after the legal date of entry. **Notes:** • Qualified aliens retain this eligibility even if they have adjusted to LPR status. • LPRs must have 40 qualifying quarters of Social Security coverage.
Deportation Withheld	• **I-94,** Arrival/Departure Record, annotated with INA Section 243(h) or Section 241(h)(3) • **I-766**, Employment Authorization Document, annotated with Code A-10 • Order from an immigration judge showing deportation withheld under INA Section 243(h) or Section 241(b)(3). Consider the date of entry as the date the status was assigned.	• eligible for TANF for the first five years after the legal date of entry; and • eligible for Medicaid (including Parents and Caretaker Relatives Medicaid) for the first seven years after the legal date of entry. **Notes:** • Qualified aliens retain this eligibility even if they have adjusted to LPR status. • LPRs must have 40 qualifying quarters of Social Security coverage.
Cuban/Haitian Entrant	• ***I-551**, Permanent Resident Card, annotated with R8-6, CH-6, CU-6 or CU-7 • **I-94**, Arrival/Departure Record, annotated with INA Section 212(d)(5) or Cuban/Haitian Entrant • **I-94**, Arrival/Departure Record, annotated with INA Section 240, Pending Hearing – Cuban, granted parole for one year • **I-94,** Arrival/Departure Record, annotated as Public Interest Parole	• eligible for TANF for the first five years after the legal date of entry; and • eligible for Medicaid (including Parents and Caretaker Relatives Medicaid) for the first seven years after the legal date of entry. **Notes:** • Qualified aliens retain this eligibility even if they have adjusted to LPR status. • LPRs must have 40 qualifying quarters of Social Security coverage.

If the qualified alien was admitted as a/an …	and the USCIS document provided is a/an …	then the alien is …
Haitian Orphan	• **I-94**, Arrival/Departure Record, indicating person has humanitarian "parole" status admitted on after January 12, 2010 • **Immigrant visa** indicating the person was lawfully admitted for permanent residence • ***I-551**, Permanent Resident Card, annotated with Status Code **CH-6**	• eligible for TANF for the first five years after the legal date of entry; and • eligible for Medicaid (including Parents and Caretaker Relatives Medicaid) for the first seven years after the legal date of entry. **Notes:** • Qualified aliens retain this eligibility even if they have adjusted to LPR status. • LPRs must have 40 qualifying quarters of Social Security coverage.
Amerasian	***I-551**, Permanent Resident Card, annotated with one of the following status codes: **AM-1, AM-2, AM-3, AM-6, AM-7 or AM-8**	• eligible for TANF for the first five years after the legal date of entry; and • eligible for Medicaid (including Parents and Caretaker Relatives Medicaid) for the first seven years after the legal date of entry. **Notes:** • Qualified aliens retain this eligibility even if they have adjusted to LPR status. • LPRs must have 40 qualifying quarters of Social Security coverage.
Afghani or Iraqi Special Immigrant	A passport with a stamp noting that the individual has been admitted under a special immigrant visa category **IV** with one of the following codes: • **SI-1, SQ-1, SI-6 or SQ-6** for the principal applicant; • **SI-2, SQ-2, SI-7 or SQ-7** for the spouse of the principal applicant; • **SI-3, SQ-3, SI-9 or SQ-9** for the unmarried child under age 21 of the principal applicant; and a • DHS stamp or notation, on passport or **I-94**, showing date of entry. For those special immigrants who are adjusting their status to LPR status in the U.S.: ***I-551** annotated with one of the following status codes: • **SI-1, SQ-1, SI-6** or **SQ-6** for the principal applicant, • **SI-1, SQ-2, SI-7** or **SQ-7** for the spouse of the principal applicant, or • **SI-3, SQ-3, SI-9** or **SQ-9** for the unmarried child under age 21 of the principal applicant. These special immigrants also may demonstrate nationality with an Afghani or Iraqi passport. **Note:** The entry date for an Afghani special immigrant must be Dec. 26, 2007, or later. An Iraqi special immigrant's entry date must be Jan. 26, 2008, or later.	• eligible for TANF for the first five years after the legal date of entry; and • eligible for Medicaid (including Parents and Caretaker Relatives Medicaid) for the first seven years after the legal date of entry. **Notes:** • Qualified aliens retain this eligibility even if they have adjusted to LPR status. • LPRs must have 40 qualifying quarters of Social Security coverage.

If the qualified alien was admitted as a/an …	and the USCIS document provided is a/an …	then the alien is …
Victim of Severe Trafficking	• Derivative T Visa annotated with **T-1** • Derivative T Visa annotated with **T-2, T-3, T-4, or T-5** (family members of a victim of severe trafficking)	eligible up to four years from date of entry or until the law enforcement extension expires. **Note:** Qualified aliens retain this eligibility even if they have adjusted to LPR status.
Native American born in Canada who is entitled by treaty to reside in the U.S.	• ***I-551** annotated with KIC – Kickapoo Indian Citizen • ***I-551** annotated with KIP – Kickapoo Indian Pass • ***I-551** annotated with S13 – American Indian born in Canada • **Letter —** A letter or other tribal document certifying at least 50 percent American Indian blood, as required by INA Section 289, combined with a birth certificate or other satisfactory evidence of birth in Canada	eligible.
Member of a federally recognized Indian tribe	**Letter —** A letter or other tribal document that verifies membership of a federally recognized Indian tribe as defined in United States Code (U.S.C.), Title 25, Chapter 14, Subchapter II, §450b(e)	eligible.

*An I-551, Permanent Resident Card, does not always include the holder's signature. See A-355, Verifying Alien's USCIS Documents.

Note: The following link to federal regulatory language provides a list of the Indian tribes recognized by the United States Bureau of Indian Affairs.

https://www.bia.gov/tribal-leaders-directory

Chart C

Staff should use the following chart to determine eligibility for all LPRs applying for TANF and adult LPRs applying for Medicaid who were admitted into the U.S. on or after August 22, 1996.

If the alien was admitted as a …	and the USCIS document is a/an …	then the alien is …

If the alien was admitted as a …	and the USCIS document is a/an …	then the alien is …
		not eligible. **Note:** A qualified alien retains the refugee eligibility period even if they have adjusted to LPR status.
Legal Permanent Resident	• **I-151**, Alien Registration Receipt Card – commonly referred to as Green Card • **I-551**, Resident Alien Card • ***I-551**, Permanent Resident Card **Notes:** • Any status code that appears on the *I-551, Permanent Resident Card, is acceptable. • USCIS did not issue I-151s after 1978; therefore, any alien admitted after 1978 will have an *I-551. • If the LPR loses the *I-551, the LPR may present either an I-94 or a passport with the following annotation: "Processed for *I-551, Temporary Evidence of Lawful Admission for Permanent Residence, valid until _____, Employment Authorized."	**Exceptions:** An LPR meets the eligibility requirements if the LPR: • has become a naturalized citizen; • is an honorably discharged veteran or active duty military member; • is a spouse, unmarried surviving spouse or minor unmarried child of an honorably discharged veteran or active duty military member (**Note:** To qualify for TANF/MP as a surviving spouse of a deceased veteran or an active duty military member, the surviving spouse must not have remarried.); • entered the U.S. before Aug. 22, 1996, and remained continuously present in the U.S. since at least Aug. 21, 1996, until obtaining qualifying immigrant status and meets the 40 qualifiying quarters of Social Security coverage requirement. (**Note:** Aliens who entered the country without proper documents, as well as those who overstayed their visa, are treated the same as those who entered and remained in the country with valid immigration documents. Any single absence from the U.S. of more than 30 days or a combined absence of more than 90 days is considered to interrupt "continuous presence."); • Received SSI and/or Medicaid on Aug. 22, 1996, and lawfully resided in the U.S. on or before Aug. 22, 1996; • entered the U.S. with a status described in Chart B and meets those eligibility criteria, or meets the criteria in A-343, How to Determine Eligibility for Battered Aliens; or • meets the 40 qualifying quarters requirements in A-354, Verifying 40 "Qualifying Quarters," and five years have passed since the alien's legal date of entry.

If the alien was admitted as a …	and the USCIS document is a/an …	then the alien is …
Native American born in Canada who is entitled by treaty to reside in the U.S.	• ***I-551** annotated with KIC – Kickapoo Indian Citizen • ***I-551** annotated with KIP – Kickapoo Indian Pass • ***I-551** annotated with S13 – American Indian born in Canada • **Letter —** A letter or other tribal document certifying at least 50 percent American Indian blood, as required by INA Section 289, combined with a birth certificate or other satisfactory evidence of birth in Canada	eligible.
Member of a federally recognized Indian tribe	**Letter —** A letter or other tribal document that verifies membership of a federally recognized Indian tribe as defined in 25 U.S.C. §450b(e)	eligible.

*An I-551, Permanent Resident Card, does not always include the holder's signature. See A-355, Verifying Alien's USCIS Documents.

Notes:

- If the alien is ineligible for TANF or Medicaid because of citizenship or alien status, the advisor must determine the alien's eligibility for Emergency Medicaid.
- The following link to federal regulatory language provides a list of the Indian tribes recognized by the United States Bureau of Indian Affairs.

  https://www.bia.gov/tribal-leaders-directory

Chart D

Medical Programs

Certain additional qualified immigrant and non-immigrant children ages 18 and under who are lawfully residing in the U.S. may qualify for Medicaid regardless of their date of entry.

Staff should use the following chart to determine eligibility for qualified immigrant and non-immigrant children.

Exceptions:

- Texas Women's Health Program (TWHP) recipients who turn age 19 during their certification period will continue to receive TWHP until their next redetermination. Staff must review the TWHP recipient's alien status at redetermination.
- Medicaid for Transitioning Foster Care Youth (MTFCY) recipients qualify through the month of their 21st birthday.
- Medicaid for Former Foster Care Children (FFCC) recipients qualify through the month of their 21st birthday.
- Medicaid for Breast and Cervical Cancer (MBCC) recipients who applied before their 19th birthday remain eligible for Medicaid through the duration of their cancer treatment or until they no longer meet all the other eligibility criteria, whichever is earlier.

If the qualified immigrant and non-immigrant's USCIS document is a/an …	then the qualified immigrant and non-immigrant is eligible if the annotation is …
I-94	• INA Section 212(d)(5) showing admission for less than one year – Parolee • INA Section 203(a)(7) – Conditional Entrant

If the qualified immigrant and non-immigrant's USCIS document is a/an …	then the qualified immigrant and non-immigrant is eligible if the annotation is …
	• CFA/RMI – Citizen of Republic of the Marshall Islands (RMI) due to the Compact of Free Association • CFA/FSM – Citizen of the Federated States of Micronesia (FSM) • CFA/PAL – Citizen of the Republic of Palau **Note:** The Bureau of Customs and Border Protection (CBP) also notates the I-94 with the letters "D/S," which stands for "duration of status," meaning that the authorized length of stay is not limited.
I-797C, or USCIS referral notice, or hearing notice or order from an immigration judge	241(b)(3): • Convention Against Torture (CAT) – An alien who has been granted withholding of removal under CAT • Applicants for asylum or withholding of removal, including under CAT • Applicants for asylum or withholding of removal, including under CAT if under age 14 who has had an application pending for at least 180 days
***I-551** **Note: If the LPR loses the *I-551, the LPR may present either an I-94 or a passport with the following annotation:** **"Processed for I-551, Temporary Evidence of Lawful Admission for Permanent Residence, valid until _____, Employment Authorized."**	Any status code that appears on the *I-551 is acceptable.
I-766	• CFA/RMI – Citizen of Republic of the Marshall Islands (RMI) due to the Compact of Free Association • CFA/FSM – Citizen of the Federated States of Micronesia (FSM) • CFA/PAL – Citizen of the Republic of Palau Aliens who have been granted employment authorization under 8 CFR 274a.12: • (c)(9) or C9 – Applicant for adjustment to lawful permanent resident status • (c)(10) or C10 – Applicant for suspension of deportation or cancellation of removal • (c)(14) or C14 – Alien currently in deferred action status • (c)(16) or C16 – Applicant for registry (resided in U.S. since before Jan. 1, 1972) • (c)(18) or C18 – Under order of supervision • (c)(20) – Applicant for special agricultural worker legalization (INA 210) • (c)(22) – Applicant for legalization under INA 245A • (c)(24) – Applicant for adjustment under the LIFE Act Legalization Program

If the qualified immigrant and non-immigrant's USCIS document is a/an …	then the qualified immigrant and non-immigrant is eligible if the annotation is …
I-797	• Alien currently in deferred action status • Action notice that identifies the alien as a self-petitioning battered alien • Special immigrant status under INA Section 101(a)(27)(J), the individual will also have Form I-360
Visa	• A or G – FSM, RMI or Palauan diplomats • TPS – Individual under temporary protected status under INA Section 244 Fiancé or fiancée of U.S. citizen as permitted under INA Section 101(a)(15)(K): • K-1 – Fiancé or fiancée • K-2 – Child of K-1 • K-3 – Spouse of U.S. citizen • K-4 – Child accompanying or following to join a K-3 alien Special immigrant under INA Section 101(a)(15)(N): • N-8 – Parent of alien classified SK-3 "Special Immigrant" • N-9 – Child of N-8, SK-1, SK-2 or SK-4, "Special Immigrant" Religious worker under INA Section 101(a)(15)(R): • R-1 – Religious worker • R-2 – Spouse or children of R-1 Witness or informant as permitted under INA Section 101(a)(15)(S): • S-5 – Informant of criminal organization information • S-6 – Informant of terrorism information Victim of severe trafficking as permitted under INA Section (a)(15)(T): • Derivative T Visa annotated with T-1 • Derivative T Visa annotated with T-2, T-3, T-4 or T-5 (family members of a victim of severe trafficking) Victims of certain crimes – Battered aliens under 101(a)(15)(U): • U-1 – Individuals who have suffered substantial physical or mental abuse as victims of criminal activity • U-2 – Spouse of U-1 • U-3 – Child of U-1 • U-4 – Parent of U-1, if U-1 is under age 21 • U-5 – Unmarried, under age 18, sibling of U-1

If the qualified immigrant and non-immigrant's USCIS document is a/an …	then the qualified immigrant and non-immigrant is eligible if the annotation is …
	Individuals with a petition pending for three years or more, as permitted under INA Section 101(a)(15)(V): • V-1 – Spouse of an LPR who is the principal beneficiary of a family-based petition (Form I-130) that was filed prior to December 21, 2000, and has been pending for at least three years • V-2 – Child of an LPR who is the principal beneficiary of a family-based visa petition (Form I-130) that was filed prior to December 21, 2000, and has been pending for at least three years • V-3 – Derivative child of V-1 or V-2
USCIS letter	An individual who is a spouse or child of a U.S. citizen, whose visa petition has been approved, and who has a pending application for adjustment of status as described in 8 CFR INA Section 103.12(a)(4)
USCIS letter	Individual under Deferred Enforced Departure pursuant to a decision made by the president
Letter	A letter or other tribal document certifying at least 50 percent American Indian blood, as required by INA Section 289, combined with a birth certificate or other satisfactory evidence of birth in Canada
USCIS document	Family Unity beneficiaries pursuant to Section 301 of Pub. L. 101-649, as amended
USCIS document	An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. §1806(e)
USCIS document	Individual who is lawfully present in American Samoa under the immigration laws of American Samoa

*An I-551, Permanent Resident Card, does not always include the holder's signature. See A-355, Verifying Alien's USCIS Documents.

Note: The documents and/or immigration statuses listed in Chart D are not all inclusive. All lawfully residing children with a valid immigration status are eligible. Follow your policy clearance request procedures for questions about documents or immigration statuses not listed in this chart.

TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Individuals eligible for emergency Medicaid are aliens residing in the U.S. who do not meet the citizenship requirements for TANF or Medical Programs. These people are non-immigrants, undocumented aliens and certain legal permanent resident aliens.

Advisors must not follow the SAVE verification procedures explained in A-355, Verifying Alien's USCIS Documents, for aliens certified on Emergency Medicaid.

Notes:

- Individuals eligible for Emergency Medicaid must meet all other eligibility requirements.
- A person must be caring for a deprived child who meets citizenship or alien status requirements in order to be eligible for TA 31 as a caretaker or second parent.

A—343 How to Determine Eligibility for Battered Aliens

Revision 18-1; Effective January 1, 2018

All Programs

Qualified aliens with a battered alien status do not need to be credited with 40 qualifying quarters of social security coverage, nor do they have a seven-year limited eligibility period.

SNAP

Advisors follow the steps in the chart below to determine whether an alien claiming battered status is potentially eligible for SNAP.

Step	Yes	No
1. Can the alien provide USCIS documentation* that identifies the alien as the self-petitioning spouse, ex-spouse or child of an abusive U.S. citizen or LPR? **Note:** Once the alien has provided proof that identifies him/her as a self-petitioning battered alien, the alien meets the definition of a "qualified alien," as defined in A-311.1, Definition of Qualified Immigrant.	Go to Step 2.	Stop — The alien is not eligible.
2. Can the battered alien meet **one** of the following conditions? The alien: ○ is under age 18; ○ is the spouse or minor unmarried dependent child of a person who is an active duty military member or an honorably discharged veteran; ○ has resided in the U.S. for 5 years from the date that the petition for battered status was approved and issued (**Note:** This is not the same as residing in the U.S. for 5 years as a qualified alien as defined in A-311.1); or ○ meets the SNAP definition of disability in B-432, Definition of Disability (regardless of when the alien acquired a disability or entered the U.S.).	Go to Step 3.	Stop — The alien is not eligible.
3. Is the battered alien living with the spouse/parent or other family member who abused or battered the alien?	Stop — The alien is not eligible.	Go to Step 4.
4. Did the alien: • enter the U.S. and acquire “qualified alien” status before Aug. 22, 1996; • reside in the U.S. before Aug. 22, 1996, adjust to “qualified alien” status on or after Aug. 22, 1996, and provide proof of continuous residence; • reside in the U.S. before Aug. 22, 1996, adjust to “qualified alien” status on or after Aug. 22, 1996, did not provide proof of continuous residence, but meets the five-year waiting period; or • enter the U.S. on or after Aug. 22, 1996, and meets the five-year waiting period?	The alien is eligible if the alien meets all other eligibility factors.	Stop — The alien is not eligible.

* Examples of acceptable USCIS documents include:

- I-551, Permanent Resident Card, annotated with one of the following status codes: **IB-1** through **IB-3** or **IB-6** through **IB-8**;
- I-797, Action Notice, that identifies the alien as a self-petitioning battered alien; or
- a final order from an immigration judge or the Board of Immigration Appeals granting suspension of deportation under Section 244(a)(3) of the Immigration and Nationality Act.

TANF and Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Follow the steps in the chart below to determine if an alien claiming battered status is potentially eligible for TANF and/or Medical Programs.

Step	Yes	No
1. Can the alien provide USCIS documentation* that identifies the alien, the battered alien’s child or the parent of a battered alien child as the self-petitioning spouse and/or child of an abusive U.S. citizen or LPR?	Go to Step 2.	Stop — The alien is not eligible.

Step	Yes	No
2. Is the battered alien living with the spouse, ex-spouse, parent or other family member who abused or battered the alien?	Stop — The alien is not eligible.	Go to Step 3.
3. Did the alien: • enter the U.S. and acquire "qualified alien" status before Aug, 22, 1996? • reside in the U.S. before Aug. 22, adjust to "qualified alien"status on or after Aug. 22, 1996, and provide proof of continuous residence; • reside in the U.S. before Aug.22, 1996, adjust to "qualified alien" status on or after Aug. 22, 1996, did not provide proof of continuous residence, but meets the five-year waiting period; or • enter the U.S. on or after Aug. 22, 1996 and meets the five-year waiting period?	The alien is eligible if the alien meets all other eligibility factors.	Stop — The alien is not eligible.

A—350 Verification Requirements

Revision 13-2; Effective April 1, 2013

A—351 Verification of Citizenship

Revision 15-4; Effective October 1, 2015

All Programs

Items used to verify citizenship for TANF can be used for SNAP and vice versa. Items used to verify citizenship for Medical Programs can also be used for TANF and SNAP. For Medicaid Programs, only verification sources listed in A-358.1, Citizenship, can be used to verify citizenship.

TANF

Advisors verify citizenship for all household members applying for benefits. Individuals are allowed 10 days to provide proof. Advisors must document the type of proof provided. Advisors do not reverify citizenship at complete or incomplete reviews unless questionable.

If the applicant or recipient refuses or fails without good cause to provide proof, the individual is disqualified until proof is provided.

Related Policy

TANF — Budgeting for a Legal Parent Disqualified for Alien Status, Failure to Prove Citizenship, Noncompliance with the Unmarried Minor Parent Domicile Requirement or State Time Limits, A-1362.1

SNAP — Budgeting for Members Disqualified for Citizenship, 18-50 Work Requirement or Noncompliance with Social Security Number Requirements, A-1362.3

SNAP

Advisors must verify U.S. citizenship for certified members if questionable or if a regional requirement.

If an individual fails to provide verification of citizenship for Medical Programs, the claim of U.S. citizenship is not considered questionable for SNAP based solely on this reason.

A person with a questionable claim is disqualified until proof of citizenship is received.

Related Policy

SNAP — Budgeting for Members Disqualified for Citizenship, 18-50 Work Requirement or Noncompliance with Social Security Number Requirements, A-1362.3

Medical Programs Except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Before certifying an individual who has declared that they are a U.S. Citizen, the advisor must verify that the applicant or recipient is a U.S. citizen. Once verified, citizenship does not need to be verified again unless questionable.

Applicants requesting three months prior Medicaid coverage must provide citizenship verification before prior coverage can be provided.

Exception: Current Medicare and SSI recipients are exempt from the verification requirement. Individuals who are receiving Retirement, Survivors and Disability Insurance (RSDI) based on disability, and who are in a 24-month waiting period to receive Medicare, are considered Medicare recipients for the citizenship and identity verification requirement.

Related Policy
At Application, A-611
Reasonable Opportunity, A-351.1
Using State Online Query (SOLQ) or Wire Third-Party Query (WTPY) to Verify Citizenship, A-351.2

A—351.1 Reasonable Opportunity

Revision 16-2; Effective April 1, 2016

Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35, TP 36 and TA 85

Medicaid and CHIP applicants or recipients who declare themselves to be U.S. citizens or declare to have an eligible alien status, but for whom verification of citizenship or alien status is unavailable, must be allowed a period of reasonable opportunity to provide verification of citizenship or alien status. Reasonable opportunity is defined as the 95-day period an individual is allowed to provide this verification.

At application and when adding a person during a redetermination or change, if the individual does not provide proof of citizenship or alien status and:

- no other information is required to determine eligibility, the individual is certified for Medicaid if all other eligibility requirements are met, sent Form TF0001, Notice of Case Action, and is provided a period of reasonable opportunity.
- other information is required to determine eligibility, the advisor must request verification of the other information in addition to citizenship or alien status prior to providing a period of reasonable opportunity. If the client returns the other information but not proof of citizenship or alien status, the individual is certified for Medicaid, sent Form TF0001, and provided a period of reasonable opportunity.

Form TF0001 informs the applicant that citizenship or alien status verification is required within 95 days and lists the names of each individual who must provide citizenship verification. The period of reasonable opportunity begins the day Form TF0001 is generated.

All new applicants must be given a period of reasonable opportunity regardless of whether they received a reasonable opportunity period previously.

The reasonable opportunity period may be triggered under the following conditions:

- The individual is unable to provide a Social Security number (SSN) needed to electronically verify citizenship with the Social Security Administration (SSA);
- There is an inconsistency between the data available from an electronic source and the individual's declaration of citizenship or alien status; or
- Electronic verification is unsuccessful, including agency efforts to resolve any inconsistencies, and additional documentation is still needed.

The day the reasonable opportunity period expires (the 95th day), the Texas Integrated Eligibility Redesign System (TIERS) will generate an alert that will create a task. The individual is denied if the individual has not provided citizenship or alien status verification. TIERS provides 30 days advance notice of adverse action to the household after informing them of the denial of ongoing benefits using Form TF0001, Notice of Case Action.

A—351.2 Using State Online Query (SOLQ) or Wire Third-Party Query (WTPY) to Verify Citizenship

Revision 15-4; Effective October 1, 2015

Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

If an applicant has an SSN, use SOLQ or WTPY to verify citizenship.

The system attempts to verify citizenship using SOLQ through Electronic Data Sources (ELDS). If the SOLQ system is unresponsive or unavailable due to system failure, advisors must attempt to verify using WTPY.

If the SSN is verified, WTPY provides a response code for verification of citizenship. Advisors follow the steps in the chart below to determine the required advisor action for each response code. These response codes are only provided for Medicaid or CHIP requests.

If the WTPY response code is…	then staff must …
A SSN is verified, there is no indication of death, and the allegation of citizenship is consistent with SSA data,	1. Select "Verified by SSA (SOLQ, WTPY, and HUB)" in the SSN verification drop-down menu. 2. Select "Verified by SSA (SOLQ, WTPY, and HUB)" in the citizenship verification drop-down menu.
B SSN is verified, there is no indication of death, and the allegation of citizenship is **NOT** consistent with SSA data,	1. Select "Verified by SSA (SOLQ, WTPY, and HUB)" in the SSN verification drop-down menu. 2. See the process for **If unable to verify citizenship (Code B)** below.
C SSN is verified, there is indication of death, and the allegation of citizenship is consistent with SSA data,	1. Select "Verified by SSA (SOLQ, WTPY, and HUB)" in the SSN verification drop-down menu. 2. Treat the death information as a change using policy in B-600, Changes.
D SSN is verified, there is indication of death, and the allegation of citizenship is **NOT** consistent with SSA data,	1. Select "Verified by SSA (SOLQ, WTPY, and HUB)" in the SSN verification drop-down menu. 2. Treat the death information as a change using policy in B-600.

If unable to

Advisors should attempt to verify citizenship using the Birth Verification System (BVS).
 	
1. If staff is unable to verify citizenship using BVS and additional information is required to determine eligibility, request the additional information and verification of citizenship and allowthe individual at least 10 days to provide proof.
  ○ If the client does not return the additional information by the final due date, the advisor must deny the case for failure to provide required information.
  ○ If the client provides the additional information, but does not provide verification of citizenship, the advisor must allow the individual a period of reasonable opportunity (explained in A-351.1, Reasonable Opportunity) to provide the verification of citizenship.
2. If staff is unable to verify citizenship using BVS and no other information is required to determine eligibility, the advisor must allow the individual a period of reasonable opportunity to provide the verification without pending the EDG.
 	
After allowing reasonable opportunity, if the recipient refuses or fails to provide proof, the advisor must deny the individual until proof of citizenship is provided.

SOLQ or WTPY responses may also include information on the receipt of SSI or RSDI. Advisors can find more information on the treatment of RSDI and SSI income explained in A-1324, Government Payments.

If the WTPY system is unresponsive or unavailable due to system failure, advisors must not deny or delay certification of Medicaid or CHIP coverage for failure to verify SSN or citizenship. Advisors must:

- enter the SSN as provided by the applicant into TIERS and allow the automated SSA interface to verify the SSN; and
- allow the individual a period of reasonable opportunity (explained in A-351.1) to provide the verification of citizenship.

A—351.3 Good Cause Determination

Revision 15-4; Effective October 1, 2015

TANF

Good cause exists when the Texas Health and Human Services Commission (HHSC) determines that circumstances beyond the individual's control prevent proving U.S. citizenship. The individual's statement that proof is delayed is acceptable.

At initial application and when adding a person, good cause is allowed until the next complete review. The individual must be advised that the verification must be provided by the next complete review or the individual will be disqualified.

A—351.3.1 Referrals to OIG

Revision 15-4; Effective October 1, 2015

TANF

Advisors must disqualify and refer an individual to the Office of Inspector General (OIG) if:

- the individual previously claimed to be a U.S. citizen but could not provide proof after allowing good cause; and
- other information indicates the individual's claim of citizenship is questionable.

A—351.4 How to Verify Citizenship

Revision 15-4; Effective October 1, 2015

All Programs

Advisors may refer to A-358.1, Citizenship, for common sources used to verify U.S. citizenship. For Medical Programs, advisors use the most reliable level of verification available from the sources listed as acceptable for Medical Programs. An affidavit is used only as a last resort when other verification is not available.

Advisors should explore derivative citizenship for any applicant born abroad to at least one U.S. citizen parent. If the applicant claims derivative citizenship, the applicant must provide a Certificate of Citizenship issued by the U.S. Citizenship and Immigration Services.

Related Policy
Reasonable Opportunity, A-351.1
Questionable Information, C-920
Providing Verification, C-930

TANF and SNAP

If the applicant cannot obtain the requested proof but can reasonably explain why it is not available, the advisor must obtain an affidavit signed by someone who knows the applicant's history. The advisor should advise signers that the affidavit is a sworn statement; signers can certify only those facts of which they have personal knowledge. The affidavit must state that the signer:

- is a U.S. citizen;
- knows that the applicant is a U.S. citizen; and
- may be fined, imprisoned or both if false information is given.

Through supervisory channels, the advisor must ask the regional attorney to make a determination if the applicant:

- does not have proof of citizenship and cannot obtain an affidavit as described above; or
- claims derivative citizenship and does not have a Certificate of Citizenship.

TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Verification requirements do not apply for undocumented aliens in the Emergency Medicaid certified group.

A—352 Verification of Alien Status

Revision 18-1; Effective January 1, 2018

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Advisors must verify alien status by:

- obtaining documentation of alien status, as explained in A-340, Qualified Alien Status Eligibility Charts; and
- accessing the USCIS SAVE VIS, as explained in A-355, Verifying Alien's USCIS Documents.

Advisors pend the EDG to allow an alien to update the alien's status with USCIS. An alien who does not have acceptable status is disqualified. If a certified alien's document expires before the next redetermination, the alien's immigration status must be re-verified following policies and procedures in A-313, Absence of Proof of Alien Status.

Advisors use the SAVE VIS:

- at application;
- when adding a new household member identified as an alien; or
- when the client's USCIS document has expired.

Notes: If the alien's USCIS document is expired and the SAVE response shows;

- The individual is a Lawful Permanent Resident - Employment Authorized and the Date Admitted is "Response is Indefinite," the individual meets an alien status criteria. These individuals must not be disqualified.
- The individual's I-766, Employment Authorization Document, is not expired. These individuals must not be disqualified due to having an expired document.

SAVE does not contain information about victims of severe trafficking or nonimmigrant alien family members. At application, advisors must call the trafficking verification toll-free number at 866-401-5510 to confirm the validity of the certification letter or Derivative T Visa and to notify the Office of Refugee Resettlement of the benefits for which the individual is applying.

Medicaid and CHIP applicants or recipients who declare an alien status, but for whom verification of alien status is unavailable, must be allowed a period of reasonable opportunity to provide verification of alien status as explained in A-351.1, Reasonable Opportunity.

TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Do not follow the SAVE VIS verification procedures.

A—353 Verification of Military Connections

Revision 13-2; Effective April 1, 2013

A—353.1 Verification of Veteran Status

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Advisors must verify an individual's eligible veteran status by:

- a discharge certificate; or
- Form DD-214 or equivalent that shows the individual previously met active duty status in the armed forces.

Note: Discharge certificates that show character of discharge as anything but "honorable" are not acceptable. A character of discharge "Under Honorable Conditions" is **not** an "honorable" discharge for purposes of eligibility.

If the veteran does not have proof of discharge status, the veteran is referred to the Veteran's Administration to obtain verification.

A—353.2 Verification of Active Duty Military

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Individuals who claim they are currently on active duty in the military must provide a:

- current Military Identification Card, Form DD-2 (Active); or
- copy of their current military orders.

If the active duty military member does not provide proof of active duty status, the advisor must request other forms of proof.

A—353.3 Verification of a Spouse or Minor Unmarried Dependent Child of a Veteran or Active Duty Military Member or Unmarried Surviving Spouse of a Deceased Veteran or Active Duty Military Member

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Staff must verify whether an alien meets the eligibility requirements as:

- a spouse or minor unmarried dependent child of a veteran or active duty military member; or
- an unmarried surviving spouse of a deceased veteran or active duty military member.

To verify, advisors may use one of the following methods:

- view Form DD-214 for the discharged veteran;
- view the Military Identification Card (DD-2) that shows that the alien is married to or is a minor unmarried dependent child of a veteran or active duty military member; or
- refer the individual to the Veteran's Administration for verification.

A—354 Verifying 40 "Qualifying Quarters"

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Advisors must verify 40 qualifying quarters for LPR applicants or household additions that must meet this requirement. Advisors use the WTPY 40 Quarters Verification System to verify covered wages. Once verified, this information does not have to be reverified.

A—354.1 Response from Social Security Administration's (SSA) WTPY System

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

SSA does not complete the posting of covered earnings quarters for any one year until the following year (around August). **Example:** Quarters earned in 2012 may not be posted on the WTPY system until August 2013. These quarters are referred to as “Lag” quarters.

A response from SSA on the 40 quarters verification request takes approximately 48 hours to receive.

Advisors base the quarters of covered earnings on the calendar year’s **total** earnings. Each year, the amount of income needed to earn a quarter changes. State office advises staff of the change each year.

For 2012, an individual must earn $1,130 to earn one quarter. If the individual earned at least $4,520 for 2012 ($1,130 x 4), the client has four qualifying quarters for the year.

Note: Advisors must not allow credit for an incomplete or future quarter. **Example:** The quarter of July to September 2012 cannot be counted until October
2012, even though the individual earned enough income by March 2012 to receive credit for three quarters in 2012.

A—354.2 Non-Covered Wages

Revision 18-1; Effective January 1, 2018

All Programs Except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Non-covered wages are those earned by an individual whose employer was not required to pay into the Social Security system (such as certain city, federal, school or religious organization employees).

If the LPR cannot meet the 40 qualifying quarter requirement using covered earnings verified by the SSA, advisors must then obtain sufficient income verification from the individual's employer to determine the earned quarters for the period in question.

Use the chart below to determine if the individual has earned sufficient money to earn a quarter.

1984	$390	**1995**	$630	**2006**	$970	**2017**	$1,300
1985	$410	**1996**	$640	**2007**	$1,000		
1986	$440	**1997**	$670	**2008**	$1,050		
1987	$460	**1998**	$700	**2009**	$1,090		
1988	$470	**1999**	$740	**2010**	$1,120		
1989	$500	**2000**	$780	**2011**	$1,120		
1990	$520	**2001**	$830	**2012**	$1,130		
1991	$540	**2002**	$870	**2013**	$1,160		
1992	$570	**2003**	$890	**2014**	$1,200		
1993	$590	**2004**	$900	**2015**	$1,220		
1994	$620	**2005**	$920	**2016**	$1,260		

Example: A former custodian worked for a school district from 2008 through 2011. The school district did not pay into the Social Security system. The advisor requested that the former custodian provide verification of their earnings for this particular period.* They brought a statement from the school district verifying their wages showing they earned $9,000 for 2008. Using the chart above, the income required to earn a quarter for 2008 is $1,050. This person can be credited with four quarters for 2008 ($1,050 x 4 = $4,200).

* If HHSC already has proof of income earned, advisors do not request that the individual provide additional verification.

Note: Credit for an incomplete or future quarter is not allowed.

A—354.3 Quarters Earned On or After January 1, 1997

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Federal law requires that quarters earned **on or after** January 1, 1997, cannot be credited if the person who earned the quarters received means-tested public benefits.

When determining the total amount of quarters earned by an LPR, advisors do not allow any quarters earned after January 1, 1997, if the person received TANF, SNAP, Medicaid or SSI benefits for the quarter. The WTPY system response does not reflect receipt of these benefits.

The SSA defines a quarter as a period of three calendar months:

- Quarter 1: January, February, March
- Quarter 2: April, May, June
- Quarter 3: July, August, September
- Quarter 4: October, November, December

A—354.4 Procedures for Verifying 40 Quarters

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Advisors must:

Step	Action
1	Ensure that the alien's LPR status has been verified.
2	Determine whose quarters of earnings have to be verified.

Step	Action

3	Obtain a consent of release before verifying quarters of coverage through the WTPY system or SSA. Use one of the following forms:
	
	Note: A consent form or signature is not required for spouses or parents who are deceased.
	
	• Form SSA-3288, Social Security Administration Consent for Release of Information, must be signed by the:
	  ▪ LPR, if the LPR did not sign the application;
	  ▪ LPR's spouse, if the spouse did not sign the application; or
	  ▪ LPR's parent.
	  ○ Form SSA-513, Request for Quarters of Coverage History Based On Relationship, is completed when the LPR, spouse and/or parent:
	  ▪ refuses to sign Form SSA-3288; or
	  ▪ cannot be located.
	
	Example: A husband, wife and their four children have applied for SNAP benefits. Both spouses and two of the children are LPRs (advisor has verified LPR status). The husband has worked in the U.S. for about six years, and the wife has worked about five years. The advisor must verify the quarters of earnings for both spouses.
	
	Since the husband was the one who signed the application, he does not have to sign Form SSA-3288; however, a signed Form SSA-3288 is required for the wife. The advisor must also complete Form H1079, Qualifying Quarters of Social Security Earnings, for both spouses.

4	If the household signed Form SSA-3288, submit Form H1079 to the appropriate WTPY data entry staff with the following information: • LPR's full name, as it appears on the Social Security card; • LPR's date of birth; and • LPR's correct Social Security number. If the household signed Form SSA-513, send the completed form to the following address: Social Security Administration P.O. Box 17750 Baltimore, MD 21235-0001
5	If you are awaiting the verification from SSA's WTPY system (normally WTPY provides a response within 48 hours), issue Form H1020, Request for Information or Action, and pend the EDG. If you sent Form SSA-513, disqualify the individual until you receive the response from SSA.
6	Use the WTPY or Form SSA-513 response to determine how many countable quarters are in the SSA records for the LPR, spouse and parent. Verify any recent earnings through the employer or case record if not yet posted on the WTPY system or not listed on Form SSA-513. Compute the quarters of covered earnings.
7	Disallow any quarters in which the wage earner received TANF, SNAP, Medicaid or SSI after January 1, 1997.
8	If the LPR: • has 40 quarters, the LPR is eligible. • does not have 40 quarters, the advisor sends Form TF0001, Notice of Case Action, to notify the household that the LPR is disqualified as an ineligible alien due to the lack of 40 allowable quarters of earnings.
9	If the individual disagrees with SSA's records for quarters of covered earnings, provide the individual with Form H1020. On Form H1020, explain that HHSC will certify the LPR if proof is provided that SSA was contacted to resolve the record of earnings. Provide the LPR copies of the WTPY response(s). If the LPR needs to resolve a disagreement about a parent's or spouse's SSA record, advise the LPR that the spouse or parent must go to SSA to reconcile the individual's record. The LPR can resolve the SSA records for a deceased spouse or parent.

Step	Action
10	If the LPR contacts SSA to resolve the disagreement, SSA provides the individual with a document or Form SSA-7008, Request for the Correction of Earnings. The document or Form SSA-7008 verifies the action being taken to resolve the disagreement about the individual's SSA record. When the LPR provides the verification, submit the verification for imaging. Consider the LPR an eligible alien for TANF, SNAP and Medical Programs for one of the following time periods: • for six consecutive months beginning the month the LPR contacted SSA, or • less than six months if the LPR resolves the disagreement with SSA before the sixth month and the LPR does not have 40 allowable quarters of covered earnings. Document this temporary eligibility period. **Note:** On a denied application, if the LPR provides the needed proof by the 60th day after the file date, reopen the application using the date the LPR provided the information as the file date.

A—355 Verifying Alien's USCIS Documents

Revision 16-4; Effective October 1, 2016

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35, and TP 36

Two methods exist for verifying the alien's USCIS documents:

- **Initial verification** — an online inquiry process, SAVE; and
- **Institute additional verification** — an online or manual process using USCIS Form G-845, Verification Request, and Form G-845 Supplement, Verification Request.

Advisors must attempt to first verify the alien's USCIS documents during the interview, if applicable, using the initial verification process. If the initial process cannot verify the number, the SAVE response instructs staff to institute additional verification.

Notes:

- Do not re-verify the alien's documents if they were previously verified and documented and have not expired.
- An I-551, Permanent Resident Card, does not always include the holder's signature and may say "Signature Waived" on the front and back of the card where a signature would normally be located. When this occurs, the individual meets an alien status criteria and must not be disqualified.

If, at the interview, the individual does not provide his USCIS document and the document …	then …

If, at the interview, the individual does not provide his USCIS document and the document …	then …
	give the individual at least 10 days (or the 30th day after the file date, if later) to provide the information. Initiate initial verification when the household provides proof. If the household does not provide proof by the 30th day after the file date, disqualify the member with no proof and certify any remaining eligible members. **SNAP** **Exception:** If the 10-day period ends after the 30th day from the file date, certify the application by the 30th day. Include the alien with the pending information even if the verification has not been provided. If the household does not provide the information by the 10th day, take adverse action to disqualify the member with no proof. **Related Policy** Disqualified Members, A-1362
is available,	
is not available because the document is lost,	instruct the alien to: • file for a duplicate card and I-94 at USCIS; and • bring the I-94 to the eligibility determination office. Give the individual at least 10 days (or the 30th day after the file date, if later) to provide the information. If the I-94 is provided, initiate initial verification. If the household does not provide proof by the 30th day after the file date, disqualify the member with no proof. Certify any remaining eligible members. See the exception above if the 10-day period ends after the 30th day. **Related Policy** Disqualified Members, A-1362

A—355.1 SAVE Program's Verification Information System (VIS)

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

The SAVE program's VIS is a web-based application that provides alien status information using the applicant’s immigrant registration number.

The SAVE system provides the following types of responses:

- Initial Verification Results — First Name, Last Name, Country, Date of Entry, Date of Birth, Class of Admission (COA), and System Response.
- Additional Verification Results — DHS Response, Expires On, Response Date, and DHS Comments.

A—355.2 How to Request an Initial Verification

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Supervisors complete and route Form 4743, Request for Applications and System Access, to the regional security officer for employees who need access to the SAVE system.

Advisors must follow these steps to access the SAVE system:

1. Open the VIS web site at https://save.uscis.gov/Web/vislogin.aspx?JS=YES.
2. Enter your User ID and password.
3. Select Initial Verification from the Case Administration menu.
4. Enter the document type that the applicant provided.
5. Enter the applicant's information as it appears on the document:
    - Alien Number — Do not include the letter A when entering the information in SAVE. If the A number has fewer than nine digits, add leading zeroes to make it a nine-digit number. USCIS# is used on the new I-551 cards instead of Alien Number.
    - I-94 Identification Number — known as the admission number, consists of an 11-digit field. Enter leading zeroes if the I-94 number provided has less than 11 digits.
    - Card Number — Card numbers for I-551 cards issued before November 2004 are at the bottom of the card toward the right-hand side. Card numbers for newer versions of I-551 are on the back of the card.
    - Last name.
    - First name.
    - Date of birth.
    - Document expiration date, if applicable.
    - Required benefits — Select the benefit type from the Benefits List (SNAP, Medicaid, TANF).
6. Select Submit Initial Verification. The response appears in the Initial Verification Results section of the same page.
7. The screen displays one of the following messages:

- **Lawful Permanent Resident – Employment Authorized**;
- **Institute Additional Verification**; or
- **Temporary Resident/Temporary Employment Authorized**.

Note: If the response is **Temporary Resident/Temporary Employment Authorized**, the alien does not meet eligibility requirements.

8. Review the results and select Print Case Details.
9. Select Complete and Close Case to close the case (only if additional verification is not necessary). Once a case is closed, the user can view it for an additional 90 days.

A—355.3 How to Request Additional Verification – Online Process

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

To request additional verification:

1. In the Initial Verification Results section, select Request Additional Verification. The Enter Additional Verification Data section appears.
2. Edit the default information if necessary, enter required information, and include as much information as possible. Use the Special Comments box to enter additional information to the Immigration Status Verifier (ISV) staff.
3. Submit the request by selecting Submit Additional Verification. The response section appears indicating that the request is in process and will return the response within three working days.
4. To view the status of the case, select View Cases from the Case Administration menu. The Case Search page appears.
5. Enter the Case Search Criteria to search for cases based on the following case status:

- all open cases;
- cases requiring action;
- cases with additional verification responses;
- cases in process; and
- closed cases.

Select Display Case Summary List to open the Case Summary List page. The list displays the Case Status for cases that require action, cases in process, and closed cases. Click the Verification Number to view the Case Details. The user is able to print the case details, request additional verification, and close the case.

When the system is unable to verify the immigration status with the information provided by the user in the automated additional verification request, or the document appears counterfeit, altered, or expired, staff may use the manual process in A-355.4, How to Request Additional Verification – Manual Process.

A—355.4 How to Request Additional Verification – Manual Process

Revision 16-3; Effective July 1, 2016

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35, and TP 36

To request additional verification:

- complete Form G-845, Verification Request and Form G-845 Supplement, Verification Request;
- attach fully readable photocopies (front and back) of original immigration documents containing the immigrant's registration number; and
- mail one set of copies to the USCIS office (see the instructions to Form G-845 and Form G-845 Supplement). Submit a second set of copies for imaging.

If the applicant's name changed since the immigrant registration card was issued, advisors attach a document that verifies the name change.

If the alien is otherwise eligible, the advisor must not delay, deny, or reduce the household's benefits while waiting for a response from the USCIS.

When the USCIS returns Form G-845 and Form G-845 Supplement, follow these procedures:

If the response indicates that the alien's document is …	then …
valid,	send Form G-845 and Form G-845 Supplement to be imaged.
not valid and the EDG is certified,	• take adverse action to disqualify the individual or deny the EDG, as appropriate • process a fraud referral; and • send Form G-845 and Form G-845 Supplement to be imaged.

A—356 Verifying Alien's Date of Entry

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

The date on the alien's immigration document often represents the alien's first date of entry into the United States. In some instances, an alien may be present in the United States without a qualified status. The individual may then depart and then return to the U.S. as an LPR. For these aliens, the date on their immigration document reflects the date of entry with LPR status, rather than the alien's original date of entry.

Advisors use immigration documents to verify date of entry. Advisors must allow aliens with a USCIS document showing an entry date on or after August 22, 1996, who claim to have entered before that date, an opportunity to submit evidence of their claimed date of entry. This evidence may include pay stubs, a letter from an employer, or a lease or utility bill in the alien's name.

A—357 Verifying Alien's Continuous Presence

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

USCIS maintains a record of arrivals to and departures from the country for most legal entrants. File Form G-845S, Document Verification Request, and Form G-845S Supplement with the USCIS to verify continuous presence in the U.S. Other entrants, including aliens who entered the U.S. without USCIS documents, must provide documentary evidence showing proof of continuous presence, such as a letter from an employer or a series of pay stubs, or utility bills in the alien's name and spanning the period of time in question. **Note:** The alien does not have to remain continuously present in the U.S after obtaining qualified immigrant status.

A—358 Verification Sources

Revision 13-2; Effective April 1, 2013

A—358.1 Citizenship

Revision 15-4; Effective October 1, 2015

TANF and SNAP Verification Sources:

- Birth Verification System automated process (for individuals born in Texas)
- Birth certificate (see **Note**)
- Naturalization papers (N-560 or N-561)
- Hospital record of birth
- Baptismal record with date and place of birth
- U.S. passport or U.S. passport card
- Military service papers
- Census records showing name, U.S. citizenship or U.S. place of birth, and date of birth or age
- Voter registration card (SNAP only)
- Local, state or federal records showing birthplace in the U.S.
- Regional attorney
- Civil service employment by the U.S. government
- American Indian Card
- Report of birth abroad (FS-240)
- Certificate of birth (FS-545 or DS-1350)

Alternate Sources

- Family Bible records
- Affidavit from U.S. citizen

Note: Individuals born in Puerto Rico must provide a birth certificate issued on or after July 1, 2010, unless previously certified using a birth certificate issued before July 1, 2010. See C-932, Advisor Responsibility for Verifying Information, for information regarding assisting

an individual in obtaining birth verification from Puerto Rico.

Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Citizenship and Identity Verification

Verification sources are divided into two levels: Level 1 and Level 2. Level 1 sources establish both citizenship and identity. Level 2 sources establish citizenship only.

Level 1: Verifies Citizenship and Identity

SOLQ/WTPY

U.S. passport

Certificate of Naturalization (DHS Forms N-550 or N-570)

Certificate of U.S. Citizenship (DHS Forms N-560 or N-561)

State Data Exchange (SDX) for denied SSI recipients when the denial reason is for any reason other than citizenship

Evidence of membership or enrollment in a federally recognized tribe

SOLQ/WTPY and documentation on reason for Medicare denial

Inquiry reflecting a current or denied TP 45 Medicaid EDG

CHIP-P inquiry reflecting a current or denied CHIP-P case for the child

Level 2: Verifies Citizenship Only

If using a source from Level 2, the individual must also provide an additional source from the Medicaid and CHIP identity verification sources. The same source that was used to verify citizenship cannot be used to verify identity. Identify verification from A-621, Verification Sources, is required.

A U.S. public birth certificate showing birth in one of the 50 states, the District of Columbia, Puerto Rico (if born on or after January 13, 1941)*, Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after January 17, 1917), American Samoa, Swain's Island or the Northern Mariana Islands (after November 4, 1986)*

BVS inquiry

Report of Birth Abroad of a U.S. Citizen (FS-240)

Certification of Birth Abroad (FS 545 or DS-1350)

U.S. Citizen Identification Card (Form I-179 or I-197)

Northern Mariana Identification Card (I-873)

Final adoption decree showing the child's name and U.S. place of birth

Evidence of U.S. civil service employment before June 1, 1976

U.S. military record showing a U.S. place of birth (Example: DD-214)

SAVE for naturalized citizens

If a child has not yet received a Certificate of Citizenship, N-560 or N-561, evidence of meeting the automatic criteria for U.S. citizenship outlined in the Child Citizenship Act of 2000, which includes:

- proof that at least one parent of the child is a U.S. citizen, by birth or naturalization;
- proof that the child is under age 18;
- proof that the child is residing in the U.S. in the legal and physical custody of the U.S. citizen parent;
- I-551, Permanent Resident Card; and
- I-551 with annotation of IR-3 or IR-4, if an adopted child.

Hospital record of birth showing a U.S. place of birth

Life, health, or other insurance record showing a U.S. place of birth

Religious record of birth recorded in the U.S. or its territories within three months of birth, which indicates a U.S. place of birth, showing either the date of birth or the individual's age at the time the record was made

Early school record (preschool or day care) showing a U.S. place of birth

Level 2: Verifies Citizenship Only
Federal or state census record showing U.S. citizenship or a U.S. place of birth
Institutional admission papers from a nursing facility, skilled care facility or other institution showing a U.S. place of birth
Medical (clinic, doctor, or hospital) record, excluding an immunization record, showing a U.S. place of birth
An affidavit signed by another individual who can reasonably declare to the applicant's citizenship, regardless of blood relationship to the individual and under penalty of perjury, and that contains the applicant's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized. Use only as a last resort when other evidence is not available.

* Individuals born in Puerto Rico must provide a birth certificate issued on or after July 1, 2010, unless certified previously using a birth certificate issued before July 1, 2010. C-932, Advisor Responsibility for Verifying Information, includes information regarding assisting an individual in obtaining birth verification from Puerto Rico.

American Indian/Alaska Natives (AI/AN)

Individuals can self-declare AI/AN status. Form H1205, Texas Streamlined Application, and Form H1010, Texas Works Application for Assistance — Your Texas Benefits, include a general question asking whether anyone in the household is an American Indian, Alaska Native, or member of a federally recognized tribe. In some instances, **Yes** may be selected on the application for this question, but information is not provided by the applicant in Appendix B, American Indian or Alaska Native Family Member (AI/AN), identifying the member of the household composition for Medical Programs to whom the status applies. If the name of the individual claiming AI/AN status is not provided, AI/AN status is considered not verified.

Related Policy
Providing Verification, C-930
Using State Online Query (SOLQ) or Wire Third-Party Query (WTPY) to Verify Citizenship, A-351.2

A—358.2 Alien Status

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

- Form I-94, I-151, I-551, I-688B (with special annotations), I-766 (with special annotations), or other valid USCIS records
- Contact with USCIS

TANF and Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Alien Entry Date

- Immigration document
- Contact with the USCIS
- Pay stubs
- Letter from employer
- Lease or utility bill in the alien's name
- School records
- Other document indicating entry date

Alien's Continuous Presence

- Contact with the USCIS
- Letter from employer
- Pay stubs or utility bills in the alien's name spanning the time period in question
- School records
- Other documents spanning the time period in question

A—360 Documentation Requirements

Revision 15-4; Effective October1, 2015

All Programs

Advisors must document the:

- alien's status and how you verified it;
- USCIS document's expiration date if any;
- basis of alien's eligibility or ineligibility; and
- temporary eligibility period for the alien, described in A-354.4, Procedures for Verifying 40 Quarters, if applicable.

Advisors must document the verification number from the SAVE inquiry in case comments.

Related Policy
Documentation, C-940

SNAP

Advisors must document the proof of citizenship, if questionable.

TANF and Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Advisors must document proof of citizenship.

Advisors must document the alien's:

- date of entry; and
- continuous presence, if necessary to establish eligibility.

Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

When using a verification source from Level 2, the advisor must document the reason Level 1 was not used.

Copies of the document used to verify citizenship must be legible and non-questionable.

Related Policy

The Texas Works Documentation Guide

TWH, A-400, Social Security Number

Revision 18-1; Effective January 1, 2018

A—410 General Policy

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35, TP 36 and TP 45

All applicants must provide a Social Security number (SSN) or apply for one through the Social Security Administration (SSA) before certification, unless they meet one of the criteria in this section.

Exception: Undocumented aliens are not required to apply for an SSN.

Non-applicants are not required to provide an SSN or proof of an application for an SSN. When non-applicants provide an SSN, advisors may attempt to verify the SSN using the procedures explained in A-440, Verification Requirements. If verification is not available through electronic data sources, verification of the non-applicant’s SSN must not be requested from the applicant.

SNAP

Children age six months or younger are not required to provide proof of an application for an SSN. Newborns may receive benefits with the household without providing proof of an application for an SSN for the later of:

- six months following the child's birth, or
- the next recertification/complete review.

Applicants eligible for expedited service may receive initial benefits without providing or applying for an SSN. Initial benefits can include the first two months if receiving a combined allotment.

Applicants who cannot provide required proof to apply for an SSN may receive the Supplemental Nutrition Assistance Program (SNAP) for each month they have good cause. Good cause exists when circumstances beyond the individual's control prevent the individual from securing proof required to obtain an SSN.

Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35, TP 36 and TP 45

Applicants do not need to provide an SSN if they meet any of the following good cause reasons:

- They are not eligible to receive an SSN;
- They do not have an SSN and may only be issued an SSN for a valid non-work reason; or
- They refuse to obtain an SSN because of a well-established religious objection. A well-established religious objection exists when the applicant:
  - is a member of a recognized religious sect or division of the sect; and
  - adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.

TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Undocumented aliens applying for Emergency Medicaid are not required to provide an SSN.

TP 45

SSN requirements do not apply to TP 45.

If a TP 45 child has an SSN, advisors enter the SSN at Application Registration or during Data Collection in the Individual Information page. If the child does not have an SSN, advisors may refer the parent or caretaker to the SSA to complete Form SS-5, Application for Social Security Number.

A—411 Determining Advisor Action at Application

Revision 18-1; Effective January 1, 2018

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35, TP 36 and TP 45

If the applicant ...	then ...
• cannot provide an SSN;* • provides an SSN that the Texas Integrated Eligibility Redesign System (TIERS) will not accept as valid; or • provides Form SSA-5028, Receipt for Application for an SSN, that is more than 30 days old,	• refer the applicant to the local SSA office using a separate Form H1106, Enumeration Referral, for each member needing an SSN; and • pend the application until SSA returns Form H1106 verifying the applicant has completed the application process. **Exception:** Follow policy in A-410, General Policy, for the applicable exceptions, by program.
• provides Form SSA-5028 (not more than 30 days old); or • provides Form SSA-2853, Message From Social Security, that is not more than 180 days old,	• accept the form as proof that the applicant applied for an SSN; • tell the applicant to report the SSN when the applicant receives it; and • enter the SSN in the Eligibility Determination Group (EDG), when reported. **Note:** See A-412, Action at TANF and Medical Program Redetermination — Forms SSA-5028 or SSA-2853, for action to take at the next periodic review for Temporary Assistance for Needy Families (TANF) or Medicaid recipients.

If the applicant ...	then ...
provides an SSN,	enter the SSN at Application Registration or during Data Collection in the Individual Information page.
provides an SSN but indicates the name and/or date of birth on record with SSA is not correct,	• enter the SSN at Application Registration or during Data Collection in the Individual Information page; and • refer the applicant to the local SSA office to update the individual's SSA file using Form H1106. Do not pend the application for SSA's response.
provides an SSN but wants a replacement for a lost card,	• enter the SSN at Application Registration or during Data Collection in the Individual Information page; and • refer the applicant to the local SSA office without Form H1106; and • inform applicants age 18 and older that replacement SSN cards can be requested online through the SSA by visiting socialsecurity.gov/ssnumber.

* If the applicant cannot provide an SSN because the applicant is a documented alien without work authorization, refer the applicant to the local SSA office using Form H1106.

Advisors must explain the following to applicants applying for an SSN:

- the type of proof they must take to SSA to obtain an SSN (see page 2 of Form H1106, Proofs You Need to Apply for a Social Security Number Card, for common types of proof);
- the referral procedure and the results of any delay;
- that SSA must conduct a face-to-face interview with a person age 18 or over applying for an original SSN; and
- that a person applying for someone else (including an adult applying for a child) must provide proof of that person's own identity in addition to proof needed for the SSN application.

When an applicant takes Form H1106 to the SSA office, SSA:

- determines whether the applicant is eligible for an SSN;
- submits Form SS-5 for those eligible; and
- adds information to Form H1106 or provides another SSA receipt or letter verifying the applicant completed the SSN application process. At the applicant's request, the SSA staff member may fax the form to the advisor listed on Form H1106.

Advisors follow procedures in A-420, Failure to Comply, if the applicant does not return Form H1106 with entries made by SSA, or another receipt or letter, verifying application for an SSN for each applicant by the 30th day after the file date, or later, to allow at least 10 days.

SNAP

If the applicant cannot complete the SSN application process in a timely manner, the advisor must explain the procedure for claiming good cause. If the applicant indicates the applicant may have good cause for not complying in a timely manner, the advisor must make a good cause determination. The application is not pended for SSA's response if good cause is applicable.

A—412 Action at TANF and Medical Program Redetermination — Forms SSA-5028 or SSA-2853

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs, except TP 43, TP 44, TP 45 and TP 48

Advisors must provide the individual with Form H1106, Enumeration Referral, at the next complete review when:

- Form SSA-5028 or SSA-2853 is accepted at application,
- the form is no longer current, and
- no SSN has been received.

Advisors must indicate on Page 2 of Form H1106, Proofs You Need to Apply for a Social Security Number Card, that the form must be returned by the SSA within 60 days. At the applicant's request, the SSA staff member may fax the form to the advisor listed on Form H1106. The advisor must explain to the individual the result of noncompliance.

The complete review must not be pended for the return of Form H1106. The advisor must set a special review for the end of the 60-day period. Follow procedures in A-420, Failure to Comply, for noncompliance if:

- Form H1106 was not returned by the deadline, and
- an SSN was not received.

TP 43, TP 44 and TP 48

Advisors follow the procedures above, but do not set a special review. Advisors must check for compliance at the next review.

A—420 Failure to Comply

Revision 15-4; Effective October 1, 2015

TANF and SNAP

If an application is certified but a member is disqualified, notification of the individual's disqualification is included on the comment section of Form TF0001, Notice of Case Action.

Exception: Advisors follow policy in A-410, General Policy, for applicable exceptions for SNAP.

Related Policy
TANF — Budgeting for a Household Member Disqualified for Noncompliance with SSN, TPR, Failure to Timely Report a Certified Child's Temporary Absence, Intentional Program Violation, Being a Fugitive or a Felony Drug Conviction, A-1362.2
SNAP — Budgeting for Members Disqualified for Citizenship, 18-50 Work Requirement or Noncompliance with Social Security Number Requirements, A-1362.3

TANF

Advisors must disqualify a required member of the certified group who fails to comply without good cause.

Exception: Advisors must deny the application/EDG if the:

- only eligible child or otherwise eligible person does not comply; or
- caretaker/payee refuses to cooperate and the advisor cannot otherwise determine eligibility of the other members.

SNAP

Advisors must disqualify an applicant who fails to comply.

Exception: Follow policy in A-410 for the following situations:

- children under age six months,
- expedited service, and
- good cause claims.

Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35, TP 36 and TP 45

Advisors must deny an individual's eligibility if the individual fails to comply with the SSN requirements explained in this section. Denying eligibility for an individual who does not comply with SSN requirements does not impact the eligibility for any other individuals applying for or receiving Medical Program benefits.

A—421 Reestablishing Eligibility

Revision 15-4; Effective October 1, 2015

TANF and SNAP

If a member is disqualified at application and later complies, the individual is included effective the month after being notified of the compliance.

A—430 Proof Required by SSA

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35, TP 36 and TP 45

The proof required to get an SSN is shown in the table below, except for special situations that are listed in A-431, Special Situations. The proof needed depends on:

- place of birth;
- citizenship status; and
- whether the request is for an original, duplicate, or corrected SSN.

If the applicant is a/an ...	applying for ...	then the applicant must furnish proof of ...
U.S. citizen born in the U.S.,	an original SSN,	age, identity, and citizenship.
U.S. citizen born in the U.S.,	a duplicate SSN,	identity.
U.S. citizen born outside the U.S.,	an original SSN,	age, identity, and citizenship.
U.S. citizen born outside the U.S.,	a duplicate SSN,	identity and citizenship.
alien,	an original SSN,	age, identity, and lawful alien status.
alien,	a duplicate SSN,	identity and lawful alien status.

Note: To correct/update SSN information, the applicant must provide proof required for a duplicate SSN as well as proof showing the new information.

Acceptable Proof

The documents must be originals, or copies made by the custodian of the record, such as a county clerk or registrar. SSA will return all documents submitted to SSA.

Proof of Age and Citizenship

A birth certificate is the preferred proof.

If no birth certificate is available, **a U.S.-born citizen** may furnish:

- a religious record showing age or date of birth (to establish citizenship, it must have been recorded within three months of birth);
- a hospital birth record;
- a notice of birth registration; or
- other documents, at least one year old, that show:
  - name,
  - age or date of birth, and
  - place of birth.

If no birth certificate is available, **a foreign-born U.S. citizen** may furnish a:

- U.S. Consular Report of Birth,
- U.S. Citizen Identification Card (Form I-197),
- Certificate of U.S. Citizenship (Form N-560),
- U.S. Passport, or
- Certificate of Naturalization (Form N-550 or N-570).

Proof of lawful alien status:

- I-551, Permanent Resident Card (Resident Alien Card);
- I-151, Alien Registration Receipt Card;
- I-94, Arrival-Departure Record; or

- I-688A, Employment Authorization Card.

Proof of Identity

Proof of identity must contain enough information to identify the applicant, such as name, age or date of birth, address, signature, and physical description. Examples of acceptable documents are:

Identity card	Adoption record
Work identification card	Medical record/vaccination record
Driver's license	Insurance policy
U.S. passport	School record/report card
Marriage or divorce record	Voter registration

A—431 Special Situations

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35, TP 36 and TP 45

The following situations require special handling.

- If the SSN applicant is a non-U.S. citizen who traditionally uses a name order different from the customary U.S. name order (first name, middle name, last or family name), determine name order according to U.S. custom and enter appropriately onForm H1106, Enumeration Referral.

Example: Vietnamese name on I-94:	Nguyen	Thi	Mai
-	last	first	middle
Enter on Form H1106:	Thi	Mai	Nguyen

- The SSA can make citizenship determinations for SSN purposes in two situations where a child is born outside the U.S. to U.S. citizen parents. They are:
  - the child was born to parents wedded to one another, both parents were U.S. citizens when the child was born, and at least one parent resided in the U.S. any time before the child's birth; or
  - the child was born out of wedlock to a U.S. citizen mother, who resided in the U.S. at least one year before the child's birth.

In these two situations, SSA requires:

- proof of the parents' U.S. citizenship,
- proof of the parent/child relationship, and
- proof the parent lived in the U.S. before the child's birth.

In all other situations, SSA will refer the SSN applicant to the U.S. Citizenship and Immigration Services for a citizenship determination.

A—432 SSN Discrepancy Clearance Procedures

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35, TP 36 and TP 45

If an individual's SSN cannot be verified, TIERS will generate an Alert 268, Social Security Administration Unable to Verify SSN (RG-083). A task is created for the Alert 268, and it is routed to the Customer Care Center (CCC) for action.

If the individual fails to cooperate in clearing the discrepancy with the SSA, advisors follow procedures in A-420, Failure to Comply.

Note: If TIERS shows the SSN as verified, but it needs to be corrected, advisors must send a memorandum with the correct SSN to State Office Data Integrity (SODI) to make a change:

SODI Section, Data Base Support

P.O. Box 14930, MC Y92-2

Or fax to Data Base Support at 512-706-7140.

Or send the request to the Data Integrity email box at HHSC DI Biographical Corrections@hhsc.state.tx.us.

SODI staff notifies the staff member by memo when the change is made.

A—440 Verification Requirements

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35, TP 36 and TP 45

Advisors must verify that a household member applied for a SSN when the applicant cannot provide an SSN. Refer to A-410, General Policy, for applicable exceptions, by program.

TANF and SNAP

SSNs are validated through the SSA interface in TIERS. Validation of an SSN is identified in the Data Collection/Individual Summary Page when the SSA box is checked for the individual.

Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35, TP 36 and TP 45

Advisors must follow the policy for verifying SSN using State Online Query (SOLQ) or Wire Third-Party Query (WTPY) as explained in A-351.2, Using State Online Query (SOLQ) or Wire Third-Party Query (WTPY) to Verify Citizenship.

If the advisor is unable to verify the SSN using SOLQ or WTPY, the advisor must:

- Review the information entered into the SOLQ or WTPY request with the information provided by the applicant. If a typographical error is found, submit a new SOLQ or WTPY request with the correct information.
- If no typographical errors are found, contact the applicant by phone to ensure the information provided is accurate. If the applicant provides new information, submit another SOLQ or WTPY request with the correct information. Update the EDG record with the correct information.
- If unable to contact the applicant by phone, send the applicant Form H1020, Request for Information or Action, to request verification of the applicant's SSN along with any additional information needed. Allow the individual 10 days to provide proof.
- If the individual fails to cooperate in clearing the discrepancy with the SSA, advisors must follow procedures explained in A-420, Failure to Comply.

Advisors must verify all good cause reasons to providing an SSN, explained in A-410.

Related Policy
Questionable Information, C-920
Providing Verification, C-930

A—441 Verification Sources

Revision 15-4; Effective October 1, 2015

All Programs

For SSN discrepancies or SSNs that cannot be verified through the SSA interface, SOLQ, or WTPY, the applicant must provide one of the following:

- Copy of the SSN card; or
- Social Security Administration letter confirming the SSN.

Acceptable proof of application of an SSN includes:

- Form SSA-5028, Receipt for Application for an SSN, less than 30 days old;
- Form SSA-2853, Message From Social Security, less than 180 days old; and
- Form H1106, Enumeration Referral.

Medical Programs

Form H1106, completed by the Social Security Administration, is the acceptable verification source for not providing an SSN due to ineligibility to receive an SSN or eligibility to receive an SSN only for a valid non-work reason. Advisors must review the response provided by the SSA on the Form H1106 to determine which good cause reason the applicant meets.

Acceptable sources of verification for a well-established religious objection include:

- an approved IRS Form 4029, Application for Exemption from Social Security and Medicare Taxes and Waiver of Benefits; or
- a letter from a leader of the religious organization, a document setting out the tenets of the religious organization which justify the good cause reason, or a similar document.

Note: If the source of verification for a religious exemption is questionable, advisors must contact their supervisor who will coordinate with the Texas Health and Human Services Commission (HHSC) regional attorneys to ensure the documentation is sufficient.

A—450 Documentation Requirements

Revision 15-4; Effective October 1, 2015

All Programs except TA 31, TP 32, TP 33, TP 34, TP 35, TP 36 and TP 45

In the Data Collection/Individual Demographics-SSN/Armed Services page, the advisor must enter the date the individual was given Form SSA-5028, Receipt for Application for an SSN, or Form SSA-2853, Message From Social Security, or the date the applicant returned Form H1106, Enumeration Referral. For EDGs with an individual currently being enumerated, the advisor sends the following documents for imaging:

- Form H1106,
- a copy of Form SSA-5028, or
- a copy of Form SSA-2853.

Advisors must document that the SSA enumerated the individual or was unable to do so.

Related Policy

Documentation, C-940

SNAP

Advisors must document good cause claims according to A-410, General Policy.

Related Policy
The Texas Works Documentation Guide

TWH, A-500, Age/Relationship

Revision 15-4; Effective October 1, 2015

A—510 Age Limits

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

For age requirements, see household composition:

- A-220 for TANF, and
- A-240 for Medical Programs.

A—520 Relationship

Revision 13-2; Effective April 1, 2013

A—521 Eligibility Requirements

Revision 16-4; Effective October 1, 2016

TANF

A child must live or be expected to live in the home of one of the relatives (either biological or adoptive) listed in A-221, Who Is Included, No. 4, Caretaker.

TANF-SP

A child must live with or be expected to live with both legal parents, or one legal parent and a stepparent.

Note: This also includes legal parents/stepparents who are disqualified for one of the reasons listed in A-222, Who Is Not Included, No. 4, Disqualified Members, unless that disqualification is due to not meeting citizenship requirements.

TP 08 and TA 31

In order to qualify for TP 08 or TA 31, an individual must be a:

- legal parent of a dependent child (both legal parents can be eligible);
- caretaker relative of a dependent child; or
- spouse of a caretaker relative.

The caretaker must be a:

- parent;
- stepparent*;
- sibling;
- step-sibling;
- grandparent;
- uncle or aunt;
- nephew or niece;
- first cousin; or
- first cousin once removed.

*A stepparent of a dependent child is considered within the degree of relationship for TP 08, Parents and Caretaker Relatives Medicaid, and TA 31, Parent and Caretaker Relative Medicaid - Emergency. The relationship to the dependent child remains even if the legal parent and stepparent are divorced or the legal parent is deceased.
The spouse of a caretaker relative may also be eligible for medical coverage if they live with the caretaker relative who cares for the dependent child receiving Medicaid.

Example: A grandfather is the caretaker relative of his granddaughter. The grandfather applies for Medicaid for himself, his granddaughter, and his spouse who lives with him. If the granddaughter is eligible for Medicaid, both the grandfather and his spouse may be eligible for TP 08.

A dependent child is an individual who:

- is under age 18; or
- if age 18, attends school full-time.

TP 32, TP 33, TP 34, TP 35, TP 43, TP 44, TP 48 and TP 56

To be eligible for these programs, a child can:

- live with the child's parents;
- live with a caretaker within the degree of relationship required for TP 08 and TA 31;
- live with a person not within the degree of relationship required for TP 08 and TA 31;
- be abandoned; or
- live independently.

TP 45

A child whose mother is eligible for and is receiving Medicaid coverage at the time of the child's birth, or whose mother is eligible for and receives Medicaid coverage retroactively for the time of the child's birth, is eligible for TP 45 coverage. The Medicaid coverage for the newborn can continue through the month of the child's first birthday if the child remains in Texas, even if the child does not reside with the birth mother.

Related Policy
Guide for Determining Relationship, C-1441
Guide for Determining Extended Relationships, C-1442

A—522 Legal Parent-Child Relationship

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

A legal parent-child relationship exists between a child and:

- an adoptive parent by proof of adoption;
- the mother by proof of having given birth to the child; or
- a man if one of the following conditions exist:
  - The man and the mother married (including a common-law marriage) in apparent compliance with the law before the child's birth (even if the marriage is or could be voided), and the child was born:
    - while they were married; or
    - within 300 days after the marriage terminated.
  - The man and the mother married (including a common-law marriage) in apparent compliance with the law after the child's birth (even if the marriage is or could be voided), and the man:
    - filed a paternity suit, including a statement of paternity in court;
    - is named the father on the child's birth certificate; or
    - has a written obligation to support the child voluntarily or by court order.
  - The courts determine that the man is the biological father.

If there is no other legal father, a legal parent-child relationship exists between a man and a child if one of the following conditions exists:

- The man and the mother do not marry, but the man consents in writing to be named as the child's father on the child's birth certificate.
- Before the child turns age 18, the child lived with the man and holds out to the public that the man is the child's father.
- The man signs an acknowledgement of paternity (AOP) with the Office of Attorney General or Vital Statistics Unit. The child's mother must also be available to sign the AOP.

A—523 When Proof of Relationship Is Unavailable

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

If Birth Verification System (BVS) records do not establish relationship or the applicant cannot provide proof of relationship shown in A-531, Verification Sources, the advisor must use alternative ways to determine relationship. See A-523.1, How to Make an Evaluative Conclusion.

A—523.1 How to Make an Evaluative Conclusion

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

The advisor must examine all available proof such as (but not limited to) school records, court records, birth records, health records, insurance policies, refugee's voluntary resettlement agency (VOLAG) or the U.S. Citizenship and Immigration Services (USCIS) records, or other sources of proof that provide the same information. The advisor should offer reasonable assistance if the individual has difficulty obtaining the information.

Advisors must obtain supervisory approval of the evaluative conclusion.

A—523.2 Children Living with Biological Father

Revision 15-4; Effective October 1, 2015

TANF, TP 08 and TA 31

A biological father may receive TANF, TP 08, or TA 31 if the biological father proves relationship. If the father cannot provide acceptable proof, the advisor must make an evaluative conclusion to establish relationship for the father and child. The OAG uses the automated child support referral to locate the mother and establish paternity of the biological father. The OAG notifies the advisor via Form H1701, Child Support, TANF Foster Care and TANF/Medicaid Case Information Exchange, that paternity is established or excluded. If paternity is excluded, advisors must process an overpayment claim for the period of time the household erroneously received benefits as specified in B-700, Claims.

Proof of a court determination of paternity is required if, at the time of the child's birth, the child's mother was married to another man who is presumed to be the child's legal father.

A—523.2.1 Children Living with Relatives of Biological Father

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

To qualify for TANF or Medical Programs, a caretaker relative must establish required relationship to the child as specified in A-221, Who Is Included, following the steps below:

The caretaker relative must provide acceptable proof of relationship between:

- the caretaker and the biological father; and
- the biological father and the child, using the conditions listed in A-522, Legal Parent-Child Relationship.

A—530 Verification Requirements

Revision 15-4; Effective October 1, 2015

TANF, TP 08 and TA 31

Advisors must verify the age and relationship of each child to the adult claiming the relationship before certifying or adding the child to the cash grant and/or before certifying the adult for Medicaid. Advisors use BVS inquiry for someone born in Texas and who is at least 46 days old but less than 19 years old.

See A-531, Verification Sources. If these verifications are not available, make an evaluative conclusion. See A-523.1, How to Make an Evaluative Conclusion.

Related Policy
Birth Verification System, C-860

A—531 Verification Sources

Revision 15-4; Effective October 1, 2015

Medical Programs

Age and Relationship

- BVS inquiry
- Temporary Assistance for Needy Families (TANF) sources

Medical Programs except TP 08 and TA 31

Age and Relationship

- Individual's self-declaration establishing age and relationship if other sources are unavailable

TANF

Age

- Birth certificate
- Hospital or public health birth records
- Church or baptismal birth record
- BVS inquiry
- Local, state, federal or military record
- Adoption papers or records
- Indian census records
- U.S. passport
- School or day care records
- U.S. Citizenship and Immigration Services records
- Attorney General child support paternity records
- Social Security Administration records

Alternate Age Sources

- Court or child welfare records
- Insurance policies
- Family Bible records
- Records of voluntary social service agencies
- Court child support order
- Written statement from a doctor or clergy who knows date of birth
- Juvenile court records
- Census records

- Written statement from a non-relative who knows date of birth

Relationship

- Birth certificate
- Adoption papers or records
- Hospital or public health records of birth and parentage
- BVS inquiry (see A-540, Documentation Requirements)
- Church or baptismal birth record
- Local, state, federal government or military record
- School or day care records
- U.S. Citizenship and Immigration Services records
- Attorney General child support paternity records
- Juvenile court records
- Indian census records
- U.S. passport
- Marriage license/certificate
- Divorce papers
- Court records of parentage

AlternateRelationship Sources

- Church records of parentage and relationship (including statement from clergy)
- Family Bible records
- Court or child welfare records
- Insurance policies
- Records of voluntary social service agencies
- Statement from clergy, doctor or school official who can verify relationship
- Statement from non-relative who has known the child since birth

Related Policy
Questionable Information, C-920
Providing Verification, C-930

A—540 Documentation Requirements

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

Advisors must document proof of age or relationship and the basis for the evaluative conclusion or enter on the Texas Integrated Eligibility Redesign System (TIERS) Individual Household page and the Relationship page.

Advisors must document the following:

- The verification source.
- The verification date.
- Children's names.
- Information from the verification source to prove the children live in the home (for collateral contacts include name and address and/or phone number).
- Reason for any temporary absence.
- Information from the verification source to prove the household member or payee returned to and lived in the home for at least 30 days when allowing another temporary absence period.

Related Policy
Documentation, C-940
The Texas Works Documentation Guide

TWH, A-600, Identity

Revision 15-4; Effective October 1, 2015

A—610 General Policy

Revision 07-4; Effective October 1, 2007

A—611 At Application

Revision 15-4; Effective October 1, 2015

TANF, TP 08 and TA 31

Advisors must verify the identity of the **person interviewed**. Once identity has been verified for an individual, advisors do not need to re-verify.

Related Policy Identifying Applicants Interviewed by Phone and Prevention of Duplicate Participation, A-2000

Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Advisors must verify the identity of **all individuals requesting benefits.** Once identity has been verified for an individual, advisors do not need to re-verify.

If questionable, advisors verify the identity of the person interviewed.

Related Policy Verification of Citizenship, A-351

SNAP

Advisors must verify the identity of the **person interviewed.**

If the authorized representative (AR) applies for the household, the advisor must verify the identity of both the AR and the person the AR represents.

Exception: If necessary to meet expedited service time limits, advisors only need to verify the identity of the AR being interviewed.

Related Policy Identifying Applicants Interviewed by Phone and Prevention of Duplicate Participation, A-2000

A—612 Redetermination

Revision 15-4; Effective October 1, 2015

SNAP, TANF and TP 08

Advisors must verify the identity of the **person interviewed** if not previously verified.

Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Advisors must verify the identity of **each individual requesting benefits** during the redetermination if identity has not been previously verified using a source from the Medical Programs list in A-621, Verification Sources, or a source from the Medical Programs list in A-358.1, Citizenship, that verifies both identity and citizenship. Once identity has been verified for an individual, advisors do not need to re-verify.

Related Policy Verification of Citizenship, A-351 Identifying Applicants Interviewed by Phone and Prevention of Duplicate Participation, A-2000

A—613 Receipt of Lone Star Card and/or PIN

Revision 15-4; Effective October 1, 2015

SNAP and TANF

Advisors must verify the identity of a person receiving a Lone Star Card and/or personal identification number (PIN) (initial issuance or replacement).

A—620 Verification Requirements

Revision 03-5; Effective July 1, 2003

All Programs

Birth records and other official records are preferred sources of verification.

A—621 Verification Sources

Revision 15-4; Effective October 1, 2015

SNAP and TANF

- Driver license or Department of Public Safety (DPS) identification (ID) card (current or expired)
- Birth certificate (see **Note**)
- Hospital or birth records
- Adoption papers or records
- Work or school ID card
- Voter registration card
- Wage or check stubs or check
- U.S. passport or U.S. passport card
- Certificate of Naturalization
- Certificate of U.S. citizenship
- Finding of citizenship by another federal/state agency
- Collateral statement
- Immigration documents
- Self-declaration of driver license or DPS ID number already on file, along with other identifying information (Social Security number and date of birth)
- Self-declaration of driver license or DPS ID number listed on Data Broker, along with other identifying information (Social Security number and date of birth)

Note: Individuals born in Puerto Rico must provide a birth certificate issued on or after July 1, 2010, unless certified previously using a birth certificate issued before July 1, 2010. See C-932, Advisor Responsibility for Verifying Information, for information regarding assisting an individual in obtaining birth verification from Puerto Rico.

TP 08, TP 43, TP 44, TP 48, TP 40 and TA 31

Copies of the document used to verify identity **for individuals requesting benefits** must be legible and non-questionable. Submit the document for imaging.

Identity and Citizenship

A-358.1, Citizenship, includes the sources that verify both identify and citizenship for Medical Programs.

Identity Only

- One of the following sources is acceptable for verification, if the document has a photograph and other identifying information such as (but not limited to) name, age, date of birth, sex, race, height, weight, eye color, or address:
  - Driver's license issued by a state or territory;
  - School identification card;
  - U.S. military card or draft record;
  - Identification card issued by the federal, state, or local government with the same information included on driver's licenses;
  - Military dependent's identification card; or
  - U.S. Coast Guard Merchant Mariner card;
- Native American Tribal document;
- Signed application for Medicaid (including the signature of an authorized representative acting on the individual's behalf) — this is applicable for all individuals on the application except the signee (no person may declare to their own identity);
- Two or more corroborating documents (examples include, but are not limited to, marriage licenses, divorce decrees, or high school diplomas);
- For children under age 19, a clinic, doctor, hospital, or school record, including preschool or day care records; and
- Form H1097, Affidavit for Citizenship/Identity, signed by another individual who can reasonably declare to the applicant's citizenship, regardless of blood relationship to the individual and under penalty of perjury, and that contains the applicant's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized and should be used only as a last resort when other evidence is not available.

Related Policy
Questionable Information, C-920
Providing Verification, C-930
Using State Online Query (SOLQ) or Wire Third-Party Query (WTPY) to Verify Citizenship, A-351.2

A—630 Documentation Requirements

Revision 15-4; Effective October 1, 2015

All Programs

Advisors must document how the identity of the person interviewed was verified.

Medical Programs except TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Advisors must document how the identity of **each individual requesting benefits** was verified. Copies of the document used to verify identity must be legible and non-questionable. Submit the document for imaging.

Related Policy
Documentation, C-940
The Texas Works Documentation Guide

TWH, A-700, Residence

Revision 18-1; Effective January 1, 2018

A—710 General Policy

Revision 18-1; Effective January 1, 2018

All Programs

Applicants must live in Texas to be eligible for benefits. The household is not required to have a permanent dwelling or fixed residence.

TANF and Medical Programs

Individuals who live in Texas (other than for migrant or itinerant work) meet the residency requirement if they are living in Texas intending to remain in Texas. People who live in Texas for a temporary purpose do not meet the residency requirement.

The person's residence becomes questionable when the post office returns Texas Health and Human Services Commission (HHSC) correspondence or benefits as undeliverable.

Migrant and itinerant workers meet the residency requirement when applying if they:

- live in the state;
- entered the state with a job commitment or an intention to seek employment (regardless of current employment status); and
- do not receive assistance from another state.

SNAP

People who live in Texas for any purpose other than a vacation meet the residency requirement, regardless of the length of time they have been here or plan to stay.

Related Policy
Form TF0001 Required (Adequate Notice), A-2344.1

A—720 New Texas Residents

Revision 15-4; Effective October 1, 2015

All Programs

A person cannot participate in more than one state in any month.

When an applicant recently received benefits in another state, the advisor must verify the last month the benefits were issued.

The following links may be used as resources to contact agencies in other states to verify that a new Texas resident's benefits have ended in another state.

Supplemental Nutrition Assistance Program (SNAP) Agencies:

National Directory of SNAP Agencies

Medicaid and Children's Health Insurance Program (CHIP) Agencies:

https://www.medicaid.gov/medicaid/by-state/by-state.html

Temporary Assistance for Needy Families (TANF) Agencies:

www.acf.hhs.gov/programs/ofa/help

Medical Programs

New Texas residents may receive overlapping Medicaid coverage. See A-822, Medicaid Coverage for New State Residents, to determine the correct medical effective dates (MEDs) for these persons.

SNAP

Residents in an approved shelter for battered persons may participate twice during the month of application if they participated first with the person who abused or threatened them with abuse.

A—730 Moves Within Texas

Revision 15-4; Effective October 1, 2015

All Programs

Individuals keep their residence status when they move within Texas.

TANF and SNAP

A person cannot participate as a member of more than one household in any month.

SNAP

Residents in an approved shelter for battered persons may participate twice during the month of application if they participated first with the person who abused them or threatened them with abuse.

Related Policy
Household Composition, A-200

A—740 Moves Out of Texas

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

A certified individual becomes ineligible if the individual moves to another state:

- with the intent to remain there, or
- without declaring intent to return.

If the individual returns to Texas within 90 days and states that the move was not intended to be permanent, the advisor must:

- reopen the Eligibility Determination Group (EDG) using the reason denied-in-error; and
- issue restored benefits, if appropriate.

SNAP

A household is not eligible for benefits issued for a month after the household leaves Texas.

When a household member notifies HHSC that the household moved out of Texas, Form TF0001, Notice of Case Action, is not required. If the household has not yet moved, the advisor must issue Form TF0001 to provide adequate notice. The EDG is denied effective the end of the month they move, if possible.

Related Policy
Canceling Benefits, B-330

A—750 Temporary Visits Out of Texas

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

Individuals do not lose their residence status when they temporarily leave Texas.

An individual can be absent from Texas for any length of time. Advisors must review the situation every three months to determine the individual's intent to maintain Texas residence. The individual must reasonably explain:

- the purpose for leaving Texas,
- the intent to return to Texas, and
- which state the individual claims residency in.

An individual is a resident of Texas unless there is substantial, factual evidence that proves otherwise. When the advisor determines that the individual is no longer a resident, the individual is denied.

SNAP

A person is not eligible for SNAP in Texas for any month the individual is out of Texas the entire month.

A—760 Verification Requirements

Revision 15-4; Effective October 1, 2015

All Programs except TP 33, TP 34, TP 35, TP 43, TP 44, TP 45 and TP 48

Advisors must verify the actual physical address of a household at each application and redetermination.

Exceptions:

- Residence verification is not a requirement for SNAP categorically eligible TANF/Supplemental Security Income (SSI) households.
- Self-declaration is acceptable as verification of residence when certifying a child for TP 56, MA-Medically Needy with Spend Down.

Note: Residence verification is a requirement for TANF and categorically eligible TANF-Non-Cash (NC) households. Refer to B-472, Special Treatment for Households Meeting Categorical Eligibility Criteria.

When an applicant recently received benefits in another state, the advisor must verify the last month the benefits were issued.

When the advisor cannot verify residence with readily available evidence, the advisor must:

- contact the landlord, neighbors or other sources of reliable information; or
- observe personal effects and living arrangements.

When residence is difficult to verify because of unusual circumstances, the advisor must document all efforts to verify and certify the EDG.

Note: If residence for any household is questionable, the advisor may require the household to provide a source of verification that is more reliable, such as one of the primary sources of verification listed in A-761, Verification Sources. The advisor cannot restrict verification to a specific source from that list.

TANF and Medical Programs

Advisors must determine that the household intends to remain in Texas at each application and redetermination.

SNAP and TP 40

Advisors must postpone residence verification if trying to meet expedited service time frames.

TP 33, TP 34, TP 35, TP 43, TP 44, TP 45 and TP 48

Self-declaration is acceptable as verification of residence.

A—761 Verification Sources

Revision 15-4; Effective October 1, 2015

All Programs except Children’s Medicaid

The following are acceptable verification sources to verify the household's current address:

- utility bills or utility company records;
- rent receipt or statement from non-relative landlord;

- mortgage receipt or statement from mortgage company;
- valid Texas driver license or Department of Public Safety (DPS) identification card;
- Data Broker residence reported on the DPS data field;
- Department of Motor Vehicles record;
- school records;
- voter registration card;
- statement from child care provider;
- employment records or statement from employer;
- official records confirming ownership of property;
- home visit;
- WTPY or SOLQ for Social Security benefit recipients, including those receiving Medicare;
- item of mail with household name and address;
- if HHSC mailed the household an appointment notice (Form H1830-I, Interview Notice) to the Texas address the individual currently reports (this includes post office boxes), attendance at the appointment (either by phone or face-to-face) can be used as residence verification;
- other HHSC correspondence the individual can provide showing the household received it at the individual's current Texas address;
- inquiry into Office of the Attorney General (OAG), Texas Workforce Commission (TWC) or another entity's automated system, outside of HHSC, showing the same Texas address currently reported by the household;
- a local landline telephone number the individual provides (not a cell phone number) that is either listed in the telephone book or an online directory with the same Texas address the household currently reports, or the household can be contacted at that local telephone number when conducting a telephone interview;
- searches resulting in a match between the address and the telephone number provided by the individual using the Data Broker Search Options Menu, Telephone Number Search;
- post office records;
- city or crisscross directory;
- church records; or
- statement from non-relative.

Exception: Self-declaration of residence is acceptable when certifying a child for TP 56, MA - Medically Needy with Spend Down.

TANF and Medical Programs

The individual's statement of intent to remain in Texas is acceptable.

Children's Medicaid

Self-declaration.

Related Policy
Questionable Information, C-920
Providing Verification, C-930

A—770 Documentation Requirements

Revision 15-4; Effective October 1, 2015

All Programs

Advisors must document the individual's:

- proof of address, and
- all efforts to verify residence when residence is difficult to verify because of unusual circumstances.

TANF and Medical Programs

For temporary visits outside of Texas, advisors must document:

- the individual's purpose for leaving;
- the individual's intent to return to Texas; and
- which state the individual considers their residence.

Related Policy
Documentation, C-940

TWH, A-800, Medicaid Eligibility

Revision 18-1; Effective January 1, 2018

A—810 General Policy

Revision 16-4; Effective October 1, 2016

Medical Programs

Applicants may receive Medicaid during the three-month period before the month they apply for Medicaid. See A-831, Three Months Prior Coverage, for eligibility criteria and application procedures.

Some former individuals on TP 08, TP 43, TP 44, and TP 48 remain eligible for Transitional Medicaid after their eligibility is denied. See the chart that follows for more information.

Reason for Denial	Type Program	Who Is Covered?
Alimony/Spousal support	TP 20 (A-850, Alimony/Spousal Support Transitional Medicaid Coverage)	The household
New or increased earnings	TP 07 (A-842, TP 07 Transitional Medicaid)	The household

Most adopted children receive Medicaid through the Texas Department of Family and Protective Services (DFPS). DFPS works with the Interstate Compact on Adoption and Medical Assistance (ICAMA) to facilitate the timely delivery of Medicaid coverage when a family moves or the adoption involves an interstate placement. If an adopted child is receiving Medicaid in another state, the parent must contact the originating state to coordinate and transfer Medicaid coverage information to Texas. If an adoptive parent has any questions about the adoptive child's Medicaid, advisors should inform them to contact their local DFPS office for assistance.

Medical Programs, Qualified Medicare Beneficiaries (QMB) and Specified Low-Income Medicare Beneficiaries (SLMB)

Individuals receiving some Texas Works Medicaid types of assistance may also qualify for the Medicaid for the Elderly and People with Disabilities (MEPD) Medicare Savings Program types of assistance, MC – QMB (TP 24) or MC – SLMB (TP 23), if they meet the eligibility criteria. See policy in the *Medicaid for the Elderly and People with Disabilities Handbook*, Q-2000, Qualified Medicare Beneficiaries (QMB) — MC-QMB.

Individuals may receive QMB and the following types of assistance:

- MA – Earnings Transitional (TP 07)
- MA – Parents and Caretaker Relatives (TP 08)
- MA – Pregnant Women (TP 40)
- MA – Children Under 1 (TP 43)
- MA – Newborn Children (TP 45)
- MA – Children 1-5 (TP 48)
- MA – Children 6-18 (TP 44)
- MA – Former Foster Care Children (FFCC) (TA 82)

The above programs cannot be dually eligible for SLMB. Even though these programs may meet SLMB eligibility requirements, the Medicare Part B premium is already paid. An individual can be dually eligible for MA – MN with Spend Down (TP 56) and SLMB.

A—820 Regular Medicaid Coverage

Revision 17-3; Effective July 1, 2017

Medical Programs

Regular Medicaid eligibility begins the day an individual meets all eligibility criteria. It is usually the first day of the application month if all eligibility criteria are met.

The following are situations when the medical effective date (MED) may not be the first day of the application month.

- The MED cannot precede a newborn's date of birth.
- The MED cannot precede the date a child enters the home.

  Exception: A child's MED can be earlier than when the child enters the home when the child is born to a woman incarcerated in the Texas Department of Corrections at Gatesville. Advisors assign the date of birth as the MED for the child requiring this coverage when contacted by a special Texas Works advisor housed at the University of Texas Medical Branch (UTMB) Hospital. Advisors must document this contact in Case Comments.

- The MED for the parent or caretaker relative cannot precede the date of birth of the newborn or a child's entry into the home when the newborn or entering child is the only child.

  TP 08 Exception: The Texas Integrated Eligibility Redesign System (TIERS) will assign an earlier MED if the parent or caretaker relative has unpaid medical bills and would have been eligible for Medicaid as a pregnant woman from the first day of her infant's birth month.

- The MED cannot precede the start date of the emergency condition for aliens eligible for Emergency Medicaid.
- The MED cannot precede the date a disqualified parent or caretaker relative complies.
- The MED cannot precede the month at least one eligible dependent child is certified for Medicaid.

If the only child that makes a parent or caretaker relative eligible for TP 08 dies before certification, advisors must process an application for Medicaid for a deceased individual. Advisors must provide coverage for the child through the date of death and for the parent or caretaker relative through the remainder of that month.

TP 40

Medicaid for a pregnant woman does not begin before the first day of the month her pregnancy began. The applicant's (pregnant woman's, case name's or authorized representative's [AR's]) verbal or written statement of the start month, the number of expected children and anticipated date of delivery is an acceptable source of verification, as are the other sources listed in A-870, Verification Requirements, if unable to obtain the applicant's statement.

If the applicant's (pregnant woman's, case name's or AR's) statement is not available, advisors may use one of the verification sources in A-870 to obtain the pregnancy start date and anticipated date of delivery.

Advisors must allow until the 15th workday for the requested information to be submitted to the Texas Health and Human Services Commission (HHSC). If it is not returned by the 15th workday, the application is denied. Advisors reopen the application if the individual provides verification by the 60th day from the file date. See B-111, Reuse of an Application Form After Denial.

Exception: Pregnancy verification is not required if the:

- application is processed after the pregnancy terminates; and
- applicant provides proof of her newborn child's birth.

A pregnant woman remains eligible through the second month following the month her pregnancy terminates if all other eligibility requirements are met and countable income is below the income limits in:

- the application month; or
- one of the three months prior to the application month if in the prior month she:
  - had unpaid Medicaid-reimbursable bills; or
  - received services from the Texas Department of State Health Services (DSHS).

Example: A pregnant woman applies for Medicaid in May 2011. Her expected delivery date is December 2011. She has unpaid medical bills in February 2011 and meets all other eligibility requirements. She does not have any unpaid medical bills in March or April 2011. The advisor must certify her for Medicaid from February 2011 through February 2012.

After determining a pregnant woman is eligible for TP 40, the woman remains eligible even if the budget group's income increases above the income limit.

If a woman is certified for expedited benefits, but postponed verifications prove she is not eligible, the advisor must provide advance notice of adverse action and deny her coverage.

TP 45

Before providing initial TP 45 coverage for a newborn child, the advisor must verify that the:

- mother was:
  - eligible for and received Medicaid in Texas on the day the child was born; or
  - retroactively eligible for Medicaid for the day the child was born;
- child resides in Texas; and
- mother was continuously eligible for Medicaid (or would have been eligible if pregnant) during the child's birth month.

Note: A newborn born to a mother who received Emergency Medicaid coverage at the time of the child's birth is eligible to receive TP 45 coverage from the child's date of birth through the end of the month of the child's first birthday.

The MED for the initial certification is always the child's date of birth.

Before resuming coverage for a newborn that has been denied TP 45 the advisor must verify that the child resides in Texas.

Related Policy
Provider Referral Process, A-125

TP 56

Medicaid coverage for children or pregnant women with spend down begins the first day the household meets spend down.
The applicant meets spend down by submitting or having a provider submit medical bills to the Clearinghouse. See A-1532.1, Spend Down EDGs.
The Clearinghouse:

- determines when the individual meets spend down; and
- notifies TIERS via an interface. TIERS then sets the MED for the certified members.

Note: The Clearinghouse may discover a discrepancy while processing a spend down Eligibility Determination Group (EDG). Processing is put on hold and the EDG is referred to State Office Data Integrity (SODI) to research. SODI sends a memo to the field asking for information to clear the discrepancy. Staff must respond quickly to these requests so that the Clearinghouse can complete the spend down process.

Emergency Medicaid

Medicaid eligibility begins on the start date of the emergency medical condition verified by the attending practitioner on Form H3038, Emergency Medical Services Certification, or Form H3038-P, CHIP Perinatal – Emergency Medical Services Certification.

Related Policy
Pregnancy, A-144.5
Medicaid Termination, A-825
How to Determine Spend Down, A-1359
Medicaid Reinstatement, B-826

A—821 Types of Coverage

Revision 15-4; Effective October 1, 2015

Medical Programs

The type of coverage determines how recipients access Medicaid services. There are two types of coverage: fee-for-service and managed care.

A—821.1 Fee-for-Service

Revision 15-4; Effective October 1, 2015

Medical Programs

Fee-for-service, also known as Traditional Medicaid, allows access to any Medicaid provider and self-referral to specialists. The provider submits claims directly to the claims administrator for reimbursement of Medicaid-covered services.

A—821.2 Managed Care

Revision 18-1; Effective January 1, 2018

Medical Programs except TP 56, TA 31, TP 32, TP 33, TP 34, TP 35 and TP 36

Medicaid managed care is health care provided through a network of doctors, hospitals, or other health care providers. The state pays a managed care organization (MCO) a capitated rate for each member enrolled, rather than paying for each unit of service. The providers submit claims directly to the MCO for reimbursement of Medicaid-covered services.

Medicaid managed care programs include:

- STAR (State of Texas Access Reform). STAR provides acute care services (like doctor visits, hospital visits, and prescriptions), and each member is enrolled in an MCO and assigned a main doctor to coordinate care. People who are dually eligible are excluded from this program. It is a statewide program.
- STAR Health. STAR Health provides comprehensive, coordinated health care services for children in foster care and kinship care. Each member is enrolled in a single MCO, Superior HealthPlan, and is assigned a main doctor to coordinate care. People who are dually eligible are excluded from this program. It is a statewide program.
- STAR+PLUS. STAR+PLUS provides acute care and long-term services and supports (LTSS). A key feature of this program is service coordination, or specialized care management. Each member is enrolled in an MCO, and Medicaid-only members are assigned a main doctor. STAR+PLUS serves Medicaid-only and dually eligible individuals, including most nursing facility residents. It is a statewide program.
- STAR Kids. STAR Kids provides acute care services and long-term services (LTSS). Additionally, people eligible for Medically Dependent Children's Program (MDCP) waiver services receive these services through STAR Kids. A key feature of this program is service coordination. Each member is enrolled in a MCO and assigned a main doctor to coordinate care. STAR Kids serves children and young adults age 20 or younger with disabilities.
- Children's Medicaid Dental Services. Children's Medicaid Dental Services provide primary and preventive dental services in managed care. Each member is enrolled in a dental maintenance organization (DMO) and has a main dental home. Most children, birth through age 20, who receive Medicaid, are eligible for dental services.

Medicaid managed care is available statewide in the following service areas: Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Medicaid Rural Service Area (RSA) West, Medicaid RSA Central, Medicaid RSA Northeast, Nueces, Tarrant and Travis.

See C-1116, Managed Care Plans, for a list of the counties with Medicaid managed care, the choices available and contact numbers.

Texas Works Medicaid recipients who reside in managed care counties must enroll in managed care. **Exceptions (not comprehensive):**

- STAR exceptions: Dual eligibles (receive Medicaid and Medicare); children enrolled in the DSHS Children with Special Health Care Needs (CSHCN) Program; children and adults residing in institutions (nursing facilities, Intermediate Care Facilities, and State Support Living Centers); Medically-needy program participants; children in foster care/kinship care; adults that receive SSI; children and adults that are in a 1915(c) waiver program.
- STAR Health exceptions: Youth adjudicated in Texas Juvenile Justice Department (TJJD) facilities; youth from other states placed in Texas, or Texas youth placed in other states; youth residing in Medicaid-paid facilities.
- STAR+PLUS exceptions: A person age 20 or younger who is not in the Medicaid for Breast and Cervical Cancer (MBCC) program; people over the age of 21 in Former Foster Care in Higher Education (FFCHE); and people over 21 who are in a 1915(c) waiver program or who reside in community home for people with Intellectual Developmental Disabilities and are dual eligibles.
- STAR Kids: A person over the age of 21 and a person under age 20 without disabilities.

- Children's Medicaid Dental Services exceptions: people age 20 or younger who reside in an institution; people in STAR Health; youth placed in other states; and adults age 21 and older.

MAXIMUS contracts with the state to enroll recipients into Medicaid managed care. MAXIMUS mails newly certified individual's enrollment packets that include information about the plan choices available in their county of residence. If the recipient does not choose a plan or a main doctor by the deadline provided in the enrollment packet, MAXIMUS assigns a plan and a main doctor and mails the individual the information.

Special populations are exempt from mandatory enrollment in Medicaid managed care and may choose to participate voluntarily. The special populations include:

- members of federally recognized Indian tribes (all managed care programs); and
- a person age 20 or younger who receive Supplemental Security Income (SSI) or SSI-related benefits and who do not reside in a nursing facility (STAR+PLUS).

At all Medicaid applications and redeterminations, advisors identify and designate individuals appropriately. If the advisor does not have this information, the advisor does not designate an individual as meeting one of the special populations. The application is not pended nor is an eligibility determination delayed for this information.

TIERS refers newly certified individuals to MAXIMUS to initiate their enrollment into managed care. MAXIMUS staff is available in some local eligibility determination offices. The client can also call the MAXIMUS Helpline at 800-964-2777 to initiate enrollment, to request a plan change, or to disenroll from managed care if the person is exempt from mandatory enrollment in Medicaid managed care.

If a person has difficulty accessing medical services in a managed care plan, the advisor refers that person to the Medicaid Managed Care Helpline at 1-866-566-8989. The Medicaid Managed Care Helpline advocates for managed care recipients having trouble getting the medical and dental care they need.

Related Policy
Office of the Ombudsman, B-1420
Managed Care Plans, C-1116

A—822 Medicaid Coverage for New State Residents

Revision 15-4; Effective October 1, 2015

Medical Programs

Advisors must determine the correct MED for applicants who:

- move to Texas from another state during the application month or the three months prior to the application month, and
- are Medicaid recipients in the losing state in the month they move.

Step	Action
1	If the losing state denied the recipient's Medicaid the last day of the month the recipient moved from the state or later, then go to Step 2. If the losing state denied the recipient's Medicaid the day the recipient moved from the state, then assign an MED = date the applicant became a Texas resident.
2	Did any member of the certified group incur Medicaid-reimbursable bills after they moved to Texas? If **yes**, then verify the effective date of denial in the losing state. Go to Step 3. If **no**, then verify the effective date of denial in the losing state. Assign an MED = first day of the month after the month the losing state denied the recipient's Medicaid.
3	Will the losing state pay for the bills incurred in Texas after the day the person became a Texas resident? If **yes**, then assign an MED = first day of the month after the month the losing state denied the recipient's Medicaid. If **no**, then assign an MED = date the applicant became a Texas resident.

Note: If the applicant is unable to provide a contact person in the losing state, the advisor must contact the appropriate state Medicaid director's office. See C-1111, State Medicaid Agencies, for telephone numbers.

When a Texas Medicaid recipient moves to another state, staff from the gaining state may contact the local office about effective dates of denial and coverage of bills incurred in the gaining state. Texas Medicaid pays for Medicaid-reimbursable services provided out-of-state if the:

- recipient needs services because of a medical emergency documented by the attending physician or other provider;
- recipient's health could be jeopardized by not obtaining services; and
- provider enrolls in the Texas Medicaid Program. Out-of-state providers can obtain enrollment information by calling the claims administrator at 1-800-925-9126.

A—823 Lock-In Status

Revision 15-4; Effective October 1, 2015

Medical Programs

HHSC identifies fee-for-service and managed care individuals who:

- received duplicative, excessive, contraindicated or conflicting health services, including drugs; or
- abused, misused or committed fraudulent actions related to Medicaid benefits and services.

These clients may choose one pharmacy and/or one main doctor to be their designated provider for Medicaid services.

The duration periods of lock-in status are as follows:

- The initial period is 36 months.
- The second period is an additional 60 months.
- The third period is for the duration of eligibility and all subsequent periods of eligibility.
- The period of lock-in status for individuals arrested, indicted or convicted of, or admitting to, a crime related to Medicaid fraud differs from the time period listed for initial, second and third periods of lock-in. These individuals will be assigned lock-in status for 60 months or the duration of eligibility and subsequent periods of eligibility up to or equal to 60 months.

For individuals with enrollment lock-in status, HHSC issues a Your Texas Benefits Medicaid card printed with "Lock-in Doctor" and/or "Lock-in Drug Store" on the front of the card, along with the name of the doctor and/or drug store. If an individual with lock-in status prints a Medicaid card from the YourTexasBenefits.com, the same information is displayed.

Staff must verify current lock-in status when issuing Form H1027-A, Medicaid Eligibility Verification. To verify an individual's lock-in status, the advisor may access the individual's **Lock-In Enrollment** page from the **Individual – Summary** page's hover menu. If an individual is in lock-in status, the **Lock-In Enrollment** page will display the provider name and begin date of the status.

Individuals are removed from lock-in status at the end of the specified period if their use of medical services no longer meets the criteria for lock-in status.

Advisors refer individuals with questions regarding their lock-in status to the HHSC Office of Inspector General (OIG) at 1-800-436-6184.

A—824 Issuance of Form H1027-A, Medicaid Eligibility Verification

Revision 15-4; Effective October 1, 2015

Medical Programs

Advisors must issue Form H1027-A, Medicaid Eligibility Verification, to an eligible Medicaid individual only if the individual:

- needs his eligibility verified to receive medical services;
- does not have access to a Your Texas Benefits Medicaid card; and
- is unable to reprint the Medicaid card from YourTexasBenefits.com.

The individual may not have a Your Texas Benefits Medicaid card if the individual:

- is newly certified and has not received it,
- lost or accidentally destroyed the card, or
- is temporarily separated from other eligible family members who have their card.

Before issuing Form H1027-A, staff must verify the individual's current eligibility, enrollment lock-in status and managed care enrollment by accessing the Individual – Summary and Individual – Medicaid History pages. If inquiry is unavailable, advisors must follow regional procedures.

Medicaid with No Enrollment Lock-in or Managed Care Coverage

Issue Form H1027-A for current eligibility if the most recent medical coverage period on the Individual – Summary and Individual – Medicaid History pages:

- is open (no close date shown), and
- reflects regular Medicaid coverage.

Enrollment Lock-in

If an individual is in enrollment lock-in status, "Yes" will display after Lock-In on the **Individual – Summary** page. Advisors select **Lock-In Enrollment** from the hover menu over the individual's client number. The **Individual – Lock-In Enrollment** page provides information regarding the provider(s) to which the individual is currently or was once locked in.

If an individual is currently in lock-in, advisors issue a separate Form H1027-A for the individual and print LIMITED and the name(s) of the provider(s) to which the individual is locked in. Form H1027-A generated in TIERS is printed with "LIMITED" in the "Type of Coverage" field.

Managed Care Coverage

If an individual is in a managed care service area, "Yes" will display after Managed Care on the Individual – Summary page. Select **Managed Care** from the hover menu over the individual's client number. Advisors select the Individual – Managed Care page to view the individual's plan to which the individual is enrolled.

Advisors must issue Form H1027-A for everyone on the case in the same managed care plan by printing the appropriate managed care program name (e.g., STAR, STAR Health, STAR+PLUS) and the name and telephone number of the plan. This information is in C-1116, Managed Care Plans.

After staff verify eligibility, enrollment lock-in status and managed care enrollment, advisors complete, sign and date Form H1027-A. The unit supervisor or other second party must approve the form indicating he verified eligibility and lock-in status.

Form H1027-A is not used if the most recent medical period:

- is closed, or
- shows institutional coverage.

Form H1027-A instructions include detailed information for completing the form.

TA 74, TA 75, TA 76, TA 83, TA 86 and TP 42

The advisor must issue Form H1027-A if the person has a completed Form H1266, Short-term Medicaid Notice: Approved, showing the date the person is approved for coverage.

Form H1027-A instructions include detailed information for completing the form.

State Paid Medicaid

TA 62

State Paid Medicaid coverage shows in the Medicaid History screen when the individual was not eligible for Medicaid and staff have issued Form H1027-A in error. State Paid Medicaid is 100 percent state-funded.

A—825 Medicaid Termination

Revision 17-3; Effective July 1, 2017

TP 08

TIERS runs Mass Update on the fifth, sixth or seventh day of the month in which the review due date falls for the TP 08 Eligibility Determination Group (EDG). TIERS automatically denies the EDG effective the end of the month if a packet received date is not entered by that date.

Related Policy
Denial at Redetermination, A-2342

Emergency Medicaid
Medicaid eligibility for Emergency Medicaid ends the earliest of either the:

- date the individual's condition stabilized as verified by the attending practitioner (or other practitioner familiar with the patient's case) on Form H3038, Emergency Medical Services Certification; or
- last day of the application month.

TP 36

Medicaid eligibility for TP 36 ends the earliest of either the:

- end date of the emergency medical condition verified by the attending practitioner on Form H3038 or, Form H3038-P, CHIP Perinatal – Emergency Medical Services Certification; or
- last day of the application month.

The individual is not eligible to receive two months post coverage once the pregnancy terminates.

Related Policy
Regular Medicaid Coverage, A-820

TP 40

Medicaid eligibility for pregnant women ends on the last day of the second month following the month the pregnancy terminates.

If the pregnancy terminates early because of molar pregnancy, abortion or premature delivery, deny the coverage effective the last day of the second month following the month the pregnancy terminated. If the pregnancy ends in a month later than expected, change the end date to reflect the new termination date.

An individual whose Medicaid for Pregnant Women coverage ends prior to the end of the original certification period, and whose case has not initiated a renewal, may be determined eligible for another type of assistance using current case information without a new application. In addition, the TP 40 EDG must not have been terminated for the following reasons:

- voluntary withdrawal;
- death;
- move out of Texas;
- receipt of benefits in another group; or
- failure to provide postponed verification.

If an individual meets the criteria, TIERS automatically determines eligibility for another type of assistance. If eligible, the individual receives a new certification period. The new certification period begins after the two months post-partum coverage on the TP 40 EDG ends.

Related Policy
Denial of an Application, A-2341
Denial at Redetermination, A-2342

TP 43, TP 44 and TP 48

A child is continuously eligible for six months. If a household fails to report required information at application that causes a child to be ineligible for Medicaid, deny the EDG and send a fraud referral to the Office of Inspector General. This does not apply if the household provides verification required by policy. For example, the household applies for Medicaid for a child, provides one pay stub, and is determined eligible. If providing more income verification would result in the child being ineligible, do not deny the Medicaid EDG. The child remains continuously eligible for the six-month period, because policy requires only one pay stub to verify income for a child's Medicaid EDG. Address the income discrepancy at redetermination.

EDGs with end dates do not require an action to close the EDG when the individual does not return a renewal form. These will close at cutoff in the sixth month of the continuous eligibility period.

Note: Independent children residing in state hospitals are continuously eligible for six months, even if the child is released from the state hospital. If a child is released from the facility prior to the end of the six-month period, process the address change and continue coverage.

For households that return a redetermination form, the advisor must process the form to determine eligibility. If the child is still eligible for Medicaid, the child is assigned a new six-month continuous eligibility period. If the child is no longer eligible for Medicaid, the advisor must process a denial action to close the EDG and record workload activity. Advisors must process the action before cutoff in the sixth month to ensure the denial code reflects the specific reason for denial.

A child is eligible through the month of the:

- first birthday for TP 43;
- sixth birthday for TP 48; and
- 19th birthday for TP 44.

When a child ages out of the current type of assistance, TIERS denies the TP 43 or TP 48 EDG through mass update and opens a new EDG for the next type of assistance if the modified adjusted gross income (MAGI) is equal to or below the corresponding Federal Poverty Income Limits (FPIL). If the MAGI is more than the FPIL for the next type program, the one or six-year-old child remains in the current program through the sixth month of their continuous eligibility period. At redetermination, the advisor determines the correct MAGI, and either extends Medicaid for
another six months or certifies the child for CHIP, if eligible.

Exception: Children aging out of TP 44 are eligible through the month of their 19th birthday.

If a child is ineligible for the next type of assistance or turns 19, the child may continue to receive Medicaid if the child:

- is hospitalized on the child's birthday;
- remains hospitalized through the end of the six-month eligibility period; and
- meets all eligibility requirements except age.

The advisor must verify the child's hospitalization and update the child's living arrangements to "hospital" to prevent TIERS from denying the child's coverage. The advisor must verify the hospitalization each month and update the child's living arrangement when the hospitalization ends.

Reminder: Redetermine a younger sibling's eligibility at renewal when removing a 19 year old from the family's budget group.

Related Policy
Processing Children's Medicaid Redeterminations, B-123

TP 45

A child's eligibility terminates the month of the child's first birthday. Deny the TP 45 EDG before the child's first birthday if the:

- child's mother was presumptively eligible and received TP 42 at the time of the child's birth, but was not eligible for regular Medicaid at the time of the child's birth. The child is eligible for TP 45 through the end of the birth month; or
- child no longer resides in Texas. The child is eligible for TP 45 through the month the change occurs.

Notes:

- If the child's mother met spend down and received TP 56 or TP 32 to cover the child's birth, the child is eligible for TP 45 from the date of birth until the end of the month the child turns one.
- The newborn's coverage is terminated before the child's first birthday by State Office Data Integrity (SODI) in situations in which the child's mother relinquishes her parental rights and information about the child's current residency and new caretaker is unknown. See policy in A-125, TP 45 Provider Referral Process.

Related Policy
Regular Medicaid Coverage, A-820

A-825.1 Recipients of TANF and TP 08

Recipients of TANF must comply with the Personal Responsibility Agreement (PRA), including cooperating with child support requirements and participating in the Choices program, unless exempt. TP 08 coverage is terminated if an individual receiving both TP 08 and TANF is sanctioned for failure to comply with the Choices PRA requirements.

Individuals certified for TP 08, but not TANF, must cooperate with medical support requirements. Failure to cooperate with the requirements result in the termination of the individual's TP 08 coverage.

Notes:

- TANF sanctions due to noncooperation with other PRA requirements do not result in termination of TP 08 coverage.
- Individuals receiving TP 08 who are not receiving TANF are not required to comply with the TANF PRA.
- The noncooperating adult may reapply for Medicaid and qualify after the identified forfeit months, with the exception of those who non-comply with child support. These individuals must comply before becoming eligible for Medicaid.

Related Policy
Sanctions for Noncooperation, A-1141
Personal Responsibility Agreement, A-2100
Choices, A-2121
Child Support, A-2122
When to Start a Full-Family Sanction, A-2141
Denial at Redetermination, A-2342

A—825.2 Medicaid Suspension

Revision 17-2; Effective April 1, 2017

TP 44

A child's Medicaid may be suspended when the child is placed in a secured juvenile facility. The Texas Juvenile Justice Department (TJJD) or Juvenile Probation Departments (JPD) makes the report to HHSC within 30 calendar days of a child's placement. Upon notification, HHSC automatically suspends the child's TP 44 eligibility effective the day after TJJD or JPD notifies HHSC that the child is placed in a juvenile facility. The child receives TP 44 eligibility through the date of the notification of placement. TP 44 eligibility is suspended only for children whose placement is reported by the TJJD or JPD.

If HHSC is notified of the child's placement from a source other than TJJD or JPD, the child's TP 44 is terminated, not suspended.

The following are scenarios for a child certified on Medicaid reported placed in a juvenile facility.

Child is certified for…	**and HHSC receives notification of the child's placement in a juvenile facility from...**	**then the child's…**
TP 44 from December 1, 2016 - November 30, 2017,	TJJD on February 7, 2017,	TP 44 eligibility is suspended effective February 8, 2017.
TP 44 from October 1, 2016 - September 30, 2017,	the child's mother on December 1, 2016,	TP 44 eligibility is denied effective December 31, 2016.

Related Policy

Child Placed in a Juvenile Facility, B-474.1.2.1
Child Placed in a Non-Secure Facility, B-474.1.2.1.1

A—826 Medicaid Reinstatement

Revision 17-2; Effective April 1, 2017

TP 44

Upon notification from the Texas Juvenile Justice Department (TJJD) or Juvenile Probation Department (JPD) that a child whose Medicaid was suspended has been released, HHSC automatically reinstates the child's eligibility effective the date of their release if the child has months remaining on their original certification period. If so, the child is certified for the remaining months on their original certification period. The child is also added back to any associated active TANF, SNAP, Medicaid, CHIP, or Medicaid for the Elderly and People with Disabilities (MEPD) EDGs if the child is a required member of the household.

The child's eligibility is reinstated even if they are released to a household that is different than the one in which they were residing at the time of their placement.

If the child is released to the same household and the case is…	**Then…**
Active or denied	The child's TP 44 eligibility is reinstated for the remainder of the child's original certification period on the same EDG.

If the child is released to a different household…	**Then…**
With an existing denied case	The child's TP 44 eligibility is reinstated for the remainder of the original certification period on a new EDG.
Without an existing case	The child's TP 44 eligibility is reinstated for the remainder of the child's original certification period on a new case.
For individuals released to a different household, any changes to the child's circumstances should be addressed at the next scheduled renewal. Children released to a different household may not administratively renew.	

If the child is released as an independent child with…	**Then…**
An existing denied case	The child's TP 44 eligibility is reinstated for the remainder of the child's original certification period on a new EDG.
Without an existing case	The child's TP 44 eligibility is reinstated for the remainder of the child's original certification period on a new case.

For individuals released as an independent child, any changes to the child's circumstances should be addressed at the next scheduled renewal. Children released to a different household may not administratively renew.

Related Policy

Medicaid Suspension, A-825.1
Child Released from a Juvenile Facility, B-474.1.2.2

A—830 Medicaid Coverage for the Months Prior to the Month of Application

Revision 13-2; Effective April 1, 2013

A—831 Three Months Prior Coverage

Revision 15-4; Effective October 1, 2015

Medical Programs except TP 40

Applicants may be eligible for Medicaid coverage during the three-month period before the month they apply for Medical Programs. Prior coverage may be continuous or there may be interrupted periods of eligibility involving all or some of the certified members.

TP 40

Medicaid for a pregnant woman does not begin before the first day of the month her pregnancy began, as explained in A-820, Regular Medicaid Coverage.

A—831.1 How to Apply for Three Months Prior Coverage

Revision 15-4; Effective October 1, 2015

Medical Programs except TP 45

A person applies for three months prior Medicaid coverage by completing Form H1113, Application for Prior Medicaid Coverage. Advisors must give this form to applicants who indicate on an application or during the application interview that the family has unpaid medical bills incurred during the three months before the application month. **Exception**: For Children's Medicaid, Form H1113 is not required if the family provides enough information to determine eligibility for prior months.

Related Policy
Continuous Medicaid Coverage, A-832
TP 45 Retroactive Coverage, A-833

A—831.2 Eligibility for Three Months Prior Coverage

Revision 17-1; Effective January 1, 2017

Medical Programs except TP 40

Advisors certify the applicant for Medicaid only for the month(s) the individual meets all eligibility requirements and has:

- unpaid medical bills for Title XIX-covered services; or
- received Medicaid services from the Texas Department of State Health Services.

Advisors provide prior Medicaid coverage even if the:

- family is not currently eligible for Medical Programs; or
- person with unpaid medical bills is deceased.

TP 08

Certify a parent or caretaker relative for a prior month(s) if they are caring for a dependent child who meets all eligibility requirements in the prior month(s), but is not certified for Medicaid in the prior month(s) because the child does not have unpaid medical bills.

TP 40

Gaps do not apply to TP 40. Once eligibility is determined in one of the prior months, it continues even if there are no unpaid medical bills in a subsequent prior month.

A—831.2.1 Reopening Three Months Prior Applications

Revision 15-4; Effective October 1, 2015

Medical Programs

Advisors must reopen Medical Programs three months prior applications for one or more month(s) in the three-month prior period when:

- the applicant requests the application be reopened within two years after the application file date, and
- Medicaid eligibility (certification with or without spend down) for the individual and/or month(s) of coverage requested was not previously established.

Advisors use any application the household previously filed within the past two years as a basis for determining eligibility for prior Medicaid coverage, even if the application did not request ongoing Medicaid or prior month's coverage or claim unpaid medical bills.

The advisor must verify an application was filed.

Note: Advisors must not reopen an application for prior Medicaid for a month in which Medicaid eligibility (certification with or without spend down) was established, even if the spend down was closed by the Clearinghouse.

A—831.3 Income Computation

Revision 15-4; Effective October 1, 2015

Medical Programs

Staff must determine eligibility for each month in which there are unpaid medical bills using the income and verification rules explained in A-1300, Income

The needs and income of people who would have been considered in the client's MAGI household composition for each month the client's MAGI household composition has unpaid medical bills are included.

A—831.4 Determining the Appropriate Type Program for the Prior Month

Revision 15-4; Effective October 1, 2015

Medical Programs

Use the following chart to determine the type program to use for eligibility in the prior month:

If the type program is …	and the modified adjusted gross income for the prior month is …	then …
TP 08,	less than or equal to the FPIL amount for TP 08 and there is no gap in coverage,	certify the application for the prior month.
TP 08,	less than or equal to the FPIL amount for TP 08 and: • there is a gap in coverage, or • the individual is not currently eligible,	certify the application for the prior month(s).
TP 08,	more than the FPIL amount for TP 08,	do not certify the application for the prior month in this type program. Check eligibility for another type program.
TP 40, TP 43, TP 44, or TP 48,	less than or equal to the FPIL amount for that program,	certify the application for the prior month.
TP 40, TP 43, TP 44, or TP 48,	more than the FPIL amount for that program,	do not certify the application for the prior month in this type program. Check eligibility for TP 56.
TP 45,	not applicable,	these applicants are always eligible back to the date of birth.
TP 56,	more than the medically needy income limit (MNIL),	determine if the household has enough medical expenses to meet spend down for the prior month. If **yes**, then certify the children or pregnant woman. If **no**, then deny the application for prior coverage.
TA 31, TP 33, TP 34, TP 35, or TP 36,	less than or equal to the FPIL amount for that program,	certify the applicant for the prior month only for the dates of the emergency medical condition verified on Form H3038, Emergency Medical Services Certification, or Form H3038-P, CHIP Perinatal – Emergency Medical Services Certification.
TP 32	above the income limits as stated above (applies only to children [under age 19] and pregnant women),	determine if the household has enough medical expenses to meet spend down for the prior month. If **yes**, then certify the child or pregnant woman. If **no**, then deny the application for prior coverage.

Note: Applicants are considered for eligibility in Medicaid for Former Foster Care Children (TA 82) and Medicaid for Transitioning Foster Care Youth (TP 70) before TP 08.

A—831.5 Medical Eligibility Date for Three Months Prior Coverage

Revision 13-2; Effective April 1, 2013

Medical Programs

The MED for a month of prior coverage begins the earliest day in the month the individual met all eligibility criteria. It is the first day of the month unless all eligibility criteria were not met.

Related Policy
Regular Medicaid Coverage, A-820

A—831.6 Applications Based on Incapacity

Revision 15-4; Effective October 1, 2015

TP 08 and TA 31

If the applicant claiming incapacity meets the other eligibility requirements for prior Medicaid coverage, the advisor must document information according to A-1080, Disability Verification.

A—832 Continuous Medicaid Coverage

Revision 15-4; Effective October 1, 2015

TP 40

Advisors provide continuous Medicaid coverage without an application or an interview for a pregnant woman through the second month after the pregnancy terminates regardless of income increases if she:

- received Medicaid on a program other than TP 40 and was ineligible because of income;
- provides verification that she was pregnant in the month she becomes ineligible for Medicaid; and

  Note: Accept the individual's (pregnant woman's, case name's or AR's) verbal or written statement of pregnancy as verification. The statement must include the name of the woman who is pregnant, pregnancy start month, number of expected children and anticipated date of delivery. The individual also may provide Form H3037, Report of Pregnancy, or another document containing information specified on Form H3037.
- received Medicaid within 11 months prior to the application month.

Note: Advisors provide continuous Medicaid coverage to a pregnant woman who was denied with an administrative denial reason (such as, but not limited to, failure to keep appointment and voluntary withdrawal) if her Medicaid would have been denied because of income if the income had been reported.

The continuous coverage policy applies to women who were receiving benefits from the following programs:

- SSI or MEPD. Note: When an SSI Medicaid recipient is denied, TIERS sends Form H1296, SSI Denial Letter, informing the recipient that she may be potentially eligible for other Medical Programs within HHSC.
- a caretaker certified on TP 08 who is not eligible for TP 07 or TP 20.
- a caretaker or child certified on TP 07 or TP 20.
- a child certified on TP 44.

TP 43, TP 44 and TP 48

A child under age 19 receives a 12-month certification period. The child is continuously eligible for Medicaid for six months or through the month of the child's 19th birthday, whichever is earlier. The second six months of coverage is non-continuous, and changes may impact the child's eligibility.

Exceptions:

- During the continuous eligibility period, if a household reports that a sibling has moved into the household and requests Medicaid for the sibling, the sibling is added to the current case. TIERS aligns the end of the new Medicaid-eligible child's certification period with the end of the existing child's certification period.
- A child is not eligible for continuous coverage if a household fails to report required information at application that causes a child to be ineligible for Medicaid. See A-825, Medicaid Termination.

If the household is eligible in the application month, process month, or ongoing month, the child is eligible for continuous coverage beginning the first month the household meets the eligibility criteria. **Note**: This includes situations where the household is eligible in the application or process month, but not in an ongoing month.

If the household is eligible only in a month prior to the application, certify the child for the prior month only. The child is not eligible for continuous coverage.

Note: Explore TP 56 for the child if the individual indicates the child has unpaid bills in a month of ineligibility.

Related Policy
Medicaid Termination, A-825
What to Report, B-621

A—833 TP 45 Retroactive Coverage

Revision 15-4; Effective October 1, 2015

TP 45

Advisors must provide retroactive TP 45 coverage for newborn children without requiring an application or an interview with the child's mother if all of the following conditions are met:

- There are unpaid Title XIX bills for the newborn child.
- The mother of the child is unwilling, unable or refuses to apply for current benefits for the child, or the child is not eligible for current benefits.
- The advisor has verification of the following eligibility factors for the newborn child:

Eligibility Factor	Eligibility Requirement
Age	Coverage must be initiated within one year of the child's birth. The child's coverage cannot continue after the child becomes 13 months old.
Residence	Child must be residing in Texas.
Natural mother's Medicaid coverage dates	Child's mother must be eligible for and receiving Medicaid on the day the child is born. The mother'seligibility can be determined retroactively. See A-820, Regular Medicaid Coverage.

The file date is the day the advisor is notified about the unpaid bills for the child.

TIERS will allow a:

- file date as late as the month of the child's first birthday, and
- medical effective date as early as the child's date of birth.

A—834 Retroactive Medicaid Coverage for Abandoned Children

Revision 18-1; Effective January 1, 2018

Medical Programs

If a newborn or child is abandoned at an acute care hospital, or at a psychiatric hospital while receiving inpatient services, DFPS requests a court order for custody. Once the court order is obtained, DFPS provides Medicaid coverage from the day in which custody is granted. The MED is the date DFPS takes conservatorship. This may result in the newborn or child having unpaid medical bills if DFPS takes conservatorship after the date of birth or the date of admission to the hospital and the date DFPS takes conservatorship.

A designated DFPS representative completes Form H1113, Application for Prior Medicaid Coverage, requesting coverage on behalf of the abandoned child and forwards the request to a designated Texas Works advisor within Centralized Benefit Services (CBS) at cbs_ffche-mtfcy@hhsc.state.tx.us.

For children abandoned in a psychiatric hospital, DFPS will only submit applications to request retroactive Medicaid for a child receiving inpatient treatment.

CBS advisors provide retroactive Medicaid coverage only during the following situations:

- A newborn is taken into foster care conservatorship after the date of birth but before the child is released from the hospital, creating a gap in coverage from the date of birth through the day before the foster care conservatorship date.
- A child of any age is taken into foster care conservatorship while in the hospital, but after the admission date, creating a gap in coverage from the date of admission to the day before the foster care conservatorship date.

Note: The MED for a child (not a newborn) cannot precede the date of admission into the hospital.

A—840 Transitional Medicaid Coverage

Revision 02-6; Effective July 1, 2002

A—841 General Eligibility Information

Revision 15-4; Effective October 1, 2015

TP 07

Some TP 08 household members may be eligible for transitional Medicaid, TP 07.

An eligibility determination for TP 07 is based on whether a parent or caretaker relative is certified for TP 08, Parents and Caretaker Relatives Medicaid, in Texas for three of the six months before the first month of ineligibility. If a parent or caretaker relative certified for TP 08 coverage is eligible for transitional Medicaid, his or her children will be eligible as well. Each individual will be certified on an individual transitional Medicaid EDG for the duration of the certification period.

Example: The household composition consists of mother, father, and two mutual children. The mother and father each are certified on an individual TP 08 EDG in Texas for three of the six months before the month of ineligibility and each child on an individual Children's Medicaid EDG. The father has an increase in income that makes him ineligible for TP 08. The father is then certified on an individual TP 07 EDG. The mother and the two children will be certified on individual TP 07 EDGs, each with the same certification period as the father.

When a TP 07 EDG has been created, other eligible household members receive a new TP 07 EDG. See A-846.1, Parents and Caretaker Relatives Enter or Already Live in the Home, and A-846.2,Child Enters or Already Lives in the Home.

A household member is not eligible for TP 07 if the member was ineligible for TP 08 because the individual committed fraud during any of the six months before the TP 07 EDG was opened. The fraud must be determined by a court or through a hearing. If the TP 07 EDG was opened before the fraud determination was known:

- the household member is disqualified using advance adverse action notice procedures, and
- transitional child care staff must be notified that the member should not have received transitional benefits because of Medicaid fraud.

TP 08 households denied for any reason (such as failure to keep an appointment) may request TP 07 during the adverse action time frame and have their eligibility determined. For example, a household who failed to keep their appointment because of a new job may be eligible for TP 07.

Individuals may request Medicaid on TP 08 any time after denial. These individuals and their household members may also request TP 07 if they become employed.

The number of months of transitional coverage is 12 months.

A—841.1 Multiple Changes That Cause TP 08 Ineligibility

Revision 15-4; Effective October 1, 2015

TP 08

If two or more changes (when one is new or increased earned income) cause the income to increase from less than the FPIL for TP 08 to more than the FPIL for TP 08 for the same month, and the household has not been notified that members are eligible for TP 07, advisors follow the steps below:

Step	Action
1	If all other case factors remain the same, is the household income increased to above the FPIL for TP 08 because of new or increased earnings? • **Yes**. The family is eligible for TP 07 if members meet the other eligibility requirements. • **No**. Go to Step 2.
2	Is the income increased to above the FPIL for TP 08 as a result of a change other than new or increased earnings? • **Yes**. The family is not eligible for TP 07. Go to Step 3. • **No**. Go to Step 4.
3	Does the family meet the income limits for the Medical Program EDGs for which they are certified? • **Yes**. Continue current Medical Program coverage. • **No**. Deny the Medical Program EDG(s) for which the individual is no longer income eligible.
4	Is the income increased to above the FPIL for TP 08 when all changes are considered? **Yes**. The family is eligible for TP 07 if the members meet the other eligibility requirements.

Changes reported in a timely manner do not stop the denial of the TP 08 EDG and creation of the TP 07 after the household is notified of transitional Medicaid eligibility, even when both changes affect the same month.

Exceptions: The EDG is denied if the household:

- moves out of Texas;
- no longer meets the household composition requirement as specified in A-841.3, Eligibility Criteria During Transitional Medicaid Coverage; or
- reports a change that makes the household ineligible before the first month of transitional Medicaid eligibility.

A—841.2 Notice to Clients

Revision 15-4; Effective October 1, 2015

TP 08

When TIERS denies a TP 08 EDG and creates a TP 07, TIERS generates Form TF0001, Notice of Case Action, to notify the household:

- that their TP 08 and their children on associated TP 43, TP 44 and TP 48 EDGs are denied;
- the date their TP 07 benefits will end; and
- about the transitional Medicaid eligibility and reporting requirements. **Note**: If the individual is in the office, the advisor may explain the reporting requirements.

A—841.3 Eligibility Criteria During Transitional Medicaid Coverage

Revision 15-4; Effective October 1, 2015

TP 07

Certified members remain eligible for transitional Medicaid if the:

- household continues to live in Texas, and
- EDG meets one of the following household composition requirements.

The transitional EDG includes an eligible child. Note: For transitional Medicaid, an eligible child is a child who meets all of the following requirements: • citizenship, • Social Security number (SSN), • age, • relationship, and domicile.	OR	A parent or caretaker relative cares for a child who receives: • SSI; • adoption assistance payments; or • federal, state or local foster care payments; or • Medicaid (TP 07, 20, 40, 43, 44, 45, or 48.

The noncomplying adult who is certified for TP 07 is denied when the advisor receives notice that the legal parent failed to cooperate with third-party resource (TPR) requirements or has been found guilty of a Medicaid intentional program violation.

If another-related caretaker failed to cooperate with TPR requirements or was found guilty of a Medicaid intentional program violation, the advisor must:

- change the status to payee, or
- deny the transitional Medicaid EDG if the other-related caretaker is the only person on the EDG.

The advisor must not:

- count unearned income of household members when determining continued eligibility for households certified for transitional Medicaid; or
- deny a transitional Medicaid EDG because of new or increased income of a household member, unless reported in the seventh or tenth month Medicaid Status Report.

A—842 TP 07 Transitional Medicaid

Revision 15-4; Effective October 1, 2015

TP 08

TP 08 certified members are eligible for TP 07 if:

- at least one of the group members was eligible for and received TP 08 in Texas for three of the six months before the first month of ineligibility; and
- the denial is because:
  - a certified parent, certified caretaker relative, or disqualified legal parent began receiving or had an increase in gross earned income; or
  - of the earnings of a new or returning absent parent who is added to the certified group because the household meets incapacity or deprivation criteria.

A—842.1 Determining the First Month of TP 07 Medicaid

Revision 15-4; Effective October 1, 2015

TP 08

The first TP 07 month is the month the change is effective (when reported and acted on timely) when new or increased earnings cause a certified parent or caretaker relative on TP 08 to be over the FPIL for TP 08.

Determine the first month of TP 07 eligibility using the following chart:

Step	Action
1	The first month of TP 07 is the first month after adverse action expires when the change is reported, verified, and processed timely (or should have expired if the change was not reported, verified, or processed timely). Note: The first month can be no later than the first month of overpayment as described in B-752.1.2, Errors After Certification, but may be earlier based on the date the notice of adverse action expires (as described in A-2343.1, How to Take Adverse Action if Advance Notice Is Required).
2	Was at least one household member eligible for and did that member receive TP 08 in Texas for at least three of the six months prior to the month identified in Step 1? (See A-842.2, Determining the Three of Six Months Eligibility Requirement.) If yes, continue to Step 3. If no, deny the EDG.
3	Designate the month from Step 1 as the first month of TP 07 eligibility.

Individuals who appeal the advisor's decision to deny the TP 08 EDG often receive TP 08 while the appeal is pending. If the hearing officer sustains the advisor's decision, the months the client received continued benefits during the appeal process are counted as TP 07 months.

A—842.2 Determining the Three of Six Months Eligibility Requirement

Revision 15-4; Effective October 1, 2015

TP 08

Advisors must determine whether at least one household member was eligible for and received TP 08 in Texas for three of the six months before the first month of ineligibility.

Advisors must **count** any month when at least one household member was eligible for and received benefits. Advisors must include any month that someone in the household received TP 08.

Advisors must **not count** any month benefits were:

-
  - issued but the household was not eligible;
  - not issued;
  - received in another state;
  - Prior Medicaid coverage; or
  - Medicaid only for the application month due to certification in a later month.

TP 08 with Other Household Members on a Medical Program

Advisors must determine whether at least one TP 08 household member was eligible for and received Medicaid in Texas for three of the six months before the first month the income increase is effective.

Advisors must **count** any month when at least one household member was eligible for and received Medicaid through:

- TP 08, TP 20, TP 40, TP 43, TP 44, TP 45, TP 48, or TP 56 and spend down was met;
- SSI, including SSI Medicaid only;
- federal, state, or local foster care; or
- adoption assistance.

Advisors must **not count** any months Medicaid benefits were:

- certified but the household member was not eligible,
- received in another state, or
- prior Medicaid benefits.

A—842.3 Automatic Denial of TP 07

Revision 15-4; Effective October 1, 2015

TP 07

Recipients terminated from TP 07 must be retested for eligibility for any other Medical Programs, as explained in A-2342.1, Retesting Eligibility.

A—843 Reserved

Revision 15-4; Effective October 1, 2015

A—844 Transitional Medicaid Reporting Requirements for TP 07

Revision 15-4; Effective October 1, 2015

TP 07

Individuals receiving TP 07 coverage are required to report the following changes during the 4th, 7th and 10th months of the transitional period:

- Changes in the household members' gross monthly earnings, and
- Changes in the household composition.

Form H1146, Medicaid Report, is computer-generated and is sent to the household at cutoff in the 3rd, 6th and 9th months. Form H1146:

- informs the household of the availability of continuing transitional coverage,
- provides information about the change reporting requirements, and
- provides a way to report the required information.

Advisors use Form H1146-M, Medicaid Report (Manual), to replace TIERS-generated forms that the household reports are lost or destroyed.

Advisors must not require verification for the transitional Medicaid EDG. **Exception**: Advisors must require appropriate verifications to determine whether a new household member is eligible to be added to the EDG. See A-846.1, Parents and Caretaker Relatives Enter or Already Live in the Home, and A-846.2, Child Enters or Already Lives in the Home.

Note: If the household does not return Form H1146, no action is required.

A—844.1 Advisor Action on the Fourth Month Medicaid Report

Revision 15-4; Effective October 1, 2015

TP 07

Advisors use the following procedures to process Form H1146, Medicaid Report, if the household returns the fourth month Medicaid Report. Advisors must ensure that action is taken on the household members' other EDGs/cases if the reported information affects those benefits.

If the household returns Form H1146 and Form H1146 indicates …	then …
the household still meets the household composition requirements in A-841.3, Eligibility Criteria During Transitional Medicaid Coverage,	take no action on the transitional Medicaid case.
a child who is **not** receiving TP 43, TP 44, TP 45, TP 48, or transitional Medicaid is in the home,	see A-846.2, Child Enters or Already Lives in the Home.
a child left the home,	see A-846.3, Household Member Leaves the Home.
a returning absent parent or stepparent,	see A-846.1, Parents and Caretaker Relatives Enter or Already Live in the Home.
the household no longer meets the household composition requirements in A-841.3,	• deny the EDG, and • send Form TF0001, Notice of Case Action.
• there are no earnings by the parent or caretaker relative in at least one of the three report months, and there is no good cause for the lack of earnings; or • the average monthly gross earnings of the household members* exceeds the applicable income limit for the household size,	shorten the transitional Medicaid coverage to end after the sixth month. **Note:** If the medical coverage is shortened because the parent or caretaker relative did not have earnings for a complete month, inform the household that they can show good cause. They must show good cause within 13 days.(See A-844.4, Good Cause Determinations.)

* See A-844.3, 185% FPIL Test, for budgeting policies.

A—844.2 Advisor Action on the Seventh and Tenth Month Medicaid Reports

Revision 15-4; Effective October 1, 2015

TP 07

Advisors use the following procedures to process Form H1146, Medicaid Report, for the seventh and tenth months. Advisors must ensure that action is taken on the household members' other EDGS/cases if the reported information affects those benefits.

If the household returns Form H1146 and Form H1146 indicates …	then …
the household no longer meets the household composition requirements in A-841.3, Eligibility Criteria During Transitional Medicaid Coverage,	deny the EDG and send Form TF0001, Notice of Case Action.
• there are no earnings by the parent or caretaker relative in at least one of the three report months, and there is no good cause for the lack of earnings; or • the average monthly gross earnings of the household members* exceeds the applicable income limit for the household size,	• deny the EDG using the appropriate denial reason, • open a new EDG for the appropriate Medical Program if applicable, and • send Form TF0001 to the household. If the EDG is denied and the household is not eligible for another type of Medical Program, send Form H1010, Texas Works Application for Assistance – Your Texas Benefits, along with Form TF0001. HHSC must act on received information (earnings) that makes the household ineligible for transitional Medicaid even if the information is received outside of the reporting period (i.e., changes); however, eligibility can only be terminated at the end of the seventh or tenth month. **Note**: If the denial is because the parent or caretaker relative did not have earnings for a complete month, inform the household that they can show good cause. They must show good cause within 13 days. (See A-844.4, Good Cause Determinations.)

If the household returns Form H1146 and Form H1146 indicates …	then …
the household continues to be eligible,	take no action.
a child who is not receiving TP 43, TP 44, TP 45, TP 48, or transitional Medicaid is in the home,	see A-846.2, Child Enters or Already Lives in the Home.
a child left the home,	see A-846.3, Household Member Leaves the Home.
a returning absent parent or stepparent,	see A-846.1, Parents and Caretaker Relatives Enter or Already Live in the Home.

* See A-844.3, 185% FPIL Test, for budgeting policies.

Note: A denial notice (Form TF0001) will be sent to the household at the end of their 12 months of transitional Medicaid.

A—844.3 185% FPIL Test

Revision 15-4; Effective October 1, 2015

TP 07

Advisors use the following policies and procedures to determine whether the household's earnings are at or below the 185 percent FPIL when processing Medicaid reports.

Advisors must include all members of the individual’s MAGI household composition when determining the MAGI income.

Exceptions:

- Advisors must not count the earnings of a child who is exempt according to A-1341, Income Limits and Eligibility Tests.
- See A-240, Medical Programs, and A-1341 for exceptions to household composition and countable income.
- When a person is disqualified because of failure to cooperate with child/medical support or TPR requirements, or is found guilty of a Medicaid intentional program violation, the person is not included in the household size.

If the person who fails to cooperate is …	then …
a certified legal parent,	count the person’s earnings.
an "other relative" caretaker who is the parent or stepparent of a child on the case,	count the person’s earnings.
an "other relative" caretaker who is not a parent or stepparent to a child on the case,	do not count the person’s earnings.

A—844.4 Good Cause Determinations

Revision 15-4; Effective October 1, 2015

TP 07

Good cause for the caretaker relative not having earnings in one or more of the report months includes:

- involuntary loss of employment,
- illness,
- actively looking for work but unable to find a job, and
- other reasons beyond the household's control.

A—845 Reinstatement of Denied Transitional Coverage

Revision 15-4; Effective October 1, 2015

TP 07

Certain households whose transitional Medicaid EDGs are denied before the end of their original eligibility period may have transitional Medicaid coverage reinstated. Advisors must reinstate eligible household members for the remainder of their original transitional Medicaid period if:

- the original transitional Medicaid end date has not expired;
- the TP 07 was denied — for example, members:
  - were recertified for TP 08; or
  - moved out of Texas;
- the household does not want to apply for TP 08 or is not eligible for TP 08 (at application, review, or change); and
- there is a dependent child in the household certified for Medicaid.

Note: Individuals requesting reinstatement of TP 07 transitional Medicaid must have remained continuously eligible for transitional Medicaid during the months the TP 07 EDG was denied. Exception: A household that moved out of Texas must meet all of the eligibility criteria except residence.

A—845.1 Advisor Action on Reinstatements

Revision 15-4; Effective October 1, 2015

TP 07

Advisors must count the months of absence from transitional Medicaid as if the family had actually received transitional Medicaid.

Advisors use the following table to determine the MED:

If the member ...	then enter the day ...
remained in Texas during the transitional Medicaid denial period and did not receive other Medicaid coverage,	following the denial date.
moved out of the state,	the member returned to Texas and was no longer eligible for Medicaid in another state (see A-822, Medicaid Coverage for New State Residents).
was certified for TP 08 or another Medical Program,	following the denial date on the other TP 08 or other Medicaid EDG.

To reinstate denied transitional Medicaid, advisors must:

- Determine which mode to use. If the case status is denied and there is:
  - no active EDG, use Reopen mode.
  - an active EDG, use Complete Action mode.
- On the Program Summary page, select Reactivation from the Program Action drop-down menu.
- On the Program Details page, enter the Reactivation Date and select the appropriate Reactivation Reason.
- From the Program – Individuals Summary display, select the person(s) requesting aid.
- Change Aid Requested to **Yes. Note:** The Date Requested is defaulted to the previous date for individuals who were on the EDG when it was terminated.
- Continue through Data Collection.
- In Disposition, choose Administrative TMA Reinstatement as the reason for eligibility.

Notes:

- Advisors must not open a new application. If a new application was created, it is denied as filed in error.
- When processing the reinstatement, any members who are no longer in the household are removed.
- Advisors send Form TF0001, Notice of Case Action, to notify the household of their continued eligibility.

Advisors must obtain information on household composition and earnings for the months the household did not receive TP 07 and is required to report on Form H1146, Medicaid Report.

If the household missed the …	then obtain information on months …

If the household missed the …	then obtain information on months …
fourth month Medicaid report,	one, two, and three.
seventh month Medicaid report,	four, five, and six.
tenth month Medicaid report,	seven, eight and nine.

If the household was …	then …
certified for Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or any of the Medical Programs,	use case information, requesting additional information from the household only if necessary.
not certified,	obtain the necessary information.

Advisors determine whether the individual was continuously eligible for TP 07 Medicaid using:

- A-844.1, Advisor Action on the Fourth Month Medicaid Report, for the fourth-month Medicaid Report;
- A-844.2, Advisor Action on the Seventh and Tenth Month Medicaid Reports, for the seventh- and tenth-month Medicaid Reports; and
- A-844.4, Good Cause Determinations, to determine good cause for no earnings.

A—846 Special Household Composition Policies for Transitional Medicaid

Revision 13-2; Effective April 1, 2013

A—846.1 Parents and Caretaker Relatives Enter or Already Live in the Home

Revision 15-4; Effective October 1, 2015

TP 07

Advisors must follow the procedures below if the household requests TP 07 benefits for a caretaker, returning absent parent, stepparent, or second parent in the home.

Advisors must add the member to the case and open a new TP 07 EDG for the individual, or change an ineligible member to eligible if the person is a caretaker or second parent who:

- was disqualified on the TP 08 or transitional EDG but has complied with the eligibility requirement for which he was disqualified (for example, TPR);
- is a returning absent parent/second parent in the home; or
- is a stepparent caretaker because the legal parent has a disability and is unable to care for the children.

A—846.2 Child Enters or Already Lives in the Home

Revision 15-4; Effective October 1, 2015

TP 07

Advisors follow the procedures in the chart below:

- when the TP 07 household reports that a child who is not receiving TP 07, TP 43, TP 44, TP 45, or TP 48 is in the home;
- when denying a TP 08 EDG and opening a TP 07 EDG; and
- upon review of another Medical Program EDG for a child who lives with a TP 07 recipient.

An other-related child's separate Medical Program EDG continues unless the caretaker needs Transitional Child Care services for the child.

If a child who is not receiving TP 43, TP 44, TP 45, TP 48, or transitional Medicaid …	then …

is a newborn, moves in, or already lives in the home,	obtain the appropriate information/verifications and determine if the child meets all of the following requirements:
	• citizenship,
	• SSN,
	• age,
	• relationship, and
	• domicile.
	
	Use information/verifications from other case records when the child is currently or has been a TANF/Medical Program or SNAP recipient.
	
	Do not consider the following criteria:
	• deprivation, and
	• income.
	
	Note: Obtain information regarding a child's earned income when processing the seventh and tenth month Medicaid reports if the child's earnings are counted, following Medical Programs policy explained in A-1341, Income Limits and Eligibility Tests.
	
	If the child is eligible, then send Form TF0001, Notice of Case Action, to the household to inform the household of the child's eligibility.
	
	If the child is not eligible or the household does not provide the information/verification, then:
	• send Form TF0001 to the household;
	• inform the household that:
	  ◦ their TP 07 EDG will continue; but
	  ◦ the child cannot be added to the case, stating the reason the child cannot be added; and
	• take no action on the case.

If a child who is added to the case has unpaid medical bills for any of the three months prior to the month the request is received to add the child, advisors must:

- determine and document three months prior eligibility according to Medical Programs policies and procedures in A-830, Medicaid Coverage for the Months Prior to the Month of Application; and
- assign the child an MED beginning the first prior month the child met all TP 07 eligibility requirements.

The child's MED cannot precede the:

- first month the household was eligible for TP 07 (advisors must determine a child's eligibility for another Medical Program if the individual applies for prior coverage that precedes the first month the household is eligible for TP 07); or
- date the child entered the household.

A—846.3 Household Member Leaves the Home

Revision 15-4; Effective October 1, 2015

TP 07

Follow the procedures in the chart below when the transitional Medicaid household reports that a child leaves the household.

If a child leaves the household and the …	then …
• child was part of the transitional certified group, and • household continues to meet the household composition requirements in A-841.3, Eligibility Criteria During Transitional Medicaid Coverage,	• send Form TF0001, Notice of Case Action, to the household informing the household that the child will no longer receive Medicaid, and • deny the child's TP 07 EDG.

If a child leaves the household and the …	then …
household no longer meets the household composition requirements in A-841.3,	• send Form TF0001 to the household, and • deny the TP 07 EDGs that no longer are eligible.

Advisors follow normal procedures to remove a parent or caretaker relative when the household reports the person is no longer in the home.

A—846.4 Minor Parents Certified as Children

Revision 15-4; Effective October 1, 2015

TP 07

See A-240, Medical Programs, for household composition rules.

A—847 Other EDG Actions

Revision 13-2; Effective April 1, 2013

A—847.1 Changes Affecting Transitional Medicaid EDGs

Revision 15-4; Effective October 1, 2015

TP 07

Advisors must not take action on the TP 07, except for the following changes:

- A child is born, moves in, or is already living with the certified group. Add the member to the case and open a TP 07 EDG for the individual following procedures in A-846.2, Child Enters or Already Lives in the Home.
- A parent or caretaker relative moves in or otherwise becomes eligible. Add the member to the case and open a TP 07 EDG for the individual following procedures in A-846.1, Parents and Caretaker Relatives Enter or Already Live in the Home.
- A member included in an individual's household composition leaves the household. Remove the member from the case following procedures in A-846.3, Household Member Leaves the Home.
- A household member is no longer eligible. Remove the member from the case. For example:
  - A child no longer meets the Medical Programs age criteria.
  - A child moves out of state.

A—847.2 Reapplication for TP 08

Revision 15-4; Effective October 1, 2015

TP 07

A household receiving TP 07 may reapply for TP 08 by submitting an application. If the household is eligible, TIERS will:

- deny the TP 07;
- certify the parent/caretaker relative on a TP 08 EDG and the child on the appropriate Children's Medicaid EDG; and
- send Form TF0001, Notice of Case Action, to the household.

Related Policy
Minor Parents Certified as Children, A-846.4

A—850 TP 20 Alimony/Spousal Support Transitional Medicaid Coverage

Revision 16-4; Effective October 1, 2016

A—851 General Eligibility Information

Revision 16-4; Effective October 1, 2016

TP 20

Individuals denied TP 08 because of new or increased alimony/spousal support may be eligible for TP 20. Determination of TP 20 eligibility will be based on a parent or caretaker relative certified for TP 08. Household members are eligible for TP 20 for four months following the last month of TP 08 eligibility if:

- the modified adjusted gross income before alimony/spousal support receipt was at or below the income limit for TP 08;
- the denial is because new or increased alimony/spousal support income is added to the budget and the individual's MAGI household income now exceeds the income limit for the household's size; and
- at least one TP 08 household member was eligible for and received Medicaid in Texas for three of the six months before the first month of ineligibility.

If the household is eligible, an individual transitional Medicaid EDG will be created for each parent or caretaker relative and one for each child.

The first month an individual may receive TP 20 is the month after adverse action expires, when change in new or increased alimony/spousal support is reported, verified, and processed timely (or should have expired if the change was not reported, verified, or processed timely). An individual may receive less than four months of TP 20 coverage if the change of new or increased alimony/spousal support is not reported or acted upon timely.

Related Policy
Determining the First Month of TP 07 Medicaid, A-842.1
Determining the Three of Six Months Eligibility Requirement, A-842.2
Changes Decreasing Benefits, B-643

A—851.1 Multiple Changes That Cause TP 08 Ineligibility

Revision 15-4; Effective October 1, 2015

TP 08

If two or more changes (when one is new or increased spousal support) cause the income to increase above the Federal Poverty Income Limits (FPIL) for TP 08 for the same month, and the household has not been notified that members are eligible for TP 20, advisors follow the steps below:

Step	Action	
1	If all other case factors remain the same, is the household income increased to above FPIL for TP08 because of new or increased alimony/spousal support?	• Yes. The household is eligible for TP 20 if members meet the other eligibility

		requirements. • No. Go to Step 2.
2	Is the income increased to above FPIL for TP 08 as a result of a change other than new or increased alimony/spousal support?	• Yes. The household is not eligible for TP 20. Go to Step 3. • No. Go to Step 4.
3	Does the household meet the income limits for the Medical Program EDGs for which they are certified?	• Yes. Continue current Medical Program coverage. • • No. Deny the Medical Program EDG(s) for which the family member is no longer income eligible.
4	Is the income increased to above the FPIL for TP08 when all changes are considered?	Yes. The household is eligible for TP 20 if the members meet the other eligibility requirements.

Changes reported in a timely manner do not stop the denial of the TP 08 EDG and creation of the TP 20 after the household is notified of transitional Medicaid eligibility, even when both changes affect the same month.

Exceptions: The EDG is denied if the household

- moves out of Texas;
- no longer meets the household composition requirement as specified in A-841.3, Eligibility Criteria During Transitional Medicaid Coverage; or
- reports a change that makes the household ineligible before the first month of TP 20 eligibility.

Related Policy
Multiple Changes that Cause TP 08 Ineligibility, A-841.1

A—852 Eligibility Criteria During Transitional Medicaid Coverage

Revision 16-4; Effective October 1, 2016

TP 20

Certified members remain eligible for Medicaid if the household continues to:

- live in Texas; and
- receive alimony/spousal support.

The legal parent who is certified for TP 20 when the advisor receives notice that the legal parent failed to cooperate with child/medical support or TPR requirements or has been found guilty of a Medicaid intentional program violation is denied.

A—853 Automated Process

Revision 16-4; Effective October 1, 2016

TP 08

If the Office of the Attorney General (OAG) receives a new or increased alimony/spousal support collection that is greater than the TP 08 income limits, TIERS determines whether the TP 08 EDG should be denied and a TP 20 opened, or whether the TP 08 EDG should be denied. If either is appropriate, TIERS notifies the individual on Form TF0001, Notice of Case Action.

A—854 Denial of TP 20

Revision 16-4; Effective October 1, 2016

TP 20

Recipients terminated from TP 20 must be retested for eligibility for any other Medical Programs, as explained in A-2342.1, Retesting Eligibility.

A—855 Reinstatement of Denied TP 20 Coverage

Revision 16-4; Effective October 1, 2016

TP 20

Certain households whose TP 20 EDGs are denied before the end of their eligibility period has expired may have transitional Medicaid coverage reinstated. Reinstate eligible household members for the remainder of the original TP 20 Medicaid period if:

- their original transitional Medicaid end date has not expired;
- their TP 20 EDG was denied because the members moved out of Texas; and
- they:
  - do not wish to apply for other medical coverage; or
  - are not eligible for other medical coverage.

Follow procedures in A-845, Reinstatement of Denied Transitional Coverage, to reinstate TP 20 coverage.

A—856 Special Household Composition Policies for Transitional Medicaid

Revision 16-4; Effective October 1, 2016

A—856.1 Parents and Caretaker Relatives Enter or Already Live in the Home

Revision 16-4; Effective October 1, 2016

TP 20

Advisors follow the procedures below if the household requests TP 20 benefits for a caretaker, returning absent parent, stepparent, or second parent in the home.

Advisors must add the member to the case and open a new TP 20 EDG for the individual if the person is a caretaker relative or second parent who:

- was disqualified on the TP 08 or transitional EDG but has complied with the eligibility requirement for which the member was disqualified (for example, child/medical support, TPR); or
- is a returning absent parent/second parent in the home.

A—856.2 Child Enters or Already Lives in the Home

Revision 16-4; Effective October 1, 2016

TP 20

Advisors follow the procedures in the chart below:

- when the TP 20 household reports that a child who is not receiving TP 20 or TP 43, TP 44, TP 45, or TP 48 is in the home;
- when denying a TP 08 EDG and creating a TP 20 EDG; or
- upon review of another Medical Program case for a child who lives with a TP 20 recipient.

Advisors must continue an other-related child's separate Medical Program EDG.

If a child who is not receiving TP 43, TP 44, TP 45, TP 48 or TP 20 …	then …

is a newborn, moves in, or already lives in the home,	obtain the appropriate information/verifications and determine if the child meets all of the following requirements:
	
	• citizenship,
	• SSN,
	• age,
	• relationship, and
	• domicile.
	
	Use information/verifications from other case records when the child is currently or has been a TANF/Medical Program or SNAP recipient.
	
	Do not consider the following criteria:
	
	• deprivation, and
	• income.
	
	If the child is eligible, then:
	
	• send Form TF0001, Notice of Case Action, informing the household of the child's eligibility for TP 20; and
	• add the child to the case and open a new TP 20 EDG for the child.
	
	If the child is not eligible or the household does not provide the information/verification, then:
	
	• send Form TF0001 to the household;
	• inform the household:
	  ○ their TP 20 EDG will continue; but
	  ○ the child cannot be added to the case, stating the reason the child cannot be added; and
	• take no action on the case.

A—856.3 Minor Parents Certified as Children

Revision 16-4; Effective October 1, 2016

TP 20

See A-240, Medical Programs, for household composition rules.

A—857 Reapplication for TP 08

Revision 16-4; Effective October 1, 2016

TP 20

A household receiving transitional Medicaid may reapply for TP 08. If the household is eligible, the advisor must:

- deny the TP 20 EDG;
- create the applicable Medical Program EDG; and
- send Form TF0001, Notice of Case Action, to the household.

A—860 Third-Party Resources (TPR)

Revision 15-4; Effective October 1, 2015

Medical Programs

A TPR is a source of payment for medical expenses other than the recipient or Medicaid. TPR include payments from private and public health insurance and from other liable third parties that can be applied toward the recipient's medical expenses. Title XIX (Medicaid) funds are to be used for the payment of medical services only after all available third-party resources have been used, except for medical services from the following:

- Texas Department of Assistive and Rehabilitative Services;
- Texas Commission for the Blind;
- Texas Kidney Health Care Program;
- Muscular Dystrophy Association;
- Children with Special Health Care Needs;
- Texas Band of Kickapoo Equity Health Program;
- Maternal and Child Health (Title V);
- State Legislative Impact Assistance Grant (SLIAG);
- Crime Victims Compensation Program; and
- adoption agencies or adoptive parents with medical obligations to the recipient.

Income maintenance insurance policies not related to actual medical expenses are not third-party resources unless the policy is assignable to a hospital or other medical provider.

When an applicant has health insurance, the advisor must instruct the individual to tell medical providers about the health insurance. The provider then bills the insurance company rather than or before billing Medicaid.

Individuals must cooperate:

- in identifying and pursuing any third party who may be liable for medical support payments, including absent parents who pay cash medical support;
- in reimbursing HHSC for medical expenses paid by Medicaid from:
  - court settlements, and
  - liability, casualty, or health insurance payments, and
- with HHSC and its Health Insurance Premium Payment (HIPP) contractor by:
  - providing information about available health insurance coverage;
  - enrolling in their employer's health insurance program; and
  - providing proof of their premium payments.

Individuals who refuse to cooperate without good cause are denied.

The denied legal parent is included in the household composition.

A—861 Third-Party Resources (TPR) and Accidents

Revision 15-4; Effective October 1, 2015

Medical Programs

The advisor must instruct individuals to report any accident-related injuries requiring medical care or accident-related unsettled legal claims within 60 days.

A—861.1 Reporting the Accident to the Third-Party Resources (TPR) Unit

Revision 15-4; Effective October 1, 2015

Medical Programs

If a recipient reports an injury requiring medical treatment for which liability/casualty insurance (the individual's own or someone else's) may provide payment, the advisor must determine the details of the accident and any legal action involved and forward the information by memorandum to:

HHSC/OIG/TPR Unit
MC 1354
P.O. Box 85200
Austin,Texas78708-5200

Advisors must include in the report:

- individual-identifying information;
- the date and nature of the accident and resulting injuries;
- information regarding the liable or potentially liable third party, including the liability insurance policy number and the name and address of the insurance adjuster, if available;
- dates, types, and sources of medical services related to the injury; and
- the status or plans for any legal action, including the name and address of any attorney involved, if available.

A—861.2 Responding to Third-Party Resources (TPR) Unit Noncooperation Notices

Revision 15-4; Effective October 1, 2015

Medical Programs

When the TPR Unit becomes aware of a possible accident through information included on a Medicaid claim form, the TPR Unit contacts the individual to obtain information about the accident.

A—861.3 Third-Party Resources (TPR) Reimbursements

Revision 15-4; Effective October 1, 2015

A—861.3.1 Client-Initiated Reimbursements

Revision 15-4; Effective October 1, 2015

Medical Programs

When a recipient reimburses HHSC for medical expenses from a court settlement or from a liability, casualty, or health insurance payment, the reimbursement should be by personal check, cashier's check, or money order payable to the Texas Department of Health and Human

Services.

Advisor action:

1. Give the individual Form H4100, Money Receipt.
2. Send the reimbursement and a copy of Form H4100 to ARTS at P.O. Box 149044, Austin, Texas 78714.
3. Enter the type(s) and date(s) of the medical service(s) in the "For" section of the form.
4. If unsure what medical services were involved, complete a memorandum giving as much information as is known concerning the reimbursement.
5. Attach a copy of any information identifying the nature of the payment, such as a statement from the insurance company, to Form H4100.

The actual claim paid by Medicaid is verified in state office, and the individual is reimbursed if the payment made is in excess of the Medicaid payment. The advisor is notified of the reimbursement. Advisors must consider the reimbursement as possible TANF and/or TP 08 income.

Related Policy
Lump-Sum Payments, A-1331
Reimbursements, A-1332

A—861.3.2 Reporting Non-Reimbursement to the Third-Party Resources (TPR) Unit

Revision 15-4; Effective October 1, 2015

Medical Programs

When an advisor becomes aware that a recipient received a reimbursement for medical expenses paid by Medicaid and failed to reimburse HHSC, the advisor reports the non-reimbursement to the TPR Unit. The advisor must include any available information about the accident and the payment in the report.

The TPR Unit investigates the claim and reports back. The advisor uses the guidelines in A-861.4, Responding to Third-Party Resources (TPR) Unit Recovery Requests, upon receipt of a memo from the TPR Unit confirming the non-reimbursement.

A—861.4 Responding to Third-Party Resources (TPR) Unit Recovery Requests

Revision 15-4; Effective October 1, 2015

Medical Programs

Advisors use the following chart in responding to TPR Unit recovery requests.

When the TPR Unit becomes aware that an individual received a private insurance payment and has not made any payments to the Medicaid provider, the TPR Unit sends a memo to the regional director. The memo includes the amount of:

- Medicaid paid; and
- the private insurance payment, if known.

The advisor must use the following procedures after receiving the memo:

Step	Action
1	Send Form H1020, Request for Information or Action, to the caretaker, requesting that the individual: • provide verification of the amount of the private insurance payment, and • contact the advisor about reimbursing HHSC. If the individual does not respond, then go to Step 2. If the individual does respond, then go to Step 3.

2 Send Form TF0001, Notice of Case Action, to initiate action to disqualify the legal parent from the certified and/or budget group. Process a referral for intentional program violation if the Medicaid payment was $100 or more. To report waste, abuse or fraud to the OIG/TPR Unit, use the online reporting form https://oig.hhsc.state.tx.us/wafrep/ or call toll-free 1-800-436-6184.

Collect the lesser of the:

- Medicaid payment, or
- private insurance payment.

3 **Note**: If the private insurance payment is greater than the Medicaid payment, count the difference as lump-sum payments for TANF, SNAP and Medical Programs. Refer to A-1200, Resources, and A-1300, Income, for policy on how to count the payments.

If the individual does not make a full payment, then go back to Step 2.

If the individual makes full payment, then go to Step 4.

When the individual makes a payment:

4
- ensure the payment is made by personal check, cashier's check or money order payable to the Texas Department of Health and Human Services;
- give the individual Form H4100, Money Receipt. Annotate the form with "TPR/TMHP Insurance Recovery"; and
- send a copy of Form H4100 with the payment to Fiscal Division, State Office, E-411.

A—861.5 Remitting Cash Medical Support Payments to the Third-Party Resources (TPR) Unit

Revision 15-4; Effective October 1, 2015

Medical Programs

After certification, Medicaid recipients must remit to the TPR Unit any cash medical support payments received for a certified child. The advisor gives the individual sufficient copies of Form H1710, Payment Identification, and TPR self-addressed envelopes, if payments are being made or might be made. The advisor instructs the individual upon receipt of a cash medical support payment from an absent parent after certification of the requirement to:

- write on the check or money order "Deposit Only - State Treasury" and to **not endorse the check or money order**;
- include Form H1710 with the check or money order; and
- send it to the HHSC/OIG/TPR Unit, MC 1354, P.O. Box 85200, Austin, TX 78708-5200.

If the individual turns in cash medical support payments to the local office, the advisor must:

- forward the payment(s) to the HHSC/OIG/TPR Unit; and
- give the individual a copy of Form H4100, Money Receipt.

Upon becoming aware that an individual did not remit a cash medical support payment, advisors must follow policy in B-700, Claims, and process a claim for the month(s) of unreported income, if required.

Related Policy
TANF, A-1124
Medical Support Payments, A-1326.2.3

A—862 Third-Party Resources (TPR) Reporting System

Revision 15-4; Effective October 1, 2015

Medical Programs

The application asks applicants and individuals whether any household members have health insurance. Form H1028, Employment Verification, asks employers to verify if health insurance is available, and whether the employee is enrolled. When an individual reports a new job or a change in employers, the advisor determines whether there is any new or potential private health insurance coverage for certified household members during the eligibility interview or application processing.

If information from the individual, the employer or other source indicates ...	then report ...
Medicaid-eligible household members have private health insurance coverage,	information about the private health insurance in the Third Party Resources logical unit of work of the case the individual is a member of in TIERS.
health insurance coverage is available for Medicaid-eligible household members but the members are not enrolled in the health insurance plan,	information about the available health insurance in the Third Party Resources logical unit of work of the case the individual is a member of in TIERS. The TPR Unit will use the information to initiate an inquiry about HIPP Program eligibility.

To contact the TPR Unit about TPR questions or problems:

- advisors may call 1-800-846-7307.
- clients may call the Client Medicaid Hotline at 1-800-252-8263.

A—863 Health Insurance Premium Payment (HIPP) Program

Revision 17-1; Effective January 1, 2017

Medical Programs

The Health Insurance Premium Payment (HIPP) program is a Medicaid benefit that helps families pay for employer-sponsored health insurance.

To qualify for HIPP, an employee must either be Medicaid eligible or have a family member that is Medicaid eligible. The HIPP program may pay for individuals and their family members who receive, or have access to, employer-sponsored health insurance benefits when it is determined that the cost of insurance premiums is less than the cost of projected Medicaid expenditures.

Note: An employee and their Medicaid-eligible family member must be enrolled in the employer-sponsored health insurance in order to receive HIPP reimbursements.

Medicaid-eligible HIPP enrollees do not have to pay out-of-pocket deductibles, co-payments, or co-insurance for health care services that Medicaid covers when seeing a provider that accepts Medicaid. Instead, Medicaid reimburses providers for these expenses.

HIPP enrollees who are not Medicaid eligible must pay deductibles, co-payments, and co-insurance required under the employer's group health insurance policy.

Report individuals who are potentially eligible for HIPP on Form H1039, Medical Insurance Input. Send Form H1039 to HHSC's Third Party Resource (TPR) Unit, Mail Code 1354.

HHSC's TPR Unit refers Form H1039 to the current state Medicaid contractor, Texas Medicaid and Healthcare Partnership (TMHP). If TMHP determines it is cost-effective for Medicaid to pay the recipient's employer-sponsored health insurance premiums, then TMHP sends:

- a letter to the recipient and requests verification of the employer-sponsored insurance plan and premium payments; and
- a premium reimbursement to the recipient upon receipt of complete documentation and proof of the premium payment.

Note: Do not consider an incurred medical deduction for the reimbursed premium for individuals participating in HIPP.

TMHP will terminate HIPP enrollment if the individual is no longer enrolled in health insurance coverage or fails to provide TMHP with the information needed to determine cost effectiveness or proof of premium payments.

For more information about the HIPP program, see HHSC's website: http://hhs.texas.gov/services/financial/insurance/health-insurance-premium-payment-hipp, or contact the Medicaid HIPP program at MCD_HIPP_Program@hhsc.state.tx.us.

Individuals may call 800-440-0493 for more information.

Related Policy

Reimbursements, A-1332

A—870 Verification Requirements

Revision 18-1; Effective January 1, 2018

Medical Programs

Advisors must:

- Verify spousal support to establish eligibility for TP 20.
- Verify unpaid medical bills for three months prior coverage. **Exception**: Refer to A-831.2, Eligibility for Three Months Prior Coverage, for TP 40 prior coverage.
- Verify income for each of the three months prior to coverage. **Exception**: For Children's Medicaid, do not request more income verification for prior Medicaid coverage than what is required for ongoing eligibility. See A-1371, Verification Sources, for Children's Medicaid.
- Verify that an application was filed when reopening an application for prior month coverage according to A-831.2.1, Reopening Three Months Prior Applications.
- Verify if the applying child is receiving Medicaid or CHIP.
- Verify eligibility for TP 07 by verifying gross earnings and the date the person received the earnings. **Exception**: If verification is not readily available, accept the person's statement unless questionable. If the household provides earnings information sufficient to determine eligibility for TP 07 but does not provide verification of the earnings, the advisor must deny the EDG and create a TP 07 EDG if the person meets the eligibility requirements in A-842, TP 07 Transitional Medicaid.
- When a household requests continuation of Medicaid for children aging out of TP 44, verify if the child:
  - is hospitalized on the child's 19th birthday;
  - remains hospitalized through the end of the six-month eligibility period; and
  - meets all other criteria according to policy in A-825, Medicaid Termination.
- Verify TPR and report to the TPR Unit any household member who:
  - has private medical insurance; or
  - is not enrolled in group medical coverage that is available to him.

This verification may be found in TALX. See C-825.11, The Work Number.

Emergency Medicaid

Advisors must verify the emergency medical condition by using Form H3038, Emergency Medical Services Certification, or Form H3038-P, CHIP Perinatal – Emergency Medical Services Certification. These forms are the only acceptable sources that can be used to verify an emergency medical condition. A licensed practitioner must complete and sign Form H3038 or Form H3038-P.

Note: An original or a faxed copy of Form H3038 or Form H3038-P is acceptable to verify the emergency medical condition.

TP 40

See A144.5, Pregnancy, for policy relating to verification of pregnancy.

Related Policy
Pregnancy, A-144.5
Regular Medicaid Coverage, A-820
Verification Requirements, A-1370
A Household with Members on TANF, TANF-State Program (SP), TP 07, TP 08 and TP 20, B-480
Questionable Information, C-920
Providing Verification, C-930

A—880 Documentation Requirements

Revision 15-4; Effective October 1, 2015

Medical Programs

Advisors must document:

- verification of income and unpaid medical bills for the three months prior coverage.
- medical insurance other than Medicaid. This information may be found in TALX. See C-825.11, The Work Number.
- method of income computation.
- eligibility for transitional and post Medicaid, including the action taken when the EDG includes:
  - an other-related child;
  - an unwed TP 08 parent's child from a previous relationship; or
  - a stepchild.
- reason for assigning less than the maximum post or transitional Medicaid coverage.
- denial of TP 20 because spousal support payments stopped.
- reason for action on a Medicaid EDG.
- gross earnings and the dates the individual received the earnings.
- cost of health insurance premium for the child(ren) before certifying for CHIP.
- name and phone number of state hospital employee.

If the household requests continuation of Medicaid for children aging out of TP 44, the advisor must document according to policy in A-825, Medicaid Termination, whether the child:

- is hospitalized on the child's 19th birthday;
- remains hospitalized through the end of the six-month eligibility period; and
- meets all other criteria according to A-825.

If providing prior coverage for more than three months, the advisor must document according to policy in A-831.2.1, Reopening Three Months Prior Applications, that:

- there was an application on file to cover any of the prior months; and
- the file date on the application was used to cover these months.

TP 40

Advisors must document the method of pregnancy verification and anticipated delivery date.

Related Policy
Documentation Requirements, A-950
Documentation, C-940
The Texas Works Documentation Guide

TWH, A-900, Domicile

Revision 17-2; Effective April 1, 2017

A—910 General Policy

Revision 16-4; Effective October 1, 2016

TANF

A child must live in the home with a relative listed in A-221, Who Is Included, No. 4. A home is the family setting maintained or being established, as evidenced by continuation of responsibility for day-to-day care of the child by the relative with whom the child is living.

Medical Programs except TP 08 and TA 31

Domicile requirements do not apply to these programs. Children can live with a parent or caretaker relative, or not live with a parent or caretaker relative (for example, independent children).

TP 08 and TA 31

For a parent or caretaker relative to be eligible for TP 08 or TA 31, they must be living with the dependent child of whom they have care and control. In general, for a caretaker to be considered as having care and control of a child, the child must live in the home with the relative. A home is the family setting maintained or being established, as evidenced by continuation of responsibility for day-to-day care of the child by the relative with whom the child is living.

The parent or caretaker relative may meet the domicile requirement when the dependent child is not included in their Modified Adjusted Gross Income (MAGI) household composition.

Example: A grandfather is living with his grandchild, but the grandchild is claimed as a tax dependent by a non-custodial parent. The grandfather is applying for health care for himself. In this example, the grandchild is not included in the grandfather's MAGI household composition since the grandfather is not claiming the grandchild as a tax dependent. However, the grandfather meets the domicile requirement if the grandchild lives with the grandfather and meets the care and control requirements explained in A-921, How to Determine Care and Control.

Related Policy
Children Admitted into State Hospitals, A-922
Children Residing in General Residential Operations Facilities, A-923

A—920 Temporary Absence from the Home

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

Advisors must not deny assistance because a household member or payee is temporarily out of the home if all of the following conditions are met:

- The person is out of the home due to:
  - temporary separation from other family members, and the family has no regular place of residence;
  - hospitalization or receipt of outpatient services;
  - attending school or training (including schools for the deaf and blind);
  - being on vacation;
  - being in a home for children not considered to be a public institution; or
  - seeking employment away from home.
- The parent or caretaker relative/payee is still responsible for the child's care and control. See A-921, How to Determine Care and Control, to determine whether the caretaker/payee still has care and control.
- The person's absence is not anticipated to be more than the allowable six- or 12-month period.

  Advisors must certify or continue eligibility, and review the Eligibility Determination Group (EDG) every three months. Advisors remove the absent household member from the EDG after:
  - six months (beginning with the first full month of absence from the home); or
  - 12 months for situations when a family member is out of the home because the member is:
    - hospitalized or receiving outpatient services;
    - attending school or training; or
    - in a home for children not considered to be an institution.

The allowable six- or 12-month period begins again if the absent person returns to and resides in the home for at least 30 consecutive days. Advisors must not apply the temporary absence time frames when a parent is out of the home solely because of employment. Advisors must include the employed parent in the certified group if the parent meets all other eligibility criteria. See A-1040, Deprivation Based on Absence from the Home.

If a member of the certified group enters a nursing home, advisors leave the member's needs in the household composition if the member will be there temporarily or until the member is certified for Supplemental Security Income (SSI). Advisors refer the recipient to the Social Security office for an SSI eligibility determination.

TANF

If the advisor removes the caretaker from the EDG, the EDG must be denied, and the advisor must ask another relative in the home that qualifies as caretaker to apply for the child(ren).

Medical Programs

If the advisor denies the parent or caretaker relative's EDG, this does not impact the other associated Medical Program EDGs, and the other individuals cannot be required to reapply for Medical Programs.

A—921 How to Determine Care and Control

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

The parent or caretaker relative/payee cannot be considered responsible for the absent child's care and control when the child:

- is placed out of the caretaker/payee's home by the court, and the caretaker/payee has no authority to remove the child; or
- has a court-appointed guardian other than the caretaker/payee.

These children are independent children. The advisor must determine their eligibility for one of the Medical Programs.

Other considerations for care and control include:

- Who has the financial responsibility for the child's medical and dental costs?
- Who makes the decisions about health care, medical care, schooling and other personal care decisions?
- To what extent is the caretaker/payee involved with the child? How often does the caretaker/payee visit the child? What is the caretaker/payee's involvement with decisions for the care, well-being, schooling, etc.?
- To what extent does the caretaker/payee actively participate in the guidance and development of the child?
- What is the caretaker/payee's financial involvement for the child? That is, does the caretaker/payee pay a regular fee for the child's enrollment and participation in the home's programs?
- What restrictions or limitations have been placed on the caretaker/payee's rights?

Based on the responses to these questions, the advisor must make a prudent person decision about the caretaker/payee still being responsible for the child's care and control.

Related Policy
Prudent Person Principle, A-137

A—922 Children Admitted into State Hospitals

Revision 15-4; Effective October 1, 2015

Medical Programs except TP 08 and TA 31

Advisors consider a child admitted into a state hospital as an independent child if the caretaker no longer has care and control and the child was admitted:

- via a court order, or
- voluntarily.

The child is not considered an independent child if the child was admitted voluntarily and the caretaker/payee continues to have care and control.

A—923 Children Residing in General Residential Operations Facilities

Revision 16-4; Effective October 1, 2016

Medical Programs except TP 08 and TA 31

Advisors consider a child admitted into certain general residential operations facilities that are members of the Texas Coalition of Homes for Children as an independent child. These residential care facilities are considered to have care and control over children in their care.

Once a child is placed in one of these facilities, the facility provides a live-in house parent model of care. The house parent(s) assumes responsibility and acts in lieu of the parent(s) in meeting the children's ongoing needs.

These facilities may apply for medical assistance on behalf of the children under their care. The facilities have limited power of attorney and are considered alternate payees for the children's Medicaid EDG.

The facilities submit an application listing the child as a case name and a representative from the facility as an authorized representative.

Below is a list of general residential operations facilities that are members of the Texas Coalition of Homes for Children:

- ACH Child and Family Services – Fort Worth
- Arms of Hope – Quinlan and Medina
- Ben Richey Boys Ranch – Abilene
- Boys and Girls Country – Hockley
- The Brownson Home – Victoria
- Buckner Children and Family Services – Dallas
- Cal Farley's Boys Ranch – Amarillo
- Cherokee Home for Children – Cherokee
- Children at Heart Ministries – Round Rock
- The Children's Home of Lubbock – Lubbock
- Children's Village – Tyler
- Christ's Haven – Keller
- Foster's Home for Children – Stephenville
- Hendrick Home for Children – Abilene
- High Plains Children's Home – Amarillo
- Lee and Beulah Moor Children's Home – El Paso
- Methodist Home for Children – Waco and Waxahachie
- Miracle Farm – Brenham
- Presbyterian Children's Home – Austin, San Antonio, Waxahachie and Itasca
- South Texas Children's Home Ministries – Beeville
- Sunny Glenn Children's Home – San Benito
- Texas Baptist Children's Home – Round Rock
- Texas Boys Ranch – Lubbock
- West Texas Boys Ranch – San Angelo

This list is not all inclusive. Staff must submit a policy clearance request if they receive an application requesting medical assistance for a child from a facility that is not included on this list. Staff must include a copy of the placement contract and the power of attorney from that facility so it can be determined if the child can be considered an independent child.

Related Policy
Authorized Representatives (AR), A-170
Children's Living Arrangements, A-241.3.1
Verification Requirements, A-940
Verification Sources, A-941

A—924 Disqualification for Failure to Report Temporary Absence

Revision 15-4; Effective October 1, 2015

TANF

If a caretaker relative (a legal parent or other caretaker relative) fails to timely report the temporary absence of a certified child, the caretaker relative is disqualified until the earlier of the following occurs:

- the child returns to the home,
- the child is removed from the certified group, or
- the EDG is denied.

Related Policy
TANF — Budgeting for a Household Member Disqualified for Noncompliance with SSN, TPR, Failure to Timely Report a Certified Child's Temporary Absence, Intentional Program Violation, Being a Fugitive or a Felony Drug Conviction, A-1362.2
General Policy, A-1210

A—930 Requirement for Unmarried Minor Parents to Live with an Adult or in an Adult-Supervised Setting

Revision 15-4; Effective October 1, 2015

TANF

To receive Temporary Assistance for Needy Families (TANF) benefits, unmarried minor parents must live:

- with a parent, legal guardian or adult relative; or

  Note: The unmarried minor parent does not have to be included in a TANF EDG with the minor parent's parent unless required by policy in A-221, Who Is Included.
- in a local second chance home, maternity home or other residential facility that provides an adult-supervised living arrangement, if available in the local community, if the unmarried minor parent:
  - has no parent, legal guardian, or adult relative:
    - who is living;
    - whose whereabouts are known; and
    - who is willing and appropriate; or
  - cannot live with such an individual because of prior or potential abuse or neglect.

Advisors must notify the minor parent of available local facilities.

An unmarried minor parent and child are not required to live in a second chance home, maternity home or other adult-supervised living arrangement if it is not in their best interest. The advisor, using the prudent person principle, determines whether the unmarried minor parent's current living arrangement is in their best interest.

"In their best interest" means either:

- there is no parent, legal guardian or adult relative with whom the minor parent and child can live; or
- there is no adult-supervised facility in the community; or
- their current living arrangement provides as much or more safety and emotional or financial security than living in a local adult-supervised facility.

Examples:

- An unmarried minor parent is employed, their child has safe child care, and the move would result in the loss of employment.
- An unmarried minor parent lives alone or with a family friend, has no living adult relative, and no alternative adult-supervised facility is available in the community.

A—931 Failure to Comply

Revision 15-4; Effective October 1, 2015

TANF

Advisors must disqualify an unmarried minor parent who fails to comply with the requirement to live with a parent, legal guardian, adult relative, or in an adult-supervised living arrangement.

Related Policy
Budgeting for a Legal Parent Disqualified for Alien Status, Failure to Prove Citizenship, Noncompliance with the Unmarried Minor Parent Domicile Requirement or State Time Limits, A-1362.1

A—940 Verification Requirements

Revision 15-4; Effective October 1, 2015

TANF, TP 08 and TA 31

Advisors must verify that a person meets the 30-day domicile requirement before allowing additional temporary absence periods. See A-920, Temporary Assistance from the Home.

TANF

Advisors must verify domicile:

- at application and redetermination for all certified children; and
- when a change occurs:
  - for newly added children; or
  - if questionable, for all certified children.

For an unmarried minor parent, advisors must:

- verify domicile at application and redetermination;
- obtain a statement from the parent, legal guardian, adult relative or an employee of the adult-supervised setting; or
- contact school officials or use a current school record showing the same address as the parent, legal guardian, adult relative or approved adult-supervised setting.

TP 08 and TA 31

Advisors must verify domicile of a dependent child:

- at application and redetermination, and
- when a change impacts the living situation or care and control of the dependent child.

Medical Programs

Advisors must verify verbally with a state hospital employee whether a child entered a state hospital via a court order or if the child was admitted voluntarily. If the child was admitted voluntarily, determine whether the caretaker/payee still has care and control.

Advisors must verify a child's placement into a general residential operations facility.

Related Policy
Children's Living Arrangements, A-241.3.1
Children Admitted into State Hospitals, A-922
Children Residing in General Residential Operations Facilities, A-923

A—941 Verification Sources

Revision 17-2; Effective April 1, 2017

TANF, TP 08 and TA 31

- For a preschool-age child, advisors must:
  - observe the interaction between the child and caretaker/payee in either the home or the office;
  - obtain a statement from a non-relative landlord; or
  - obtain a statement from a non-relative neighbor.
- For a school-age child, obtain from the individual the name of the school for each school-age child. If the individual does not know where the child attends school and cannot provide a reasonable explanation, consider domicile questionable. When domicile is questionable, contact the school to verify domicile. If domicile is not questionable, use any of the following sources to verify domicile:
  - contact school officials or use a current school record showing the same address as the caretaker;
  - obtain a statement from a non-relative landlord;
  - obtain a statement from a non-relative neighbor; or
  - follow the same observation procedures for a preschool-age child if it does not interfere with school attendance.
- For individuals reported as released from juvenile placement by Texas Juvenile Justice Department (TJJD)/Juvenile Probation Department, use the Juvenile Medicaid Tracker.

If a child is home schooled, obtain domicile verification from another collateral source. See A-1640, Verification Requirements.

Note: Use Form H1155, Request for Domicile Verification, to request written domicile verification from a non-relative. Use Form H1857, Landlord Verification, to obtain verification from a non-relative landlord.

Medical Programs except TP 08 and TA 31

Advisors may accept self-declaration as verification of domicile.

For a child placed into a general residential operations facility:

- limited power of attorney to obtain health care and educational services; and
- placement contract.

Related Policy
Children's Living Arrangements, A-241.3.1
Children Residing in General Residential Operations Facilities, A-923
Questionable Information, C-920
Providing Verification, C-930

A—950 Documentation Requirements

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

Advisors must document:

- information from the verification source to prove the children live in the home (for collateral contacts, include name and address and/or telephone number);
- the reason for any temporary absence;
- information from the verification source to prove the household member or payee returned to and lived in the home for at least 30 days when allowing another temporary absence period;
- the living arrangement for unmarried minor parents;
- if the caretaker/relative continues to provide care and control when a child is admitted voluntarily into a state hospital;
- if a child was admitted into a state hospital voluntarily or via a court order; and

- if a child was admitted into a general residential operations facility.

Note: For Medical Programs except TP 08 and TA 31, accept self-declaration as verification of domicile.

TANF, TP 08 and TA 31

Advisors must document the school name, obtained from the caretaker/payee during the interview, for each school-age child.

TANF

Advisors must document how the minor parent meets or does not meet the unmarried minor parent domicile requirement, according to policy in A-930, Requirement for Unmarried Minor Parents to Live with an Adult or in an Adult-Supervised Setting.

Related Policy
Documentation, C-940
The Texas Works Documentation Guide

TWH, A-1000, Deprivation

Revision 15-4; Effective October 1, 2015

A—1010 General Policy

Revision 15-4; Effective October 1, 2015

TANF

Deprivation is the loss of financial support from a legal parent for one of the following reasons:

- absence of parent(s) from the home;
- death of parent(s);
- physical or mental incapacity of parent who is living in the home; or
- unemployment or underemployment of one or both parents in a two-parent household.

A—1020 Establishing Deprivation for Children of Unwed Parents

Revision 04-7; Effective October 1, 2004

A—1021 Unwed Parents Living Together

Revision 15-4; Effective October 1, 2015

TANF

When a child lives with both biological parents and the father:

- is not married to the child's mother;
- is not the legal father as determined through court adjudication; and
- acknowledges paternity,

staff should follow the procedures below to establish deprivation:

If the child's mother …	then …
is or was married (other than by common-law) to another man presumed to be the child's legal father,	**the child is** deprived based on absence and the biological father should not be certified. Both fathers must be referred to the Attorney General (see A-1100, Child Support).
was never married to a man presumed to be the child's legal father,	**the child is** deprived, but not based on absence.
was married by common-law to another man,	**the child is** deprived, but not based on absence.

A—1022 Paternity Conflicts — Unwed Parents

Revision 15-4; Effective October 1, 2015

TANF

If an application is filed for a child living with the mother and a man who may be the child's father and the couple disagrees about paternity, the mother must provide written proof of her statement.

If the mother proves the man is …	then deprivation is …
the child's father,	not based on absence, but rather on the relationship to the biological father living in the home.
not the child's father,	based on absence.

If the mother is unable to provide written proof, staff must accept the man's statement and determine deprivation accordingly. If there are other paternity conflicts, assistance should be requested from the regional attorney.

A—1030 Deprivation Based on Death of a Parent

Revision 15-4; Effective October 1, 2015

TANF

Deprivation exists when a child's legal parent(s) is deceased. Staff must explore possible survivor's benefits for the child and/or remaining parent.

A—1040 Deprivation Based on Absence from the Home

Revision 03-7; Effective October 1, 2003

A—1041 How to Determine Deprivation Based on Absence

Revision 15-4; Effective October 1, 2015

TANF

Deprivation based on absence exists when:

- a child's legal parents do not live together because of:
  - divorce,
  - legal separation,
  - desertion,
  - incarceration, or
  - deportation;
- the child's biological father lives in the home with the mother and child but a legal parent-child relationship exists between the child and another man;
- a parent resides outside the U.S. and there is a legal impediment that prevents the parent from living in this country; or
- a parent convicted of an offense and sentenced by a court to perform unpaid community service during work hours lives at home while serving the sentence.

If absence is anticipated to last for:

- 30 days or less, the absence is considered temporary and the child is not deprived.
- more than 30 days, the absence is considered continuing.

Note: If the absence is currently less than 30 days but is anticipated to last longer than 30 days, the Eligibility Determination Group (EDG) should not be pended for deprivation.

A parent should be included in the certified group if the parent is temporarily absent for a reason listed in A-920, Temporary Absence from the Home.

Deprivation based on absence does not exist when a parent is absent solely because of:

- employment; or
- active duty in the uniformed services of the United States, even if the parent is incarcerated or absent without leave (AWOL).

Exception: Deprivation may exist if there is a break in the family relationship unrelated to active duty in the service, and information indicates the family members are not functioning as a family unit. Information can be a statement from the caretaker that she and the second parent consider themselves to be separated so that the parents and children are not functioning as one family unit.

A—1041.1 Joint Custody

Revision 15-4; Effective October 1, 2015

TANF

A child living with parents who have court-ordered joint custody may be deprived based on absence. In joint custody cases, either parent may apply for Temporary Assistance for Needy Families (TANF) for the child. When the child alternately lives with either parent each month, either parent may apply. See A-910, General Policy.

A—1042 Contact with the Absent Parent

Revision 15-4; Effective October 1, 2015

TANF

Contact the …	when the address or phone number is known and …	Determine …
legal absent parent,	• there is reason to believe the absent parent is making cash contributions other than child support; or	• if the absent parent is making contributions other than child support;

	• conflicting information is provided regarding the parent's absence.	• the reason for the absence; • how long the absent parent has been absent; and • if the absent parent has plans to return and the anticipated return date.
alleged parent with no legal parent-child relationship,	• there is reason to believe the absent parent is making contributions other than child support to the household; or • the absent parent lives in the home and is a potential legal father through common-law marital status.	• if the absent parent is making contributions other than child support; or • if a common-law marriage exists.

Advisors must notify the applicant/individual before contacting the absent parent. Advisors should not contact the absent parent if the individual has a pending or valid claim of good cause. See A-1130, Explanation of Good Cause.

A—1043 Absent Parent Returns to the Home (Extension of the TANF Grant or Addition of the Returning Parent)

Revision 15-4; Effective October 1, 2015

TANF

When an absent parent returns to the home, the absent parent should be added to the case following policy in B-641, Additions to the Household, and eligibility and benefits should be determined.

- If eligible, advisors must document the new reason for deprivation and notify the Office of the Attorney General (OAG).
- If ineligible, advisors must deny TANF. If the absent parent’s earnings cause the case to be denied, advisors must transfer the case to TP 07 and include the absent parent.

Related Policy Earnings of a New TANF Spouse, A-1249.2

A—1050 Deprivation Based on Incapacity

Revision 15-4; Effective October 1, 2015

TANF

A parent is incapacitated if a medically determined mental or physical impairment results in a substantial reduction in the ability to support or care for the child. This impairment kept or will keep the parent from performing the parent’s usual work for at least 30 days.

The individual's usual work is the individual's main occupation for the last 15 years. In the case of a homemaker, the activities related to caring for a child are considered usual work.

A—1051 Determining Incapacity

Revision 15-4; Effective October 1, 2015

TANF

Advisors must determine whether the household meets all other eligibility criteria. If the household meets all other eligibility criteria, a disability determination request should be processed as follows:

1. Advisors must determine whether the household is receiving Supplemental Security Income (SSI) or Retirement, Survivors and Disability Insurance (RSDI) based on disability. If the individual receives either of these benefits, deprivation is established. **Note:** Eligibility for SSI or RSDI based on age does not establish deprivation.
2. If the applicant has a disability that is:

- obvious, advisors must certify the household for TANF and require a completed Form H1836-A, Medical Release/Physician's Statement, at the next redetermination.
- not obvious, the advisor must complete the disability determination. A disability determination consists of the advisor completing and sending Form H1836-A to the physician who treated the individual within the past 60 days for the incapacity being claimed. **Note:** The physician is not paid for completing this verification.

If Form H1836-A is returned indicating that the individual has …	then the household should be certified for …
a temporary disability,	TANF or TANF-State Program (SP), and the individual must be informed that the disability will be reviewed at each periodic redetermination.
a permanent disability,	TANF or TANF-SP.
no disability,	TANF or TANF-SP, and the requirements for participation in the Choices program must be explained.

A—1052 Processing Medical Reviews

Revision 15-4; Effective October 1, 2015

TANF

Medical reviews must be processed at each periodic review following the steps in A-1051, Determining Incapacity.

If the disability was …	then …
determined at initial certification without Form H1836-A, Medical Release/Physician's Statement, or was temporary and has ended (based on Form H1836-A) and the individual still claims to have a disability,	the advisors must require the individual to provide Form H1836-A before recertifying the case. If the individual does not provide the statement and the disability is not established, the advisor must then certify the household for TANF, if otherwise eligible.
permanent (based on Form H1836-A) and has not ended,	the advisor must continue to base deprivation on incapacity and not require another Form H1836-A unless the individual is working and/or the condition has improved.

A—1060 Deprivation Based on Unemployment

Revision 02-8; Effective October 1, 2002

A—1061 How to Determine Deprivation Based on Unemployment

Revision 15-4; Effective October 1, 2015

TANF

Deprivation based on unemployment may exist when a legal parent is:

- unemployed, or
- underemployed.

A—1070 TANF-State Program (SP)

Revision 15-4; Effective October 1, 2015

TANF-SP

Eligibility for TANF-SP may be determined when:

- a child lives with both of the child's natural or adoptive legal parents/stepparents, even if one or both are disqualified for one of the reasons listed in A-222, Who Is Not Included, No. 4, Disqualified Members, unless that disqualification is due to not meeting citizenship requirements; and
- the household meets all other TANF eligibility requirements.

A—1071 Employment Services Requirements

Revision 02-8; Effective October 1, 2002

A—1071.1 Choices Requirements

Revision 15-4; Effective October 1, 2015

TANF

Choices participation requirements and procedures are explained in A-1800, Employment Services.

A—1080 Disability Verification

Revision 15-4; Effective October 1, 2015

TANF

Verify the disability status using Form H1836-A, Medical Release/Physician's Statement.

A—1081 Verification Sources

Revision 15-4; Effective October 1, 2015

TANF

Death

Sources for verification of death include:

- copy of death certificate;
- Birth Verification System record;
- doctor's statement;
- Social Security claim number or evidence of receipt of widow's or survivor's benefits from the deceased person's Social Security number;
- U.S. Department of Veterans Affairs or military service records;
- Indian census record;
- statement from funeral director;
- records from the hospital or other institution where the person died; and
- insurance company records.

Alternate sources include:

- newspaper death notice listing survivors;
- state or local public assistance records (including burial payment records);
- lodge, club or other organization records;
- police records;
- statement from clergy; and
- "In Memoriam" card.

Sources for verification of continued absence include:

- statement from the absent parent;
- rent receipt/statement from the absent parent's non-relative landlord;
- statement from clergy, landlord, or other knowledgeable non-relative;
- correctional institution records;
- telephone directory;
- absent parent's child(ren)’s school records;
- tax records;
- absent parent's employment records;
- union records;
- court records;
- statement from law enforcement officials;
- insurance records;
- medical records;
- post office address records for the absent parent;
- other agency records;
- absent parent's unemployment compensation records;
- Department of Motor Vehicles record showing the absent parent's address (includes driver license, identification card, and motor vehicle registration);
- city or crisscross directory; and
- Social Security, U.S. Department of Veterans Affairs, or other government agency records.

Sources for proof of deprivation for TANF-SP include:

- Texas Workforce Commission inquiry;
- tax records;
- check stubs;
- employer's statement;
- business records; and
- Form H1028, Employment Verification.

Related Policy

Questionable Information, C-920
Providing Verification, C-930

A—1090 Documentation Requirements

Revision 15-4; Effective October 1, 2015

TANF

Advisors must document the:

- facts about the incapacity and any expected changes;
- processing dates of incapacity applications and reviews;
- facts about good cause claims;
- facts about adverse actions for noncooperation;
- name and last known address of the legal and/or biological father of an unborn child, if the mother receives TANF;
- permanent or temporary disability status; and
- basis for a special review and the special review date.

Related Policy Documentation, C-940

The Texas Works Documentation Guide

TWH, A-1100, Child Support

Revision 16-2; Effective April 1, 2016

A—1110 General Policy

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

The Office of the Attorney General (OAG) Child Support Division is responsible for the child support program. The OAG attempts to establish and enforce child support and medical support for children on Temporary Assistance for Needy Families (TANF) and certain medical programs.

TANF

Caretakers and payees must cooperate in obtaining child support and medical support for a child receiving TANF unless good cause exists.

TP 08

Parents and caretaker relatives are mandatory participants and must cooperate in obtaining medical support for a child receiving Medicaid unless good cause exists. They may refuse assistance in obtaining child support, but not medical support. If the individual refuses assistance in obtaining child support, the OAG will not attempt to establish or enforce child support unless the individual has a previous TANF case with arrears that must be paid back to the state. Advisors must explain to individuals that when the OAG pursues medical support, Texas courts also pursue a child support order. If the individual chooses medical support only, the OAG will not attempt to enforce the child support orders.

Note: The advisor must request information on parents living outside of the home during an interview for TP 08. Information about parents living outside of the home is not requested for Medical Programs on the application.

Related Policy
Explanation of Good Cause, A-1130

Medical Programs except TP 08

Medical support requirements do not apply to children's medical programs. Applicants and individuals may volunteer to receive child or medical support services. There is no penalty for noncooperation.

Note: The OAG may contact and continue to collect benefits for a household receiving only children's medical assistance due to previous receipt of TANF.

Households may contact the OAG if they have questions or would like assistance in obtaining OAG services by calling 1-800-252-8014.

A—1111 Office of the Attorney General (OAG) Case Information and Inquiry

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

If the custodial or noncustodial parents or employers have questions regarding child support payments, distribution, or withholdings, they should be referred to the local child support office or to 1-800-252-8014.

Custodial or noncustodial parents should be referred to the local OAG office if they request verification and certification of public assistance received. The OAG staff complete Form 1740, Request for Public Assistance Payment Certification, when the amount of public assistance is in question or when it is needed in court to establish child support. Texas Health and Human Services Commission (HHSC) Fiscal Management Services (E-411) researches and certifies the amounts and date on Form 1745, Report of Total Public Assistance Payments, for the OAG.

A—1120 Child Support Program Requirements and Procedures

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

Form H1712, Explanation of Child/Medical Support, Family Violence and Good Cause, is used to explain the:

- child support process;
- benefits of the child support program;
- penalties for noncooperation;
- details about the family violence option;
- details of the good cause claim for not cooperating; and
- individual's responsibility to:
  - provide information to the OAG and HHSC on all possible biological and/or legal parent(s);
  - help the OAG find the absent parent;
  - help the OAG establish paternity, if necessary;
  - go to the OAG office or to court to sign papers or provide necessary information; and
  - remit all child/medical support payments received after TANF is approved.

A—1121 Authorization and Assignment of Child and Medical Support

Revision 15-4; Effective October 1, 2015

TANF and TP 08

The assignment of rights to child and medical support is accomplished when an applicant signs an application that includes a request for TANF or TP 08. Signing the application gives the OAG permission to receive and process any child or medical support payments made payable to the child.

A—1122 Parent Profiles for Child and Medical Support Referrals

Revision 02-6; Effective July 1, 2002

A—1122.1 Parent Profile Questionnaire

Revision 15-4; Effective October 1, 2015

TANF and TP 08

Form H0050, Parent Profile Questionnaire, information is required for each absent parent. **Note:** The absent parent information may be obtained verbally and entered onto the Absent Parent page. If a child has both a legal and a biological absent parent, information on both the legal and biological parent is required unless the individual can reasonably explain why it is impossible to provide information or can establish good cause. The individual must provide the following information about the absent parent:

- the absent parent's first and last name;
- information about the relationship (divorced, separated, never married) between the child's mother and father; and
- at least one of the following:
  - the absent parent's Social Security number,
  - the absent parent's current or last known address, or
  - the absent parent's employer information (current and/or previous employer).

The advisor must address each item on Form H0050 and help the individual obtain information about the absent parent(s). The OAG establishes cases based on information collected from the applicant and entered by the advisor. Failure to provide complete and accurate information may affect the successful enforcement of child support.

TP 43, TP 44 and TP 48

If the individual volunteers to receive services provided by the OAG, staff must collect absent parent information as noted above and refer the child's Eligibility Determination Group (EDG) to the OAG.

A—1122.2 Child Support and Medical Support Referrals

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs except TP 40 and TP 36

Advisors must send referrals to the OAG on legal and biological parent(s):

- when deprivation is based on absence;
- when deprivation is based on death;
- if paternity cannot be established using policy in A-1021, Unwed Parents Living Together, for a biological father who is in the home;
- if the family volunteers to receive services provided by the OAG for Children's Medicaid programs; or
- the adult caretaker receives TP 08. See A-1122.1, Parent Profile Questionnaire, for Children's Medicaid programs.

Advisors do not send a referral if:

- a child in the home is not deprived because both parents are in the home or deprivation is based on unemployment or underemployment (TANF-State Program [SP]);
- a claim of good cause has been established;
- deprivation is based on physical or mental incapacity; or
- the legal or biological father of a pregnant woman's unborn child has no other children receiving Medicaid.

Advisors must review Form H0050, Parent Profile Questionnaire, with the individual to ensure no items are blank, that the individual provided complete and current information, and entered the information in the Absent Parent logical unit of work (LUW). The Texas Integrated Eligibility Redesign System (TIERS) automatically sends the referral to the OAG.

A—1123 Updates to Child Support Referrals

Revision 15-4; Effective October 1, 2015

TANF and TP 08

Advisors must advise the client to report new information about the absent parent(s), review the information previously submitted for accuracy, and update items as needed. The OAG will receive the update automatically.

A—1124 TANF

Revision 15-4; Effective October 1, 2015

After certification, TANF individuals must remit to the OAG all child support payments received for a certified child. Individuals should be given sufficient copies of Form H1710, Payment Identification, and OAG self-addressed envelopes, if payments are being made or might be made. When the individual receives a child support payment from an absent parent following certification, the individual must:

- write on the check or money order "Deposit Only - State Treasury" and **not** endorse the check or money order;
- include Form H1710 with the check or money order; and
- send it to the Texas Child Support Disbursement Unit, P.O. Box 659791, San Antonio, Texas 78265-9941.

If child support is intended for a child on TANF and one on Supplemental Security Income (SSI), the individual must remit the payment to the OAG for proration and distribution to occur.

If the individual turns in child support payments to the local office, advisors must:

- forward the payment(s) to the Child Support Disbursement Unit; and
- give the individual a copy of Form H4100, Money Receipt.

Advisors must send Form H1701, Child Support, TANF Foster Care and TANF/Medicaid Case Information Exchange, including the amounts and months involved, to the OAG if the advisor becomes aware that the individual did not remit a child support payment. Advisors should follow policy in A-1140, Noncooperation with Child Support Program Requirements, to sanction the individual for noncooperation. If the individual indicates they will continue to keep child support received from the absent parent, the advisor should follow policy in B-700, Claims, and process a claim for the month(s) of unreported income.

If the OAG becomes aware that the individual received child support and did not remit the payments, the child support officer notifies the advisor on Form H1701. The advisor must process a claim for the unreported income.

TANF-SP

The household must not be required to remit any child support collected on behalf of a non-mutual child.

Related Policy
Remitting Cash Medical Support Payments to the Third-Party Resources (TPR) Unit, A-861.5
Child Support, A-1326.2

A—1125 OAG Distribution

Revision 15-4; Effective October 1, 2015

TANF

After individuals are certified for TANF, they must send all child support payments received to the OAG Child Support Division. The OAG:

- sends the $75 disregard to the individual;
- reimburses the state for TANF paid to the individual; and
- sends HHSC the monthly interface file of child support collections for TANF recipients.

HHSC uses the information to determine whether the collection exceeds the grant plus the disregard, and to determine grant in jeopardy if it exceeds the grant.

If the individual receives child support for an SSI child in the household, the OAG will distribute (directly to the individual) the prorated share of support intended for the SSI child.

The month after the OAG receives a child support payment, the OAG will send the individual up to $75 (disregard payment). The amount sent is the lesser of:

- the court-ordered payment amount,
- the amount the OAG received during a given month, or
- $75.

When the OAG receives a child support collection that exceeds the grant plus unreimbursed assistance, the excess is sent to the individual. Form H1714, Notice of Grant Jeopardy; Form H1715, Notice of Excess Payment; or Form H1717, Notice of Grant Jeopardy/Excess Payment — Denial, will notify the advisor of the date and amount of the payment.

A grant-in-jeopardy EDG may be generated for EDGs involving SSI children. In processing the grant-in-jeopardy, TIERS determines whether the prorated share of child support exceeds the TANF grant, minus the disregard. If the prorated share exceeds the TANF grant, minus the disregard, TIERS will deny the EDG. If the amount does not exceed the TANF grant, TIERS will allow the TANF EDG to continue.

Example:	The household consists of a caretaker and one child who receives TANF and one child who receives SSI.	
-	$300	child support for both children
-	-150	will go directly to SSI child
-	150	child support for TANF child
-	- 75	disregard
-	$75	does not exceed TANF for a caretaker and one child; the state retains the child support

Note: If the individual appeals the action described in A-852, Automated Process, and receives continued benefits, the advisor must count the excess payment as income during the appeal period if the advisor anticipates that the child support payments will continue.

Related Policy Automated Process, A-852 Child Support, A-1326.2 $75 Disregard Deduction, A-1422 Child Support Systems, C-830

A—1130 Explanation of Good Cause

Revision 15-4; Effective October 1, 2015

TANF and TP 08

The purpose of good cause is to allow individuals to access benefits safely. Good cause provides a waiver from cooperating with the OAG's child support and medical support requirements.

Advisors must explain the family violence option and good cause to all individuals. Advisors use Form H1712, Explanation of Child/Medical Support, Family Violence and Good Cause, to explain the family violence exemption from the child support and medical support requirements. The explanation must include the situations that justify good cause and the required verifications. Advisors must also explain that individuals do not have to cooperate with child support or medical support requirements if they can prove that cooperation is not in the child's best interest. Individuals must claim good cause separately for each absent parent and advisors must notify the OAG of the individual's good cause claim.

After explaining Form H1712 to the individual, advisors should review Part I of Form H1713, Service Plan for Family Violence Option and Report of Good Cause, with them during the interview. The advisor completes only Part I of Form H1713 if the individual indicates on this form that the individual does not want to claim good cause. If the individual wants to claim good cause, the advisor must make an assessment referral to a family violence specialist as explained in A-1131.1, Good Cause for Family Violence Option.

Once the family violence specialist makes a determination of good cause, the advisor sends Form H1713 to the local child support office and HHSC Family Violence Program (FVP) staff to report the final decision.

Note: FVP staff use the good cause determination information for TANF federal reporting.

A—1131 Good Cause Situations

Revision 15-4; Effective October 1, 2015

TANF and TP 08

Good cause exists when:

- a child was conceived as a result of incest or rape;
- a child or caretaker may be physically harmed;
- a child or caretaker may be emotionally harmed to the extent that the caretaker's capacity to adequately care for the child is impaired; or
- legal proceedings for the child's adoption are pending before a court or a licensed or private social agency is helping the individual decide whether to keep the child or relinquish the child for adoption.

Note: This issue must not have been under discussion more than three months and staff must update the absent parent referral if the issue remains unsolved beyond the third month.

A—1131.1 Good Cause for Family Violence Option

Revision 15-4; Effective October 1, 2015

TANF and TP 08

Cooperating with the OAG's child support and medical support requirements poses a potential safety risk for family violence victims and their children. The advisor must explain and offer the family violence option at each application and redetermination. Options for explaining good cause:

1. In face-to-face interviews, advisors must:
   - explain Form H1712, Explanation of Child/Medical Support, Family Violence and Good Cause, and give a copy of the form to the individual;
   - review Part I of Form H1713, Service Plan for Family Violence Option and Report of Good Cause, with the individual; and
   - if the individual wants to claim good cause, make an assessment referral to a family violence specialist at a nearby family violence service provider. Only a family violence specialist can recommend good cause relating to family violence.
     A list of family violence shelters is located at hhs.texas.gov/services/safety/protective-services/family-violence-program#_Centers_that_Provide_1 .
     The advisor can make the referral in the following ways:
     - The individual has a confidential telephone interview from the local eligibility determination office with the family violence specialist.
     - The individual arranges to meet with the family violence specialist. The advisor gives Form H1706, Good Cause Recommendation and Family Violence Exemption,to the individual and tells them to contact a family violence service provider to speak with a family violence specialist. The individual must explain the need to claim good cause for not complying with TANF or Medicaid child support and medical support requirements and request a good cause recommendation.

After the family violence specialist makes the good cause determination, the family violence specialist completes Form H1706 and can either mail, fax or send the form back with the individual to HHSC.

2. In phone interviews, advisors must:
   - Explain Form H1712 and give a copy of the form to the individual.
   - Complete Part I of Form H1713 and mail it to the individual along with the following forms:
     - Form H1706, Good Cause Recommendation and Family Violence Exemption
     - Form H0050, Parent Profile Questionnaire (**Note:** Tell the individual that HHSC does not require Form H0050 if the individual is granted good cause.)
   - Tell the individual to contact a family violence service provider to speak with a family violence specialist. A list of family violence shelters is located at https://hhs.texas.gov/services/safety/protective-services/family-violence-program.
     If no shelter serves the individual's area, give the individual the National Domestic Violence Hotline number [1-800-799-7233 (1-800-799-SAFE) or 1-800-787-3324 TTY for individuals who are deaf] to help the individual locate the closest family violence service provider.
   - Have the individual explain the need for claiming good cause and for not complying with TANF or Medicaid child support and medical support requirements and request a good cause recommendation. The individual arranges to speak with the family violence specialist.

   After the family violence specialist makes the good cause determination, the family violence specialist completes Form H1706 and can either mail, fax or send the form back with the individual to HHSC.

Advisors must remind the individual that HHSC requires a completed Form H0050 if the family violence specialist determines there is not good cause or the individual decides not to pursue good cause. If the individual does not pursue good cause, the individual must complete and return Form H0050 or provide absent parent information before the advisor can approve the TANF and/or Medicaid EDG.

Advisors must allow the individual 10 days to return Form H1706, Form H1713 and Form H0050 (if required). HHSC keeps copies of Form H1706 and Form H1713 in the electronic case record.

The advisor must:

- complete Part II and Part III of Form H1713,
- send a copy to the local child support office, and
- send a copy to the family violence coordinator via one of the following methods to report the final decision:
    - Interagency mail: Family Violence Coordinator, Mail Code 2010
    - Regular mail: Family Violence Coordinator 909 W. 45th St., Mail Code 2010 Austin, TX 78751
    - Email: Familyviolence2@hhsc.state.tx.us (completed and scanned documents only)

Once the good cause claim has been established, advisors re-evaluate the claim at each redetermination. If the individual is no longer claiming good cause, advisors should update the absent parent referral by removing the good cause indicator to allow the OAG to help the family get child support and/or medical support services for their children. If the individual continues to claim good cause, advisors continue to allow good cause.

A—1131.2 Good Cause Related to Adoptions, Rape or Incest

Revision 15-4; Effective October 1, 2015

TANF and TP 08

If an individual claims good cause based on an adoption, rape, or incest, advisors must:

- allow individuals 20 days to provide evidence;
- extend the deadline for evidence if additional time is needed to obtain the necessary information;
- document the reason for extending the deadline and obtain supervisory approval; and
- flag the case and evaluate the evidence when receivedand recommend either that the individual:
    - has good cause for not cooperating and the OAG should not continue child support locate and enforcement efforts; or
    - does not have good cause for not cooperating and the OAG should continue child support locate and enforcement efforts.

Note: For adoption situations, the issue must not have been under discussion for more than three months. If the issue is unresolved beyond the third month, staff must update the absent parent referral.

A—1140 Noncooperation with Child Support Program Requirements

Revision 15-4; Effective October 1, 2015

TANF and TP 08

At initial certification and redetermination or incomplete reviews, the advisor must determine whether the individual failed to cooperate with child support requirements.

The advisor determines noncooperation when:

- an individual fails to cooperate with child support requirements without good cause (see A-1120, Child Support Program Requirements and Procedures, for individual responsibilities); or
- HHSC receives Form H1708-A, Report of Noncooperation (Automated), from the OAG via the weekly interface.

Medical Programs except TP 08

There is no penalty for noncooperation for Medical Programs. Advisors do not take any action on an individual who volunteers to receive child and medical support services but later noncomplies.

A—1141 Sanctions for Noncooperation

Revision 16-2; Effective April 1, 2016

TANF and TP 08

The Child Support Division of the OAG notifies HHSC via a weekly interface when an individual fails to cooperate with child support or medical support. Upon receipt of the notice of child support noncooperation, HHSC must take action to process the noncooperation within five workdays. See A-2140, Full-Family Sanction, and A-2150, Pay for Performance.

TANF

Adult TANF recipients, second parents and minor parents certified as adults, payees or disqualified adults are required to sign Form H1073, Personal Responsibility Agreement, and cooperate with child support requirements. Failure to do so results in a full-family sanction. If the TANF recipient or payee has more than one TANF EDG and fails to cooperate with child support requirements, the sanction applies to all of their TANF EDGs. See A-2140 and A-2150.

TP 08

Parents and caretaker relatives receiving TP 08 must cooperate in establishing medical support. Failure to cooperate with requirements results in the loss of medical coverage for the noncooperating adult.

The advisor must deny a noncooperating adult's TP 08 EDG. See A-1142, Noncooperation Situations.

Medical Programs except TP 08

Recipients applying for Children's Medicaid programs, including TP 40 for a pregnant teen under age 19, are not required to cooperate with child support requirements. Therefore, there is no penalty for noncooperation. Recipients may volunteer for child support services.

A—1142 Noncooperation Situations

Revision 15-4; Effective October 1, 2015

TANF and TP 08

If a child support noncooperation is received on …	and the household does not have good cause, then …
• a denied EDG in a TANF cash benefit month,	• TIERS identifies the noncooperation; and • sends Form TF0001, Notice of Case Action, advising the household of the noncooperation and how to cooperate. **Note:** If the household fails to cooperate by the last calendar day of the second month, the household will be subject to pay for performance requirements when they reapply for TANF.
• a denied case in a non-TANF cash benefit month,	no action is required.
• an active TANF or TP 08 EDG, the month after the child is no longer in the home, and the noncooperation date is after the date the child was removed from the EDG,	no further action is required.

If a child support noncooperation is received on …	and the household does not have good cause, then …
• an EDG already sanctioned for a child support noncooperation on a different absent parent,	TIERS sends Form TF0001 advising the household of the noncooperation and how to cooperate. **Note:** The OAG will not issue Form H1701, Child Support, TANF Foster Care and TANF/Medicaid Case Information Exchange, until the individual cures all noncooperations.
• an active TP 08 EDG,	TIERS denies the noncooperating adult's TP 08 EDG.
• an active EDG and the child receives SSI, • a TANF-SP EDG with a child in the household who is deprived due to the absence of a parent, • an active TANF cash EDG and the individual and absent parent have reconciled and are in the home together, or • an active TP 08 EDG and the individual and absent parent have reconciled and are in the home together,	refer to A-2140, Full-Family Sanction, to impose a full-family sanction. If the household fails to cure the noncooperation before the last day of the second noncooperation month, they will need to reapply under pay for performance. TIERS denies the noncooperating adult's TP 08 EDG.

Note: The advisor must determine whether the individual has good cause for not cooperating with child support requirements using policy in A-1130, Explanation of Good Cause. If the individual has good cause, the advisor should not impose a full-family sanction.

Related Policy

Explanation of Good Cause, A-1130

Noncooperation with Child Support Program Requirements, A-1140

Good Cause for Child Support Noncooperation, A-2122.3

Full-Family Sanction, A-2140

Pay for Performance, A-2150

A—1150 Verification Requirements

Revision 15-4; Effective October 1, 2015

TANF and TP 08

Advisors must verify all good cause claims.

A—1151 Verification Sources

Revision 15-4; Effective October 1, 2015

TANF and TP 08

The following are acceptable verification sources or evidence for:

- Emotional or Physical Harm for Individuals — a written recommendation from a family violence specialist. The specialist must be an employee of a family violence program that contracts with HHSC. The family violence specialist must complete Form H1706,Good Cause Recommendation and Family Violence Exemption,which serves as verification for the good cause claim.
- Incest or Rape — a birth certificate or medical or law enforcement records indicating the circumstances surrounding the child's birth.
- Adoption or Pending Adoption — a court document, other related records, or written statement of the facts from the social services agency.

Related Policy Questionable Information, C-920 Providing Verification, C-930

A—1160 Documentation Requirements

Revision 15-4; Effective October 1, 2015

TANF and TP 08

Advisors must document:

- that the individual cooperated with the child support requirements;
- every aspect of the good cause investigation, the determination, the basis for the determination, and the evidence provided;
- determination made at each re-evaluation of good cause, which must occur at each periodic review; and
- the reason an individual cannot provide minimum information on an absent parent.

TANF

Advisors must document the name and last known address of the legal and/or biological father of an unborn child if the mother receives TANF.

Medical Programs except TP 08

Advisors must document that the individual did not want to volunteer for child/medical support services.

Related Policy

Documentation, C-940

The Texas Works Documentation Guide

TWH, A-1200, Resources

Revision 17-4; Effective October 1, 2017

A—1210 General Policy

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Resources are assets or possessions that are either countable or exempt, depending on the program. There are liquid and nonliquid resources. Liquid resources are those that are readily available (such as cash, checking or savings accounts, debit accounts, savings certificates, stocks, or bonds). Nonliquid resources include vehicles, buildings, land, or certain other property. Texas Health and Human Services Commission (HHSC) staff must count the equity value of all resources unless otherwise specified or listed as exempt. The equity value is the fair market value of an item minus:

- all money owed on it; and
- the cost associated with its sale or transfer.

Staff must count resources of the:

- members of the:
  - Temporary Assistance for Needy Families (TANF) certified group;
  - Supplemental Nutrition Assistance Program (SNAP) household; and
  - child's TP 32 and child's TP 56 household composition;
- alien's sponsor according to the policy in A-1245, Resources of an Alien's Sponsor;
- disqualified persons; and
- stepparents in TANF households according to policy in A-1247, Resources of Stepparents.

If payments exempted as resources are kept in a separate account, those payments remain exempt. If the money is placed in an interest-bearing account, the interest must be counted as income in the month received. If the money is combined with money that is countable, staff must exempt the excluded funds for six months from the date the funds are combined. After six months, the total amount of combined funds should be counted as an available resource.

SNAP

Categorical eligibility extends to any household authorized to receive services funded by the TANF program. TANF non-cash (TANF-NC) services consist of various services such as family planning, adult education, prevention and treatment of substance abuse, and employment services. For determination of categorical eligibility based on receipt of TANF-NC, households are subject to a resource and income test.

The resource test consists of the following criteria:

- the household's countable liquid resources plus excess vehicle value must be $5,000 or less. Up to $7,500 cash value of a prepaid burial insurance policy, funeral plan, or funeral arrangement for each certified household member is exempt. Any cash value exceeding $7,500 must be counted as a liquid resource.
- Up to $15,000 of the fair market value (FMV) for the highest valued countable vehicle is exempt. The excess over $15,000 FMV is counted toward the combined resource limit.
- Up to $4,650 FMV for all other countable vehicles is exempt. The excess over $4,650 FMV is counted toward the combined resource limit. **Note**: Refer to the policy in A-1238, Vehicles, for additional reasons a vehicle can be exempted.

Once the recipient is authorized for TANF-NC services based on the initial resource test, all other nonliquid resources are exempt. Regular TANF policy must be followed when determining countable liquid resources within TANF-NC. The majority of resources are not applicable to SNAP.

Related Policy
Limits, A-1220
Prepaid Burial Insurance, A-1233.2
Vehicles, A-1238
How to Determine Fair Market Value of Vehicles, A-1238.5
General Policy, A-1310
Categorically Eligible Households, B-470
What to Report, B-621

Medical Programs except Children on TP 56 and Children on TP 32

Resources are not considered as a factor in determining eligibility.

Children on TP 56 and Children on TP 32

Resources are considered as a factor in determining eligibility for children on TP 56 and TP 32.

Exception: Staff must not consider resources when determining a newborn's eligibility for TP 56 when the newborn's mother was eligible for TP 56 or TP 32 at the time of the newborn's birth.

A—1211 Requirement to Pursue Resources

Revision 15-4; Effective October 1, 2015

TANF

An individual must pursue all resources to which the individual is legally entitled unless it is unreasonable to pursue the resource. Advisors should develop a plan with the individual to pursue the potential resource and allow reasonable time (at least three months) to pursue the resource.

Advisors should use the comment section of Form TF0001, Notice of Case Action, to inform the individual of the requirement to pursue the resource, including the time the individual has to pursue it, and the resource is not considered available during that time.

If the individual does not pursue the resource within a reasonable time, the Eligibility Determination Group (EDG) is denied.

Exception: The individual does not have to pursue a resource if it would be unreasonable. It is unreasonable to pursue a resource if any of the following conditions exist:

- The cost to the individual to pursue the resource exceeds the potential resource's value or causes the individual financial hardship;
- Pursuing the resource would endanger the individual's health or safety; or
- Legal action is required, but a private attorney or legal service refuses to accept the case. The individual must make a reasonable effort to obtain legal assistance.

SNAP

Individuals receiving SNAP benefits do not have to pursue resources.

Note: Pursuing resources could help an individual become self-sufficient, and individuals should be provided examples of resources they might be entitled to receive.

A—1212 Transferring Resources

Revision 13-2; Effective April 1, 2013

A—1212.1 Penalties for Transferring Resources

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Households are ineligible if, within three months before application or any time after certification, the household transfers a countable resource for less than its fair market value to qualify for assistance. This penalty applies if the total of the transferred resource added to other resources affects eligibility.

Resources transferred between members of the same TANF/SNAP household do not affect eligibility. If spouses separate and one spouse transfers individual property, the other spouse's eligibility is not affected.

Children on TP 56 and Children on TP 32

Applicants or individuals who transfer resources to qualify for assistance must not be denied.

A—1212.2 How to Determine Intent

Revision 15-4; Effective October 1, 2015

TANF and SNAP

In determining an individual's intent for transferring resources for TANF and SNAP benefits, staff must consider the following:

- How recent was the transfer of property? A recent transfer may indicate the household transferred the resource to qualify for benefits.
- How did the applicant support the household after transferring the resource? If the applicant was self-supporting or supported by the person who received the property, then the applicant's intent was to have support rather than qualify for benefits.

- How did the applicant transfer the property? If the applicant loaned the property but cannot recover its value after making a reasonable effort, the applicant is eligible.
- Special or unpredictable hardships that prevent the individual from making payments for the transferred resource do not affect eligibility. The supervisor and program manager must approve these situations.

A—1212.3 Length of Denial Period

Revision 15-4; Effective October 1, 2015

TANF and SNAP

The length of denial must be based on the amount by which the transferred resource exceeds the resource maximum when added to other countable resources.

Amount in Excess of Resource Limit	Denial Period
$.01 to $249.99	1 month
$250 to $999.99	3 months
$1,000 to $2,999.99	6 months
$3,000 to $4,999.99	9 months
$5,000 and more	12 months

Examples:

TANF: A two-person household has $1,250 in a bank account and transfers ownership of a car worth $5,650. The first $4,650 of the car's value is exempt. Add the remaining $1,000 to the other $1,250 resource. Subtract the $1,000 resource limit from the total. Use$1,250 to determine the number of months of ineligibility. According to the above chart, the household is ineligible for six months.

SNAP: A two-person household has $2,000 in a bank account and transfers ownership of a car worth $19,000. Exempt the first $15,000 FMV of the vehicle and add the remaining $4,000 to the $2,000 bank account. Subtract the $5,000 resource limit from the total. Use $1,000 to determine the number of months of ineligibility. According to the above chart, the household is ineligible for six months.

A—1212.4 Beginning the Denial Period

Revision 15-4; Effective October 1, 2015

TANF and SNAP

The denial period begins in the application month unless the household is already certified when the advisor discovers the transfer.

Once the household is certified, the advisor must send a notice of adverse action and follow adverse action procedures. The advisor must begin the denial period the first month after the month the notice of adverse action expires unless the individual requests a fair hearing and receives continued benefits.

A—1220 Limits

Revision 15-4; Effective October 1, 2015

TANF

A household is not eligible for benefits if the total value of accessible resources is over $1,000.

A household is not eligible for benefits if resources are over the limit on or after the first interview date.

If a TANF applicant/recipient fails to provide resource verification for TANF, the advisor must:

- deny the TANF application, and
- process the application for non-public assistance (NPA) SNAP eligibility.

SNAP

A household is not eligible for benefits if the total value of countable resources (liquid resources and excess vehicle value) is over $5,000.

A household is not eligible for benefits if resources are over the limit on or after the first interview date. Additionally, striker households are ineligible if resources are over the limit the day before the strike.

Children on TP 32 and Children on TP 56

A child is not eligible for benefits if the total value of accessible resources is over:

- $3,000 in households with a member who is aged or has a disability and meets relationship requirements; or
- $2,000 for all other households.

Advisors must use the SNAP definitions of aged and disability found in B-431, Definition of Elderly, and B-432, Definition of Disability. The individual who is aged or has a disability does not have to be part of the Medical Programs budget group, but must meet relationship requirements.

A child is not eligible for benefits if resources are over the limit on the process date. In determining eligibility for a prior month, the household is not eligible if resources are over the limit anytime during the prior month.

Related Policy
General Policy, A-1210
Prepaid Burial Insurance, A-1233.2
Vehicles, A-1238
How to Determine Fair Market Value of Vehicles, A-1238.5
General Policy, A-1310
Categorically Eligible Households, B-470

A—1230 Types of Resources

Revision 03-3; Effective April 1, 2003

A—1231 Accounts

Revision 07-4; Effective October 1, 2007

A—1231.1 Bank Accounts

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Advisors must count the cash value of checking and savings accounts unless exempt for another reason.

Related Policy
Payments Exempt as a Resource While Being Considered Income, A-1243
Inaccessible Resources, A-1241

A—1231.2 Debit Accounts

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Advisors must count the cash value of benefits in a debit account, less amounts deposited in the current month, as a resource. Government benefit payments may be deposited into a debit account. Advisors must verify the balance in the account using the most current information.

The most common debit accounts established for deposit of government benefits are the:

- Electronic Benefit Transfer (EBT) cash accounts for TANF benefits;
- unemployment insurance benefits (UIB) debit accounts;
- Texas debit card accounts for child support payments, Office of Attorney General (OAG);
- debit card accounts for child support payments from other states; and
- Direct Express card debit accounts for Social Security; Retirement, Survivors and Disability Insurance (RSDI); or Supplemental Security Income (SSI) benefits payments.

This list is not intended to be all inclusive as more agencies and businesses move toward the use of debit cards to issue benefits.

Account inquiry is accessible to:

- TANF recipients by calling the Lone Star Help Desk automated voice response system at 1-800-777-7EBT (1-800-777-7328);
- UIB recipients online at www.ucard.chase.com or at any Chase Bank automated teller machine (ATM) free of charge;
- child support recipients online at www.EPPICard.com;
- Social Security recipients online at www.USDirectExpress.com, by calling 1-888-741-1115, or balance information may be obtained free of charge at any ATM that displays the MasterCard® logo.

Exception: See A-1248, Resources of TANF and SSI Recipients.

Related Policy
Retirement, Survivors, and Disability Insurance (RSDI), A-1324.16
Supplemental Security Income (SSI), A-1324.17
Temporary Assistance for Needy Families (TANF), A-1324.18
Unemployment Compensation, A-1324.19
Counting Child Support, A-1326.2.1
Client Inquiries, B-382

A—1231.3 Individual Development Accounts (IDAs)

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Staff must use the following policy to determine whether an IDA is a countable or exempt resource.

TANF IDAs — TANF IDAs must be used for one of the following purposes:

- paying for a college education,
- purchasing a home, or
- starting a business.

The household is not required to be a TANF recipient to qualify for an IDA, but the household must be financially needy and have a child living with the custodial parent or other adult relative who meets the TANF relationship criteria or the household must consist of a pregnant

woman.

The household is considered financially needy if the household is eligible to receive TANF, SNAP, or any Medical Program except TP 56. For TP 56, the household is considered financially needy if its gross income is below 185 percent of the Federal Poverty Income Limit (FPIL).

Any earnings, including Earned Income Tax Credit (EIC), deposited in a TANF IDA must be excluded from resources. Any interest earned on the account must be excluded from resources. Any deposits into an IDA not made with earnings, or withdrawals from an IDA that are not made for an allowable qualifying purpose, should count as a resource.

Assets for Independence Act (AFIA) IDAs — AFIA IDAs are funded and authorized under the AFIA and must meet one of the same qualifying purposes as TANF IDAs. Any earnings, including EIC, deposited in an AFIA IDA must be excluded from resources. Any interest earned on the account must also be excluded from resources. Any deposits into an IDA not made with earnings, or withdrawals from an IDA that are not made for an allowable qualifying purpose, should count as a resource.

Other IDAs — These IDAs do not meet one of the qualifying purposes of paying for a college education, purchasing a home, or starting a business and should be counted as a resource. The interest earned on these accounts must be counted as unearned income.

For any type of IDA, matched funds are not counted as a resource, as they are not accessible to the household.

Exception: IDAs are exempted if Long Term Care certifies them as meeting the Social Security criteria for a Plan to Achieve Self-Sufficiency (PASS).

A—1231.4 Retirement Accounts

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

A retirement account is one in which an employee and/or the employer contributes money for retirement. There are several types of retirement plans.

Some of the most common plans authorized under Section 401(a) of the Internal Revenue Services (IRS) Code are the 401(k) plan, Keogh, Roth individual retirement account (IRA), and a pension or traditional benefit plan. Common plans under Section 408 of the IRS Code are the IRA, Simple IRA, and Simplified Employer Plan.

- A 401(k) plan allows an employee to postpone receiving a portion of current income until retirement.
- An IRA is an account in which an individual contributes money to supplement the individual's retirement income (regardless of the individual's participation in a group retirement plan).
- A Keogh plan is an IRA for a self-employed individual.
- A Simplified Employee Pension (SEP) plan is an IRA owned by an employee to which an employer makes contributions or an IRA owned by a self-employed individual who makes contributions for the individual's self.
- A pension or traditional defined benefit plan is employer-based and promises a certain benefit upon retirement regardless of investment performance.

The following retirement accounts or plans are excluded:

- Accounts established under Internal Revenue Code of 1986, Sections 401(a), 403(a), 403(b), 408, 408A, 457(b), 501(c)(18);
- Plans established under the Federal Thrift Savings Plan, Section 8439, Title 5, United States Code; and
- Other retirement accounts determined to be tax exempt under the Internal Revenue Code of 1986.

Any other retirement accounts not established under plans or codes listed above are counted.

Related Policy
Lump-Sum Payments, A-1242

A—1231.5 Education Tuition Savings Plan

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Internal Revenue Service Code, Section 529 and 530, Coverdell Education Tuition Savings Plans, which provide special tax benefits for school tuition savings accounts, are exempt.

Section 529 qualified tuition programs allow owners to prepay a student's education expenses or contribute to an account to pay those expenses. Examples of Section 529 accounts are:

- Texas College Savings Plan;
- LoneStar 529 Plan; and
- Texas Guaranteed Tuition Plan (formerly the Texas Tomorrow Fund).

A Coverdell Education Savings Account is a trust or custodial account set up in the U.S. for the sole purpose of paying qualified education expenses for the designated beneficiary of the account. There is no limit to the number of accounts that can be established for a beneficiary. The designated beneficiary must be under age 18 at the time the account is established. The plan may be for elementary school through college.

A—1231.6 Achieving a Better Life Experience (ABLE) Accounts

Revision 17-1; Effective January 1, 2017

Achieving a Better Life Experience (ABLE) programs allow individuals who become blind or disabled before age 26 to establish tax-free savings accounts for the designated beneficiary's disability-related expenses.

TANF, SNAP, Children on TP 32 and Children on TP 56

Funds held in an ABLE account are excluded from countable resources when determining eligibility.

Related Policy:

Achieving a Better Life Experience (ABLE) Accounts; A-1326.25

A—1231.7 School-Based Savings Accounts

Revision 17-4; Effective October 1, 2017

All Programs

School-Based Savings Accounts are accounts set up by students or their parents at financial institutions that partner with school districts. The accounts are intended to help students save for higher education.

TANF, Children on TP 32 and Children on TP 56

Funds in School-Based Savings Accounts are exempt up to an amount set by the Texas Higher Education Coordinating Board (THECB) each year. The current exempt amount is $11,896. Count any excess over the exempt amount as a resource.

Note: This amount is updated annually.

SNAP

The total amount of funds in a School-Based Savings Account is exempt.

Related Policy

School-Based Savings Accounts, A-1326.26

A—1232 Government Payments

Revision 07-4; Effective October 1, 2007

A—1232.1 Crime Victim's Compensation Payments

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Crime victim's compensation payments are exempt from resources.

A—1232.2 Federal Tax Refunds and Earned Income Tax Credits (EIC)

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Federal tax refunds and EIC payments are exempt from resources for a period of 12 months after receipt.

Related Policy
Federal Tax Refunds and Earned Income Tax Credits (EIC), A-1323.5.1

A—1232.3 Energy Assistance Payments

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Payments or allowances made under any federal law for the purpose of energy assistance are exempt.

Related Policy
Energy Assistance, A-1326.3

A—1232.4 Government Disaster Payments

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Federal disaster payments and comparable disaster assistance provided by states, local governments, and disaster assistance organizations if the household is subject to legal penalties when the funds are not used as intended (including temporary employment of six months or less for disaster-related work, paid under the Workforce Innovation and Opportunity Act and funded by the National Emergency Grant) are exempt.

Examples:

- Payments by the Individual and Family Grant Program or Small Business Administration to rebuild a home or replace personal possessions damaged in a disaster.
- Payments from the Federal Emergency Management Agency (FEMA) to assist with rent.

Related Policy
Government Disaster Payments, A-1324.3

A—1232.5 Transitional Living Allowance

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Transitional living allowances are exempt.

Related Policy
Transitional Living Allowance, A-1324.5

A—1232.6 Native and Indian Claims

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

The following payments resulting from Public Laws are exempt:

- Payments to Grand River Band of Ottawa Indians (Public Law [PL] 94-540).
- Payments to Passamaquoddy Tribe, the Penobscot Nation, and the Houlton Band of Maliseet Indians received according to the Maine Indian Claims Settlement Act of 1980 (PL 96-420, Section 9(c)).
- Payments to members of the Seneca Nation (PL 101-503).
- Payments to Confederated Tribes and Bands of the Yakima Indian Nation and the Apache Tribe of the Mescalero Reservation, received from the Indian Claims Commission (PL 95-433).
- Payments made under the Sac and Fox Indian Claims Agreement (PL 94-189).
- Payments received by certain Indian tribal members under PL 94-114, Section 6, regarding submarginal lands held in trust by the United States.
- Payments from Indian lands held jointly with the tribe or land that can be sold only with approval of the Bureau of Indian Affairs.

SNAP and TANF

The following distributions and payments are exempt:

- Distributions from native corporations made under the Alaska Native Claims Settlement Act (ANCSA) (PL 92-203 and Section 15 of PL 100-241), as follows:
  - cash up to $2,000 per person per calendar year;
  - stocks;
  - a partnership interest;
  - land or interest in land; or
  - an interest in a settlement trust.
- Payments (and any initial purchases made with such funds) distributed by the Secretary of Interior to families or individual tribal members (PL 93-134) including:
  - tribal trust funds distributed to individual members of an Indian tribe (PL 98-64);
  - judgment funds granted to a tribe because of claims against the United States and held in trust or distributed per capita (PL 97-458); and
  - payments distributed per capita to or held in trust for members of any Indian tribe under PL 92-254.

SNAP

The following four types of property belonging to a member of a federally recognized Indian tribe are exempt:

- Property, which may be real property and improvements, that is held in trust located on a reservation, including any federally recognized Indian tribe reservation, pueblo or colony. Property may be located on former reservations in Oklahoma, in Alaska native

regions established by the Alaska Native Claims Settlement Act, and on Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs.
- For any federally recognized tribe not listed in the previous item, property located on a past federally recognized reservation.
- Ownership interests in rents, leases, royalties, or usage rights related to natural resources that are federally protected by the Bureau of Indian Affairs.
- Ownership or usage rights to property not in the previous items that have unique religious, spiritual, traditional or cultural significance, or ownership or usage rights that allow the continuation of the Indian lifestyle according to tribal law or custom.

A—1232.7 Payments to Children of Vietnam Veterans

Revision 03-7; Effective October 1, 2003

A—1232.7.1 Payments to Children of Vietnam Veterans Who Are Born with Spina Bifida

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Exempt Veterans Affairs (VA) payments made under PL 104-204.

A—1232.7.2 Payments to Children of Women Vietnam Veterans Born with Certain Birth Defects (Public Law 106-419)

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Exempt VA payments made under PL 106-419.

A—1232.8 Payments to Civilians Relocated During Wartime

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Payments to civilians relocated during wartime made under Title I of PL 100-383 are exempt. These payments are made to Aleuts or individuals of Japanese ancestry (or their heirs) who were relocated during World War II.

A—1232.9 Payments to Victims of Nazi Persecution

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Payments made to individuals because of their status as victims of Nazi persecution are exempt.

A—1232.10 Radiation Exposure Compensation Act Payments

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Payments provided from the Radiation Exposure Compensation Act, PL 101-426, are exempt.

A—1232.11 Payments to World War II Filipino Veterans and Spouses

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Under the American Recovery and Reinvestment Act of 2009 (Division A, Title X, Section 1002), some World War II Filipino veterans who served in the military forces of the Government of Commonwealth of the Philippines, and their spouses, are authorized to receive one-time lump sum payments of up to $15,000.

These payments are exempt.

A—1232.12 Relocation Assistance

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Payments provided by the following are exempt:

- The Uniform Relocation Assistance and Real Properties Acquisition Act of 1970.
- PL 93-531 to members of the Navajo or Hopi tribes.

A—1232.13 DFPS Relative Caregiver Reimbursement Program Payments

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

The remaining balance of the One-Time Integration Payment is considered as a resource in the month(s) after receipt.

The remaining balance of the Flexible Support Payments is considered as a resource in the month(s) after receipt.

Related Policy
DFPS Relative Caregiver Reimbursement Program Payments, A-1324.21

A—1233 Insurance

Revision 03-5; Effective July 1, 2003

A—1233.1 Life Insurance

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

The cash value of life insurance policies is exempt.

A—1233.2 Prepaid Burial Insurance

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Up to $7,500 cash value of a prepaid burial insurance policy, funeral plan, or funeral agreement for each certified household member is exempt. The cash value exceeding $7,500 is counted as a liquid resource.

The individual's statement of cash value should be accepted, unless the amount is questionable or close to the maximum allowable limits.

Related Policy
General Policy, A-1210
Limits, A-1220
Vehicles, A-1238
How to Determine Fair Market Value of Vehicles, A-1238.5
General Policy, A-1310
Categorically Eligible Households, B-470

A—1234 Noneducational Loans

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Financial assistance is considered as a loan if:

- there is an understanding the money will be repaid, and
- the individual can reasonably explain how the loan will be repaid.

These loans are exempt from resources, but assistance that is not considered a loan, such as a contribution, is counted as unearned income.

Related Policy
Cash Gifts and Contributions, A-1326.1
Loans (Noneducational), A-1326.7

A—1235 Personal Possessions

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Exempt personal possessions.

A—1236 Property

Revision 03-1; Effective January 1, 2003

A—1236.1 Burial Plots

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Exempt all burial plots.

Related Policy
Prepaid Burial Insurance, A-1233.2

A—1236.2 Homestead

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

The usual residence and surrounding property not separated by property owned by others is exempt. The exemption remains in effect if public rights of way, such as roads, separate the surrounding property from the home. The homestead exemption applies to any structure the individual uses as a primary residence, including additional buildings on contiguous land, a houseboat, or a motor home, as long as the household lives in it. If the household does not live in the structure, the structure is counted it as a resource. Houseboats and motor homes count according to vehicle policy, if not considered the household's primary residence or otherwise exempt. The equity value of extra buildings counts unless the buildings are exempt for another reason.

For households that currently do not own a home, but own or are purchasing a lot on which they intend to build, the lot and partially completed home are exempt.

TANF

Households cannot claim real property outside Texas as a homestead. **Exception:** Migrants and itinerant workers who meet the residence requirements in A-710, General Policy, may claim an exemption for a homestead outside Texas.

SNAP

All homesteads and property are exempt.

A—1236.2.1 Homestead Temporarily Unoccupied

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

A homestead temporarily unoccupied because of employment, training for future employment, illness (including receiving medical treatment), casualty (fire, flood, state of disrepair, etc.), or natural disaster, if the household intends to return, is exempt.

A—1236.2.2 Sale of a Homestead

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Money remaining from the sale of a homestead is counted as a resource.

A—1236.3 Income-Producing Property

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Income-producing property is any real or personal property that generates income. Property is exempt if the property:

- is essential to a household member's employment or self-employment, such as tools of a trade, farm machinery, stock, and inventory (this property continues to be exempt during temporary periods of unemployment if the individual expects to return to work);
- annually produces income consistent with a fair market value comparable in the community, even if used only on a seasonal basis such as rental property (to determine that the income produced is comparable to the fair market value for similar usage of real property in the area, eligibility staff may contact local realtors, tax assessors, the Small Business Administration or similar sources); or
- is necessary for the maintenance or use of a vehicle exempted as income-producing or as necessary for transporting a household member with a physical disability. The portion of the property used for this purpose is exempt.

Note: For farmers or fishermen, the value of land or equipment continues to be exempt for one year from the date that the self-employment ceases.

A—1236.4 Real Property

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Equity value of real property counts unless it is otherwise exempt.

Any portion of real property directly related to the maintenance or use of a vehicle is exempt if the vehicle is:

- necessary for self-employment, or
- to transport a household member with a physical disability.

The equity value of any remaining portion counts unless it is otherwise exempt.

SNAP

Real property is exempt.

A—1236.4.1 Exemption Based on Good Faith Effort to Sell

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Real property is exempt if the household is making a good faith effort to sell it.

A—1236.5 Jointly Owned Property

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Property jointly owned by the household applying and other individuals not applying for or receiving benefits is exempt if the:

- household provides proof they cannot sell or divide the property without consent of the other owners; and
- other owners will not sell or divide the property.

SNAP

Jointly owned property is exempt.

Related Policy
Solely Owned Vehicles, A-1238.1

A—1237 Trust Funds

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Trust funds are exempt if all of the following conditions are met:

- The trust arrangement is unlikely to end during the certification period;
- No household member can revoke the trust agreement or change the name of the beneficiary during the certification period;
- The trustee of the fund is either a:
  - court, institution, corporation, or organization not under the direction or ownership of a household member; or
  - court-appointed individual who has court-imposed limitations placed on the use of the funds; and
- The trust investments do not directly involve or help any business or corporation under the control, direction, or influence of a household member. Trusts established from the household's own funds are exempt if the trustee uses the funds:
  - only to make investments on behalf of the trust; or
  - to pay the education or medical expenses of the beneficiary.

A—1238 Vehicles

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

The total value of all licensed vehicles used for income-producing purposes is exempt. A vehicle is considered income-producing if it:

- is used as a taxi, a farm truck or fishing boat;
- is used to make deliveries as part of the individual's employment;
- is used to make calls on individuals or customers;
- is required by the terms of employment; or
- produces income consistent with its fair market value.

A vehicle necessary to transport a member with a physical disability on the EDG or a person with a physical disability living in the home is exempt even if the person is disqualified and regardless of the purpose of the trip. No more than one vehicle for each member with a physical disability may be exempt. There is no requirement that the vehicle be used primarily for the person with a physical disability. The SNAP work-registration criteria should be used to determine physical disability for this exclusion.

Note: These exemptions remain in effect when the vehicle is temporarily not in use.

SNAP

The following vehicles are exempt even when the vehicle is temporarily not in use:

- vehicles necessary for long-distance travel for employment such as the vehicle of a traveling salesperson or of a migrant farm worker who is following the migrant stream (this does not include daily commuting);
- vehicles used as the household's home;
- vehicles necessary to carry fuel for heating or water when it is anticipated to be the primary source of fuel or water for the household during the certification period. Examples of situations in which a vehicle may be exempt because it is necessary to carry the household's primary source of water or fuel for heating include the following:
    - the home does not have any connected utilities; or
    - the home is connected to utilities but the utilities cannot be used for some reason, such as:
        - a verifiable health risk exists if the household drinks the water, or
        - the utilities are disconnected because the household failed to pay its bills.

The vehicle exemption remains in effect until the above criteria no longer exist. The vehicle exemption also remains in effect for:

- any licensed vehicle with equity value less than or equal to $1,500;
- one vehicle with an FMV less than $4,650 for each adult household member, regardless of how the vehicle is used*;
- any other licensed vehicle with an FMV less than $4,650 that a minor (under age 18) drives to work, training, school, or to seek employment*; and
- for all other licensed and unlicensed vehicles, the FMV in excess of $4,650 is counted as a resource.

* This also applies to any person who is an ineligible alien or disqualified member of the SNAP household. The FMV of each vehicle in excess of $4,650 is counted as a resource.

Up to $15,000 of the FMV for the highest valued countable vehicle is exempt. The FMV in excess of $15,000 is counted as a resource.

TANF, Children on TP 32 and Children on TP 56

Vehicles with an FMV of less than $4,650 are excluded, regardless of the number of vehicles owned by a TANF-certified or disqualified household member. The FMV in excess of $4,650 counts toward the household's resource limit.

A—1238.1 Solely Owned Vehicles

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

A vehicle with a title registered solely in one person's name is considered an accessible resource for that person. This includes:

- vehicles involved in community property issues when one person's name is on the title; and
- a vehicle registered solely in the individual's name that the individual claims to have purchased for someone else.

Exceptions: The vehicle is inaccessible if the title holder verifies that:

- the vehicle was sold but the name on the title has not been transferred to the buyer (in this situation, the vehicle belongs to the buyer);

Note: Any payments made by the buyer to the individual or the individual's creditors (directly) count as self-employment income (see A-1323.4, Self-Employment).

- the vehicle was sold but the buyer has not transferred the title into the buyer's name;
- the vehicle was repossessed;
- the vehicle was stolen; or
- the title holder filed for bankruptcy (Title 7, 11 or 13), and the individual is not claiming the vehicle as exempt from the bankruptcy estate. **Note:** In most bankruptcy petitions, the court will allow each adult individual to keep one vehicle as exempt for the bankruptcy estate. This vehicle is a countable resource.

A vehicle is accessible to an individual even though the title is not in the individual's name if the individual:

- purchased or is purchasing the vehicle from the person who is the title holder; or
- is legally entitled to the vehicle through an inheritance or divorce settlement.

A—1238.2 Jointly Owned Vehicles

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Vehicles jointly owned with another person not applying for or receiving benefits are considered inaccessible if the other owner is not willing to sell the vehicle.

Exception: See A-1247, Resources of Stepparents.

A—1238.3 Vehicles Over 20 Years Old

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

The value of a vehicle over 20 years old is exempt if the value is not available. If the applicant provides the value for a vehicle older than 20 years, the amount provided should be accepted. **Note:** A vehicle’s age during any month of that year should be considered.

A—1238.4 Leased Vehicles

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

A person leasing a vehicle is not generally considered the owner of the vehicle because the:

- vehicle does not have any equity value,
- person cannot sell the vehicle, and
- title remains in the leasing company's name.

A leased vehicle is exempt until the individual exercises the option to purchase the vehicle. Once the individual becomes the owner of the vehicle, the vehicle counts as a resource.

The individual is the owner of the vehicle if the title is in the individual's name, even if the individual and the dealer refer to the vehicle as leased, and the vehicle counts as a resource.

A—1238.5 How to Determine Fair Market Value of Vehicles

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

The FMV of licensed vehicles is determined using the average wholesale value listed in the Vehicles Registered at Address report from the Data Broker System. After the vehicle value is verified, it does not have to be re-verified unless resources are close to the resource limit and a change in the vehicle value results in a change in eligibility status. **Note:** If the household claims the listed value does not apply because the vehicle is in less-than-average condition, the household must provide proof of the true value from a reliable source, such as a bank loan officer or a local licensed car dealer.

The basic value of a vehicle is not increased because of low mileage, optional equipment, or special equipment for a person with a disability.

The household's estimate of the value of vehicles no longer listed in the Data Broker System should be accepted, unless it is questionable and would affect the household's eligibility. In this case, the household must provide an appraisal from a licensed car dealer or other evidence of the car's value, such as a tax assessment or a newspaper advertisement indicating the sale value of similar vehicles.

The value of new vehicles not yet listed in the Data Broker System may be determined by asking the household to provide an estimate of the average wholesale value from a new car dealer or bank loan officer. If this cannot be done, the individual's estimate should be accepted unless it is questionable and would affect eligibility. The car's loan value should be used only if other sources are unavailable. Advisors must request proof of the value of licensed antiques and custom made or classic vehicles from the household if an accurate appraisal cannot be made.

Determining Vehicle Resource Values

Type of Vehicles	SNAP	TANF, Children on TP 32 and Children on TP 56
Income-producing	Exempt	Exempt
Vehicle for a person with a physical disability living in the home	Exempt	Exempt
Equity value less than or equal to $1,500	Exempt	Not applicable
Long distance travel for employment	Exempt	Exempt up to $4,650 of FMV. Count excess.
Household's home	Exempt	Exempt up to $4,650 of FMV. Count excess.
Carry fuel or water	Exempt	Exempt up to $4,650 of FMV. Count excess.
Primary vehicle/Highest valued countable vehicle	Exempt up to $15,000 of FMV. Count excess.	Exempt up to $4,650 of FMV. Count excess.
One vehicle for each adult household member, regardless of use	Exempt up to $4,650 of FMV. Count excess.	Exempt up to $4,650 of FMV. Count excess.
Any vehicle used by a household member under age 18 for employment, training, education or to seek employment	Exempt up to $4,650 of FMV. Count excess.	Exempt up to $4,650 of FMV. Count excess.
Other licensed vehicles	Exempt up to $4,650 of FMV. Count excess	Exempt up to $4,650 of FMV. Count excess.
Unlicensed vehicles	Exempt up to $4,650 of FMV. Count excess.	Exempt up to $4,650 of FMV. Count excess.

See A-1238, Vehicles, for the specific policy for determining the countable value of a vehicle.

A—1239 Educational Assistance

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Educational assistance (including education loans, regardless of the source) is exempt during the period it is intended to cover. If the individual combines the educational assistance with other countable funds, such as a bank account, the educational assistance is exempt during the period that it is intended to cover. For example, educational assistance intended for the months of January through May is an exempt resource during the same months.

Related Policy
Educational Assistance, A-1322.1

A—1240 Determining Countable Resources in Special Situations

Revision 06-4; Effective October 1, 2006

A—1241 Inaccessible Resources

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

The equity value of resources that are not legally available (inaccessible) to the household are exempt.

Examples: Irrevocable trust funds, property in probate, security deposits on rental property and utilities, and the balance of a note from the sale of property.

Money received from a nonmember is inaccessible if:

- it is intended and used only for a nonmember's benefit, and
- the individual can provide verification of the intent and use of the money.

This includes any bank account that a household member has access to. A bank account is considered inaccessible if the money in the account is used solely for the nonmember's benefit.

The household must provide verification that the bank account is used solely for the nonmember's benefit and that no household members use the money in the account for their benefit. If household members use any of the money for their benefit, the bank account must be considered accessible to the household.

A temporarily inaccessible resource is exempt until the resource is accessible. Government savings bonds are an example of a temporarily inaccessible resource. These types of savings plans are usually inaccessible for a definite time from the date the individual makes a withdrawal request. The date the household applies is used as the date of the withdrawal request, unless the household has a withdrawal request pending at the time of application. For these pending withdrawals, the date of the actual withdrawal request is used to determine the length of time the resource is inaccessible.

Related Policy
Solely Owned Vehicles,A-1238.1
Jointly Owned Vehicles, A-1238.2
Bank Accounts, A-1231.1

A—1241.1 Nonliquid Resources

Revision 17-1; Effective January 1, 2017

SNAP

Nonliquid resources, except vehicles, are exempt. Vehicle policy in A-1238, Vehicles, applies.

TANF, Children on TP 32 and Children on TP 56

Count the equity value of nonliquid resources.

A—1242 Lump-Sum Payments

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Countable lump-sum payments include, but are not limited to, retroactive lump-sum RSDI, public assistance, retirement benefits, lump-sum insurance settlements, refunds of security deposits on rental property or utilities, and lump-sum payments on child support.

Lump-sum payments received once a year or less frequently are counted as resources in the month received (unless specifically excluded by other policies).

Lump-sum payments received or anticipated to be received more often than once a year are counted as unearned income in the month received.

If a portion of a lump sum will be received as ongoing income, that ongoing portion is counted as income for that month.

Example: An individual receives a lump-sum payment in the amount of $4,950 from the Social Security Administration in the month of March. Effective that same month, the individual receives his first monthly RSDI payment of $950, which is included in the $4,950 lump-sum payment. Staff must budget the $950 RSDI payment beginning with the month of March as an ongoing payment and consider the $4,000 as a lump-sum payment.

Exceptions:

- Federal tax refunds and EICs are exempt from resources for a period of 12 months after receipt.
- If an individual is scheduled to receive retroactive SSI benefits in installment payments (up to three payments, paid every six months):
  - the payments count as a resource in the month received if the individual is not a current SSI recipient, or
  - the payments are excluded if the individual is a current SSI recipient.

Related Policy
Cash Gifts and Contributions, A-1326.1
Lump-Sum Payments, A-1331

TANF, Children on TP 32 and Children on TP 56

The One-Time Temporary Assistance for Needy Families (OTTANF) payment is exempt from resources for the month of receipt because the household is a TANF recipient that month. The remaining OTTANF benefits are considered a resource the month after receipt.

A One-Time Grandparent payment is a resource of the TANF-certified grandchild(ren) and is exempt from resources as explained in A-1248, Resources of TANF and SSI Recipients.

Related Policy
When Receipt of TANF Is Uncertain, A-161

A—1243 Payments Exempt as a Resource While Being Considered Income

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

If a payment or benefit counts as income for a particular month, it is not counted as a resource in the same month. If you prorate a payment as income over several months, no portion of the payment is considered a resource during that time.

Example: Income of students or self-employed persons that is prorated over several months.

If the individual combines this money with countable funds, such as a bank account, the prorated amounts are exempt for the time prorated.

A—1244 Reimbursements

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Reimbursements are counted as a resource in the month after receipt.

Reimbursements earmarked and used for replacing or repairing an exempt resource are exempt indefinitely.

Related Policy
Reimbursements, A-1332

A—1245 Resources of an Alien's Sponsor

Revision 16-4; Effective October 1, 2016

TANF, SNAP and Children on TP 56

Resources of an alien's sponsor and spouse (if the spouse also signed an affidavit of support) must be evaluated. The sponsor's countable resources must be determined when determining the applicant's resources. The total value of these resources must be reduced by $1,500. See the Glossary for the definition of an alien sponsor.

The remainder must be added to the alien's countable resources. If someone sponsors more than one alien, the amount of countable resources is prorated evenly among all the aliens who apply for or get benefits.

This policy does **not** apply to sponsored aliens who:

- are under age 18;
- are ineligible for benefits (examples include those who are disqualified from getting benefits or those considered non-members, such as students who do not meet SNAP student eligibility criteria);
- have become naturalized U.S. citizens;
- have worked or can receive credit for 40 quarters of work;
- have a deceased sponsor;
- have a sponsor who is a member of the alien’s household/Modified Adjusted Gross Income (MAGI) household composition;
- are refugees, parolees, asylum grantees, Amerasians, victims of severe trafficking or Cuban/Haitian entrants;
- are battered alien spouses of U.S. citizens or of legal permanent residents, children of battered aliens, or parents of battered children, if (1) HHSC determines the battery is substantially related to the need for benefits, and (2) the battered person does not live with the batterer; or
- are indigent.

  Notes:
  - The criterion for indigent aliens applies only if the alien does not meet one of the other exceptions noted in this list. Only the amount the sponsor will give the alien for a 12-month period starting the date HHSC makes the indigence determination should be deemed. Each determination is renewable for additional 12-month periods.

Each time a determination of indigence is made, a memo must be sent with the name, address, Social Security number and date of birth, of both the indigent alien and the indigent alien's sponsor, to Texas Works Policy Section, Austin, Mail Code 2115. Before sending the memo, tell the alien that the state office must report the sponsor to the OAG for failure to give support as required on the sponsor affidavit. The alien may choose to have the sponsor's resources deemed if the alien does not want the state office to send this report.

- The sponsor's resources must not be deemed for 12 months for battered aliens, starting the month the alien is certified for any benefit. A new 12-month period must not be assigned if the alien reapplies after denial of benefits. After the first 12 months, the sponsor's resources continue to be exempt from deeming if (1) a court or the U.S. Citizenship and Immigration Services recognize the battery, (2) HHSC determines the battery has a substantial connection to the need for benefits, and (3) the alien does not live with the batterer.
- The following list of circumstances may be used as a guide in making the substantial connection between the battery and the need for benefits. Staff may determine whether the battered alien needs the benefits:
  - to become self-sufficient after leaving the abuser;
  - to escape the abuser and/or the community in which the abuser lives;
  - to ensure the battered alien's safety;
  - to replace financial support lost as a result of the separation from the abuser;
  - because of the loss of a job or reduced earnings resulting from the battery or cruelty;
  - because the battered alien needs medical attention or mental health counseling or now has a disability due to the battery;
  - because the battered alien lost the home, and the separation from the abuser jeopardizes the battered alien's ability to care for the children;
  - to reduce nutritional risks;
  - to get medical care for a pregnancy resulting from sexual assault or abuse; or
  - to replace medical coverage or health care services.

TANF and Children on TP 56

This policy does not apply to:

- sponsored aliens whose sponsors get TANF or SSI; or
- the dependent child of a sponsor or sponsor's spouse.

SNAP

This policy does not apply to:

- sponsored aliens whose sponsors get SNAP as a member of the same household; or
- organizations or groups that sponsor aliens.

A—1246 Resources of Residents in Shelters for Battered Persons

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Resources of residents in shelters for battered persons are exempt if:

- the resources are jointly owned by the household in the shelter and members of the former household; and
- the shelter resident's access to the value of the resource depends on the agreement of a joint owner who still lives in the resident's former household.

A—1247 Resources of Stepparents

Revision 15-4; Effective October 1, 2015

TANF

All resources of a stepparent must be counted if the stepparent is included in the certified group. When the stepparent is not included in the certified group, only the legal parent's half of a jointly owned resource should be counted.

Children on TP 32 and Children on TP 56

When a stepparent is included in the child's household composition, all resources of a stepparent are counted.

Related Policy
Earnings of a New TANF Spouse, A-1249.2

A—1248 Resources of TANF and SSI Recipients

Revision 15-4; Effective October 1, 2015

TANF, Children on TP 32 and Children on TP 56

Resources of an SSI recipient living in the home (even when the resources are available to the TANF-certified member or Medical Programs household member) are exempt if:

- the SSI recipient would otherwise be a certified member in the TANF or Medical Programs EDG;
- the SSI recipient would otherwise be someone whose income is:
  - "applied" to the TANF budget; or
  - included in the Medical Programs household composition; or
- a TANF-certified or disqualified person or member of the Medical Programs household composition is the SSI recipient's payee.

Note: This policy applies to:

- persons whose SSI financial assistance is denied because of earnings who continue to receive SSI Medicaid; and
- children who receive SSI Medicaid (TP 19) whom the individual chooses not to include in the TANF-certified group.

If other SSI recipients live in the home and contribute to a member of the TANF-certified/disqualified group or Medical Programs household composition, policy for contributions in A-1326.1, Cash Gifts and Contributions, should be followed.

SNAP

Resources of TANF and SSI recipients are exempt unless the recipient owns them with another member of the same SNAP household who does not receive TANF or SSI.

Note: A household member is a TANF or SSI recipient even if the benefit:

- has not yet been received,
- is suspended, or
- is being recouped.

When a TANF or SSI recipient owns a resource with a member of the same SNAP household who does not receive TANF or SSI, countable resources are determined as follows:

- **Nonliquid resources** — The TANF or SSI recipient's portion of a nonliquid resource is exempt if the recipient jointly owns it with another member of the SNAP household.
- **Liquid resources** — Liquid resources are determined to be exempt or countable according to the following guidelines:
  - Commingled resources — The TANF or SSI recipient's portion of commingled resources are exempt for six months from the month the individual combined them. After six months, the total amount of commingled resources is counted as an available resource to the non-TANF/SSI recipient if it continues to be accessible.
  - Jointly owned resources (not commingled) — These resources are exempt if all the money is contributed only by the TANF or SSI recipient and the resource is used solely for:
    - expenses of the TANF or SSI recipient; or
    - common household expenses.

A—1249 Resources Resulting from Earnings

Revision 04-1; Effective January 1, 2004

A—1249.1 Earnings of a Child

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32 and Children on TP 56

Staff must exempt any liquid resources resulting from the earnings of a child (certified child for TANF or eligible child for Medical Programs) who is attending school:

- full time, or
- less than full time and employed less than 30 hours a week.

Note: A child who is home schooled or attends general equivalency diploma (GED) classes is eligible for the resource exclusion.

Resources of a child that are commingled with resources of other household or non-household members are excluded. The child's liquid resources are exempt for six months from the month the resources were combined. After six months, the amounts previously earned as a resource are counted.

A—1249.2 Earnings of a New TANF Spouse

Revision 15-4; Effective October 1, 2015

TANF

The liquid resources of a TANF recipient's new spouse are excluded for six months beginning the month after the date of the marriage if the:

- resource results from the new spouse's earnings, and
- total gross income of the budget group does not exceed 200 percent FPIL for the family size.

Note: This applies to both ceremonial and common law marriages. The following are included in the budget group:

- the caretaker or payee of the TANF-certified group;
- the new spouse of the TANF caretaker or payee;
- each dependent of the TANF caretaker or payee and the new spouse who meets the TANF age and relationship requirements and lives in the household; and
- anyone who would be a required member if not disqualified or ineligible such as an SSI recipient or ineligible alien.

If the household fails to provide verification of the marriage, the exclusion is not allowed. After six months, the amount previously earned is counted as a resource.

A—1250 Verification Requirements

Revision 16-2; Effective April 1, 2016

TANF, SNAP, Children on TP 32 and Children on TP 56

Staff must verify:

- resources if:
  - they are questionable,
  - the value is within $300 of the maximum allowable limit, or
  - it is a regional requirement.
- all checking or savings accounts at application or when a household reports a new account (except SNAP, see below).
- that inaccessible resources, including bank accounts:
  - are used solely for the non-member's benefit, and
  - that no household members use the money for their benefit.
- a person's statement about the inaccessibility of a vehicle if it is within $300 of the resource limit.
- the fair market value of licensed vehicles as explained in A-1238.5, How to Determine Fair Market Value of Vehicles.
- an exempt trust fund that meets conditions in A-1237, Trust Funds.
- the exempt or countable status of an education and/or retirement plan or account at application or when a household reports a new account.
- the death of an alien's sponsor (does not apply to children on TP 32).

TANF, Children on TP 32 and Children on TP 56

Staff must verify a good faith effort to sell by verifying that the:

- property is for sale, and
- household has not refused a reasonable offer.

SNAP

Staff must verify:

- the equity value of a licensed vehicle if exempting the vehicle because the equity value is less than or equal to $1,500.
- a bank account if verification can be obtained during the interview. If verification cannot be obtained during the interview, the person's statement may be accepted without verification if:
  - the person states that the household's total combined balance for all accounts does not exceed $1,000; and
  - the person's statement is not questionable.

The EDG is pended only if the reported account balance exceeds $1,000 or the person's statement is questionable.

TANF

Staff must verify:

- the date of marriage between a TANF recipient and new spouse. The date of marriage is used to determine the six-month period in which the new spouse's earnings can be excluded as a resource.
- the amount of liquid resources resulting from the earnings of a new TANF spouse.

A—1251 Verification Sources

Revision 16-2; Effective April 1, 2016

TANF, SNAP, Children on TP 32 and Children on TP 56

Vehicles

- Data Broker System;
- Statements from:
  - Finance company or bank,
  - Insurance agent,
  - Car dealers, or
  - Texas Motor Vehicle Commission;
- City or county government records; and
- Newspapers.

Real Property

- Data Broker System;

- Statements from:
  - Tax appraisal/collector office,
  - County courthouse official,
  - Real estate company,
  - Bank or financial institution,
  - Local land owners (nonrelative), or
  - County agent.

Alien Sponsor's Death

- Copy of death certificate
- Birth Verification System record
- Doctor's statement
- Social Security claim number or evidence of receipt of widow's or survivor's benefits from the deceased person's Social Security number
- U.S. Department of Veterans Affairs or military service records
- Indian census record
- Statement from funeral director
- Records from the hospital or other institution where the person died
- Insurance company records

Note: Does not apply to children on TP 32.

Alternate Sources for Alien Sponsor's Death

- Newspaper death notice/obituary
- State or local public assistance records (including burial payment records)
- Lodge, club or other organization records
- Police records
- Statement from clergy
- "In Memoriam" card

Note: Does not apply to children on TP 32.

TANF, SNAP, Children on TP 32 and Children on TP 56

Bank Account

- Current bank statements (within last three months), or
- Statement from bank official.

Debit Account

- EBT cash accounts via the:
  - Administrative Terminal (AT); or
  - Lone Star Help Desk automated voice response system at 1-800-777-7328, if the advisor has the cardholder's 19-digit personal account number (PAN);
- UIB debit accounts via:
  - Online at www.ucard.chase.com; or
  - Any Chase Bank ATM;
- Texas (OAG) child support debit accounts online at www.EPPICard.com;
- Social Security Direct Express card (RSDI or SSI) debit accounts via:
  - Online at www.USDirectExpress.com;
  - Calling the Direct Express card help desk automated voice response system at 1-888-741-1115, if the advisor has the cardholder's 16-digit card number; or
  - Receipt (free of charge) from any ATM that displays the MasterCard® logo.

Other Liquid Assets/Personal Property

- Recent sales slips;
- Insurance or tax appraisals;
- Catalogs or newspaper;
- Statements from:
  - Experts or other collectors,
  - Bank,

    - Brokers, or
    - Local merchants;
- Retirement benefit letters; and
- Education plan/account benefits summary letters.

Life Insurance

- Insurance policy; or
- Statements from:
    - Insurance company;
    - Insurance agent; or
    - Union, employer, funeral director, organization or agency that provides insurance.

Nonrecurring Lump-sum Payments

- Statements from the company, agency or organization that provided payment;
- Checks, award letters or check stubs; and
- Bank statements/deposit slips.

TANF

Ceremonial Marriage

- Marriage license or certificate,
- Church records,
- Statement from clergy, and
- Family Bible records.

Common Law Marriage

- Declaration of Informal Marriage filed with the county clerk; or
- Sworn statement signed by both spouses.

Related Policy
Questionable Information, C-920
Providing Verification, C-930

A—1260 Documentation Requirements

Revision 16-2; Effective April 1, 2016

TANF, SNAP, Children on TP 32 and Children on TP 56

Staff must document:

- that a resource is countable or exempt and explain if questionable;
  Note: For SNAP, this requirement only applies to vehicles, prepaid burial insurance and liquid resources.
- calculations to show equity value for those resources with allowable deductions;
- the total value of countable resources;
- the dates and amounts of any resources received while the EDG is active;
- the facts surrounding a transfer of resources;
- how resources were verified and the date of verification;
- that an indigent alien who is exempt from deeming requirements was told that state office must report the alien's sponsor to the OAG (if the alien does not want the report sent, staff must document that the alien chose to deem the sponsor's resources). **Note:** Does not apply to children on TP 32;
- the type of any retirement account/plan and/or education tuition savings plan and the Internal Revenue Code under which the plan was established; and
- the source used to verify the death of an alien's sponsor.

TANF, Children on TP 32 and Children on TP 56

Staff must document a good faith effort to sell and the:

- reason for exempting the property, and
- household's efforts to sell it.

TANF

Staff must document:

- the months of the six-month period in which the earnings of a new spouse of a TANF recipient will be excluded as a liquid resource;
- the amount of the earnings of the new spouse of a TANF recipient that will be excluded as a liquid resource; and
- the reason for not pursuing a legally entitled resource per policy in A-1211, Requirement to Pursue Resources.

TANF and SNAP

Staff must document the facts surrounding a transfer of resources per policy in A-1212, Transferring Resources.

Related Policy
Documentation, C-940
The Texas Works Documentation Guide

TWH, A-1300, Income

Revision 18-1; Effective January 1, 2018

A—1310 General Policy

Revision 15-4; Effective October 1, 2015

All Programs

Income is any type of payment that is of gain or benefit to a household. Income is either counted or exempted from the budgeting process. Earned income is related to employment and entitles a household to deductions not allowed for unearned income. Unearned income is income received without performing work-related activities. Unearned income includes benefits from other programs. Factors specific to the source of income and the distance it has to travel through the mail (weekends and holidays) may be used to determine the date income can reasonably be anticipated.

TANF and SNAP

Retirement, Survivors, and Disability Income (RSDI); Supplemental Security Income (SSI); Veterans Affairs (VA) benefits; or other such funds legally obligated to a beneficiary are not counted if a payee who is not a member of the household:

- receives the funds; and
- does not make the money available to the beneficiary.

In the beneficiary’s Eligibility Determination Group (EDG), the total amount of the legally obligated funds the payee makes available to the beneficiary in cash, by way of vendor payment or through items purchased for the beneficiary using the beneficiary's money (includes payments made by the payee to a third party on behalf of the beneficiary) is counted as unearned income. Any portion of the funds the payee keeps for the payee's own use is counted as unearned income in the payee's EDG.

TANF

The income of the following individuals must be considered for Temporary Assistance for Needy Families (TANF):

- any person who is included in the certified or budget group/EDG member, including disqualified members;
- any person living in the home who is not included in the certified or budget group but who is legally responsible for a member of the certified group; and
- an alien's sponsor.

For TANF, if the income is not made available to the beneficiary, the individual must follow the requirements for pursuing legally obligated income. See A-1311, Requirement to Pursue Income.

SNAP

The income of the following individuals must be considered for the Supplemental Nutrition Assistance Program (SNAP):

- any member of the SNAP household, including disqualified members; and
- an alien's sponsor.

Medical Programs

Modified Adjusted Gross Income (MAGI) rules are based on Internal Revenue Service (IRS) rules for counting income and are used to determine financial eligibility for Medical Programs and, in addition, federal insurance affordability programs.

In order to determine financial eligibility, the following items must be identified for each individual within the MAGI household composition:

- earned income,
- unearned income,
- self-employment income,
- American Indian (AI)/Alaska Native (AN) disbursements,
- overpayments, and
- expenses.

The income of the following individuals must be considered for Medical Programs:

- any person who is included in the individual's MAGI household composition; and
- an alien's sponsor (if applicable, as explained in A-1361, Alien Sponsor's Income).

Note: Household composition for Medical Programs is determined on an individual level for each applicant or recipient. The income of certain individuals may be exempted from an applicant's or recipient's MAGI household income as explained in A-1341, Income Limits and Eligibility Tests, Medical Programs, Step 3.

TP 40

If a pregnant woman is determined to be eligible, the EDG must not be denied if the pregnant woman's MAGI household composition income increases above the income limit. The budget should be adjusted to reflect the new income.

TP 45

Income is not an eligibility factor for TP 45.

Related Policy
Income Limits and Eligibility Tests, A-1341
Eligibility Criteria, B-471
Special Provisions for Households with Elderly Members or Members with a Disability, B-433
Categorically Eligible Households, B-470

A—1311 Requirement to Pursue Income

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

All legally entitled income must be pursued and accepted by the individual entitled to the income. Advisors should inform the individual of this requirement and, together with the individual, develop a plan to pursue the potential income. Reasonable time (at least three months) should be allowed to pursue the income, and the income should not be considered available during this time. Staff must document the plan and the time allowed for pursuing the income.

In the comments section of Form TF0001, Notice of Case Action, staff must inform individuals of their obligation to pursue potential income and include the time allowed for pursuing the income.

Exception: The individual does not have to pursue income if it would be unreasonable. Situations are considered to be unreasonable if:

- the cost to the individual exceeds the potential income or causes financial hardship;
- pursuing the income would endanger the individual's health or safety; or
- legal action is required, but a private attorney or Legal Services refuses to accept the case. The individual must make a reasonable effort to obtain legal assistance.

If the household refuses or fails to follow the agreed plan without good cause, the EDG must be denied.

TANF and TP 08

Advisors must set a special review if the anticipated change in income will occur before the next periodic redetermination.

A—1311.1 Requirement to Pursue SSI/RSDI

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

Advisors must provide and explain Form H1859, Social Security Administration Benefits for People with Disabilities Receiving TANF, to households claiming a disability or caring for a child with disabilities. Staff must also document that Form H1859 was provided and explained to the individual.

Advisors are not required to set a special review when referring individuals for Social Security benefits. At the next periodic redetermination, the household must provide verification that the individual with disabilities applied for SSI/RSDI benefits.

In the comments section of Form TF0001, Notice of Case Action, the advisor must inform individuals of their obligation to pursue potential income and include the time allowed for pursuing income. The advisor must include the following appropriate statement for households claiming a disability or caring for a child with disabilities:

- English – "You must apply for assistance with the Social Security Administration and provide proof of the application at your next TANF interview."
- Spanish – "Tiene que solicitar asistencia de la Administración del Seguro Social y presentar prueba de la solicitud en su próxima entrevista de TANF."

If the household fails to apply for SSI/RSDI without good cause, the EDG is denied. If the household chooses to no longer claim the Choices exemption, the advisor should update the exemption code and document the decision. The individual may not claim the Choices exemption if the individual reapplies within 12 months from the denial date. If the individual claims the exemption before the 12 months, the EDG should be pended and the individual should be given the opportunity to provide verification that he or she applied for SSI/RSDI benefits.

A—1311.1.1 SSI/RSDI Application Assistance

Revision 15-4; Effective October 1, 2015

TANF

State office has an automated process that identifies TANF recipients with a Choices exemption for caring for a child with disabilities and unable to work due to mental or physical disability and sends referrals to the contractor who administers the Social Security Outreach Application Program (SSOAP). SSOAP outreaches the TANF household, provides information, and answers questions about the Social Security Administration (SSA) process.

If an individual states that the household applied for SSI/RSDI, but does not have verification available, the advisor should refer to the Wire Third-Party Query (WTPY)/State Online Query (SOLQ) system. If the WTPY/SOLQ system does not show that the individual applied for benefits, the advisor should request that the individual provide verification.

The EDG should not be denied if:

- the individual is physically or mentally unable to complete the SSI/RSDI application process; and
- SSOAP and SSA fail or are unable to provide assistance needed to complete the SSI/RSDI application process.

A—1311.1.2 Social Security Administration (SSA) Definitions and Guidelines

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

The SSA administers two programs that provide benefits based on disability:

- RSDI provides disability benefits to individuals, and to their dependents with disabilities under certain conditions.
- SSI provides benefits to individuals with disabilities (including children under age 18) who have limited income and resources.

The Social Security Act and SSA's regulations provide a definition of disability:

- For all individuals applying for RSDI and adults applying for SSI, the definition of disability is the same. The law defines disability as the inability to engage in substantial gainful activity because of physical or mental impairment(s) which may result in death, or which has lasted or is expected to last for a continuous period of not less than 12 months.
- For children under age 18 applying for SSI, the law defines disability as a physical or mental impairment(s) which results in marked and severe functional limitations, and which may result in death, or which has lasted or is expected to last for a continuous period of not less than 12 months.

Advisors should refer the individual to SSI if one of the following conditions is met:

- Psychological/psychiatric problems:
  - Actual clinical diagnosis or medical documentation that indicates the individual is unable to work,
  - Odd and/or inappropriate behavior, or
  - Inability of a long-time TANF individual to get or keep a job for more than 30 days because of a mental impairment.
- Obesity combined with any other physical problems such as arthritis, high blood pressure, heart failure, respiratory disease, or vascular disease.
- Low intelligence:
  - Former special education student,
  - Inability to read or write even though person has been to school,
  - Basis test scores below 200,
  - Failure to comprehend even the simplest directions, or
  - Down's syndrome.
- Serious substance abuse when combined with other related health problems.
- Serious health problems:
  - Multiple sclerosis, cancer, stroke, multiple surgeries for the same problem, multiple trauma and other situations;
  - Chronic health problems; or
  - Newborns with low birth weight (1200 grams or less within the first few days after birth).
- Age 50 or over with health problems, especially if combined with limited education and limited work history.

Note: A claimant, including a child, applying for SSI based on disability or blindness may receive up to six months of payments before the final determination of disability or blindness if the claimant is determined to presumptively have a disability or be blind and meets all other eligibility requirements.

Related Policy
Definition of Disability, B-432
Social Security's Criteria for Disability, B-432.1
Form H1859, Social Security Administration Benefits for People with Disabilities Receiving TANF

A—1320 Types of Income

Revision 15-4; Effective October 1, 2015

All Programs

There are differences between TANF, Medical Programs and SNAP in countable and exempt income.

TANF and SNAP

Income that is not specifically listed in this section must be counted.

A—1321 Disability Benefits

Revision 13-2; Effective April 1, 2013

A—1321.1 Agent Orange Settlement Payments

Revision 15-4; Effective October 1, 2015

All Programs

Agent Orange Settlement Payments disbursed by AETNA Insurance Company and paid to the following individuals are exempt:

- veterans with disabilities exposed to Agent Orange while in Vietnam who suffer from total disabilities caused by any disease, and
- survivors of these deceased veterans.

These veterans receive yearly payments. Survivors of these deceased veterans receive a lump-sum settlement payment.

TANF and SNAP

VA payments are counted as unearned income, including benefits paid to veterans with service-connected disabilities resulting from exposure to Agent Orange. See A-1324.20, Veterans Benefits.

Related Policy
Lump-Sum Payments, A-1331

A—1321.2 Disability Insurance Benefits

Revision 16-4; Effective October 1, 2016

All Programs

Disability insurance benefits are normally paid to an individual who has suffered injury or impairment. These payments may be from an employer, insurance provider, or other public or private fund.
Advisors must determine the source of the benefit.

- If the source is covered by an income type listed in A-1320, Income Types, such as RSDI [see A-1324.16, Retirement, Survivors and Disability Insurance (RSDI)], the procedures for that benefit must be used.
- If the source is not covered by another income type listed in A-1320, the policy listed below must be used.

TANF and SNAP

Count as unearned income.

Medical Programs

Disability insurance benefits are exempt.

A—1321.3 Radiation Exposure Compensation Act Payments

Revision 15-4; Effective October 1, 2015

All Programs

Payments from the Radiation Exposure Compensation Act (the “Act”), Public Law 101-426, are exempt.

The Act established a program to pay damages to individuals for injuries or deaths caused by exposure to radiation from nuclear testing and uranium mining. When the affected individual is deceased, the surviving spouse, children, parents, grandchildren, or grandparents receive the payments.

A—1321.4 Worker's Compensation

Revision 15-4; Effective October 1, 2015

TANF and SNAP

The gross benefit is counted as unearned income, less amounts:

- recouped for a prior worker's compensation overpayment; or
- paid for attorney's fees. **Note:** The Texas Workers' Compensation Commission (TWCC) or a court sets the amount of the attorney's fee to be paid.

A deduction from the gross benefit for court-ordered child support payments is not allowed.

Exception: Worker's compensation benefits paid to the individual for out-of-pocket medical expenses are considered as reimbursements.

Medical Programs

All workers’ compensation payments are exempt.

A—1322 Education and Training

Revision 13-2; Effective April 1, 2013

A—1322.1 Educational Assistance

Revision 15-4; Effective October 1, 2015

All Programs

Educational assistance, including educational loans, scholarships, fellowships, grant monies, and work study, are exempt, regardless of the source. Loans for education, including loans from relatives or other people, are considered as educational assistance only if payment is deferred.

Educational assistance is:

- any financial aid for vocational or educational courses from:
  - an organization (such as fraternal, alumni, etc.); or
  - a government program or agency (such as the U.S. Office of Education, Department of Veterans Affairs, or Texas Department of Assistive and Rehabilitative Services).

- provided to students who are enrolled in a:
  - program that provides for completion of a secondary high school diploma or the equivalent (such as a general equivalency diploma [GED]);
  - school for people with intellectual or physical disabilities; or
  - post-secondary institution.

  Note: "Post-secondary" includes institutions of higher education and others not requiring a high school diploma (such as community colleges and vocational educational programs) authorized by the state to provide educational or training programs beyond secondary education.

The U.S. Office of Education under Title IV of the Higher Education Act administers most educational assistance programs. A few examples of the most common Title IV educational assistance grants include:

- Pell Grants,
- Stafford Loan Program,
- Parent Loans for Students (PLUS Loans),
- Supplemental Educational Opportunity Grants,
- College Work Study, and
- Carl D. Perkins Loans (Title IV, Part E) (formerly National Direct Student Loans).

The National Community Services Act (NCSA) program also provides educational assistance. Individuals are awarded from $1,000 to $4,000 per year of completed services to apply toward past or future educational expenses. The educational award is not counted, as it is always made payable directly to the financial institution or institution of higher learning.

The Department of Veterans Affairs administers education programs designed for veterans, reservists, members of the National Guard, and their widows and orphans. These include:

- Montgomery GI Bill (MGIB) Active Duty Educational Assistance Program,
- Vocational Rehabilitation,
- Post-Vietnam Era Veterans' Educational Assistance Program (VEAP),
- Survivor's and Dependent's Educational Assistance (DEA), and
- MGIB - Selected Reserve Educational Assistance Program.

Related Policy
Educational Assistance, A-1239

A—1322.2 Job Training

Revision 03-7; Effective October 1, 2003

A—1322.2.1 Workforce Innovation and Opportunity Act (WIOA)

Revision 15-4; Effective October 1, 2015

All Programs

Temporary employment of six months or less for disaster-related work, paid under the Workforce Innovation and Opportunity Act and funded by the National Emergency Grant, is exempt.

TANF and Medical Programs

All WIOA payments are exempt.

SNAP

All WIOA payments are exempt except on-the-job training (OJT) payments funded under the Workforce Innovation and Opportunity Act. OJT payments are counted as earned income for adults.

OJT payments are exempt if received by a child who is under:

- age 19, and
- under parental control of another household member.

Related Policy
Government Disaster Payments, A-1324.3

A—1322.2.2 Other Job Training and Training Allowances

Revision 15-4; Effective October 1, 2015

All Programs

Portions of payments earmarked as reimbursements for training-related expenses are exempt, and any excess is counted as earned income.

A—1323 Employment and Self-Employment Income

Revision 13-2; Effective April 1, 2013

A—1323.1 Children's Earned Income

Revision 15-4; Effective October 1, 2015

TANF

A dependent child's earned income is counted unless the child (as defined in A-221, Who Is Included) is a:

- full-time student, including a home-schooled child; or
- part-time student employed less than 30 hours a week.

Exception: See A-1322.2.1, Workforce Innovation and Opportunity Act (WIOA).

SNAP

A child's earned income is counted unless the child:

- is under age 18;
- attends elementary, high school or general equivalency diploma classes, including home schooling; and
- lives with natural or adoptive parents, stepparent or is under parental control of another household member.

Exception: See A-1322.2.1.

TANF and SNAP

Breaks in school attendance, such as summer vacation and holidays, do not change the student status of a child. Advisors should ensure that the child's enrollment will continue following the break.

If the child's earnings cannot be separated from that of other household members, the total earnings should be divided equally by the number of working members.

Medical Programs

A child's income may be exempted from the MAGI household income as explained in A-1341, Income Limits and Eligibility Tests, Medical Programs, **Step 3**.

A—1323.2 Contractual Earnings

Revision 05-5; Effective October 1, 2005

All Programs

Contractual earnings are wages and salaries only. Self-employment income, unearned income, or income received on an hourly or piecework basis are not included. The two basic types of contractual earnings are:

- Seasonal employment — available only during certain months of the year and recurs each year. Examples: school-related employment, certain types of farm work, and summer or winter employment. Divide seasonal employment that is a household's annual means of support over 12 months. If the income supports the household for only a portion of the year and the household has income from other sources the rest of the year, average the earnings over the time they are intended to cover.
- Contractual employment — nonseasonal employment that is contracted for a specific time and does not recur. Divide earnings over the time covered by the contract.

A—1323.2.1 Monthly Budgeting of Contractual Earnings

Revision 15-4; Effective October 1, 2015

All Programs

If the individual's employment situation changes, advisors should:

- recompute the income or adjust the benefits accordingly; and
- document all the facts that caused the recomputation or adjustment.

Contractual earnings may be budgeted monthly by:

- dividing the total gross amount earned under the contract by the number of months the contract covers or by 12 months, whichever is applicable; and
- adding this amount to any other income, and budgeting according to usual procedures. **Note:** These steps should not be followedif the income is not received as stipulated in the contract or if labor disputes interrupt income.

A—1323.3 Military Pay Allotments and Allowances

Revision 15-4; Effective October 1, 2015

All Programs

Military pay and allowances for housing, food, base pay, and flight pay is counted as earned income less pay withheld to fund education under the G.I. Bill.

An allotment is a specified amount of money from each paycheck of the military wage earner that is designated to go to someone else. Military allotments are counted as unearned income.

A—1323.3.1 Family Subsistence Supplemental Allowance (FSSA)

Revision 15-4; Effective October 1, 2015

TANF and SNAP

The Family Subsistence Supplemental Allowance is a monthly payment made to certain low-income service members and their families so they will not have to depend on SNAP to meet their needs. The service members' pay statements usually include the FSSA and are counted as earned income.

Medical Programs

FSSA payments are exempt.

A—1323.3.2 Combat (Hazardous Duty) Payments

Revision 15-4; Effective October 1, 2015

TANF

All of the combat payments, also known as hazardous duty payments, received by a legal parent who is a member of the U.S. military, absent solely because the individual has been deployed to a combat zone, are counted.

SNAP

Any portion of military pay identified as combat pay, including any portion of combat pay contributed to a household from military personnel deployed to a combat zone, is excluded.

The advisor must determine whether any funds contributed to the household by military personnel, such as through joint bank accounts or military allotments, are considered combat pay. Any portion identified as combat pay is exempt from income. The following steps should be used to determine the amount of military income to exclude as combat pay:

Steps	Action
1.	Verify the monthly amount of combat pay received, as required in A-1370, Verification Requirements.
2.	Determine the amount of military pay the deployed individual was making available to the household **before** deployment to the combat zone. If the deployed person was: • a household member before deployment, the amount would be the individual's net military pay. • **not** part of the household before deployment, then consider any amount made available from the individual's pay before deployment.
3.	Determine the amount of military pay the deployed individual is making available to the household **after** deployment to the combat zone.
4.	If the amount of contribution the household receives from the military personnel after deployment: • is equal to or less than the amount the household was receiving before deployment, then none of that contribution would be considered combat pay. Count the full amount of the contribution as unearned income. • exceeds the amount received before deployment, exclude the excess as combat pay (not to exceed the verified monthly amount of combat pay) and count the remainder (if any) as unearned income.

Medical Programs

Combat (hazardous duty) payments are exempt.

Related Policy
Who Is Included, A-241.1
Verification Requirements, A-1370
Glossary, Combat Pay and Combat Zone

A—1323.4 Self-Employment

Revision 12-4; Effective October 1, 2012

All Programs

Self-employment income is usually income from one's own business, trade, or profession rather than from an employer. However, some individuals may have an employer and receive a regular salary. If an employer **does not** withhold income taxes or FICA, even if required to do so by law, the person is considered self-employed.

Advisors must inform households in writing to keep self-employment records and receipts for verification purposes for future recertifications. Form TF0001, Notice of Case Action, contains the self-employment information.

Note: If a household has self-employment income and meets the streamlined reporting criteria, assign a six-month certification period.

A—1323.4.1 Types of Self-Employment Income

Revision 15-4; Effective October 1, 2015

All Programs

Types of self-employment include:

- odd jobs, such as mowing lawns, babysitting, and cleaning houses;
- owning a private business, such as a beauty salon or auto mechanic shop;
- farm income;
- income from property; and
- independent contracting.

A—1323.4.2 Property Income

Revision 15-4; Effective October 1, 2015

All Programs

Income from renting, leasing, or selling property on an installment plan is self-employment income. Property includes equipment, vehicles, and real property.

TANF and SNAP

Income from property is counted as:

- earned if the:
  - person spends an average of at least 20 hours a week in management or maintenance activities; or
  - income is from noncommercial boarding situations.

- unearned if the person spends an average of less than 20 hours a week in management or maintenance activities.

Work-related expenses are allowed for earned income. For unearned income, only the expenses associated with producing the income should be deducted.

If the individual sells property on an installment plan, the payments are counted as income. The balance of the note is exempted as an inaccessible resource.

Medical Programs

Income from renting, leasing, or selling property on an installment plan is counted as self-employment income.

A—1323.4.3 Noncommercial Roomer/Boarder Payments

Revision 15-4; Effective October 1, 2015

TANF and SNAP

The noncommercial roomer/boarder policy is used if a noncertified household member makes payments to a certified member under a formal or informal landlord/tenant relationship. Payments made by boarders for room, meals, and other shelter expenses are counted. Payments made by roomers for room and other shelter expenses are counted.

See A-1323.4.5, Allowable Costs of Producing Income, to determine the countable amount of noncommercial roomer/boarder payments. If there is not a formal or informal landlord/tenant relationship, the policy in A-1326.1, Cash Gifts and Contributions, applies.

TANF

Roomer/boarder status should not be given to:

- anyone whose income can be applied to the certified group; or
- a dependent child who is an ineligible alien.

SNAP

To be considered a boarder, a person residing with the household must pay reasonable compensation for meals and lodging. Reasonable compensation is:

- the amount of the full allotment for the number of boarders if the boarders eat an average of more than two meals a day with the household; or
- two-thirds of the full allotment for the number of boarders if the boarders eat an average of two meals a day or less with the household.

In determining "reasonable compensation," only the amount paid for meals is counted if it can be separated from lodging.

If the individual chooses to include a boarder as a household member:

- all of the boarder's income, resources and deductions are counted; but
- the payment from the boarder is not counted as income since it is transferred between household members.

If the individual chooses not to include a boarder as a household member:

- the boarder's income, resources, or deductions are not included in the household; but
- the payment from the boarder is counted as self-employment income for the household.

Medical Programs

The noncommercial roomer/boarder policy is used when an individual in the MAGI household composition receives payments from someone in their physical household under a formal or informal landlord/tenant relationship. Payments made by boarders for room, meals, and other shelter expenses are counted as self-employment income. Payments made by roomers for room and other shelter expenses are counted as self-employment income.

See A-1323.4.5, Allowable Costs of Producing Income, to determine the countable amount of noncommercial roomer/boarder payments. If there is not a formal or informal landlord/tenant relationship, the policy in A-1326.1, Cash Gifts and Contributions, applies.

Related Policy
Nonmembers, A-232.1

A—1323.4.4 Determining the Amount of Self-Employment Income

Revision 16-4; Effective October 1, 2016

All Programs

If the household receives self-employment income monthly or more often (such as semi-monthly, bi-weekly, weekly or daily), recent self-employment pay amounts may be used to project income.

If the household had self-employment income for the past year that was received less often than monthly, the income figures from the previous year's business records or tax forms, including the IRS Schedule C-Form 1040- Profit or Loss from Business, may be used if the records are anticipated to reflect current self-employment income and expenses.

Exceptions:

- If the previous year's records do not accurately represent the household's current self-employment income because the household has experienced a substantial increase or decrease in business, anticipate income using more current information such as updated business ledgers or day books, or contact people who have similar businesses.
- If the business is new and there is insufficient information to make a reasonable projection based on last year's records, anticipate earnings and expenses using only the recent business records along with the individual's statements about expected income and expenses and any applicable information from collateral sources.
- If the income terminates before completing the EDG, budget actual income and expenses for the month the income terminates.
- For Children’s Medicaid programs (TP 43, TP 44, TP 45 and TP 48), the previous year’s business records or tax forms are acceptable, no matter the pay frequency.

When calculating self-employment income, the financial profit from a sale or transfer of capital goods, possessions (such as products, raw materials, equipment), or ownership of a business, must be considered.

Financial profit from the sale or transfer of capital goods that the household expects to receive in the next 12 months should be added and the total averaged over 12 months. This averaged amount should be used for each certification period within the next 12 months, unless a new average is computed because the person received a profit from the sale or transfer of capital goods that was unanticipated or a different amount than anticipated.

Determining the Amount of Self-Employment Income at Application

All Programs

New applicants who have not received TANF, Medical Program coverage, or SNAP for a period of three consecutive months before the application month, or new household members who have not received benefits for three months before moving into the household, may not have been keeping accurate records of self-employment income and expenses. The policy in C-932, Advisor Responsibility for Verifying Information, should be used to obtain verifications needed to determine eligibility and what types of verification are readily available to the household. Any business records that are available for use (even if this documentation is for a short period of time) should be accepted, in addition to the individual's statement and any proof that might be available from a collateral source, as sufficient proof.

The advisor must verify:

- at least the last two recent pay amounts when determining the amount of self-employment income received monthly;
- at least four consecutive recent pay amounts when determining the amount of self-employment income received more often than monthly, such as semi-monthly, bi-weekly or weekly; and
- at least four consecutive weeks for self-employment income received daily.

The individual is not required to provide verification of self-employment income and expenses for more than two calendar months before the interview date for income received monthly or more often.

The applicant's statement is accepted as proof if:

- there is a reasonable explanation why documentary evidence or a collateral source is not available; and

- the applicant's statement does not contradict other individual statements or other information received by the Texas Health and Human Services Commission (HHSC).

Exception: If the business is new and there is insufficient information to make a reasonable projection, the income is calculated based on anticipated earnings and expenses.

The advisor must inform the household in writing to keep self-employment records and receipts for verification purposes for future recertifications. Form TF0001, Notice of Case Action, contains the self-employment information.

Medical Programs

If the individual applies for three months prior Medicaid, the following should be budgeted in each prior month:

- actual income and expenses for self-employment income received monthly or more often, or
- projected monthly average amount for self-employment income received annually or seasonally.

Determining the Amount of Self-Employment Income at TANF Periodic Reviews, SNAP Recertifications, and Medical Programs Renewals

All Programs

For income received less often than monthly, only information from the period of time since HHSC last requested verification of self-employment needs to be verified. Verification that was previously verified is not needed (see C-932). Verification is needed for:

- at least the last two recent pay amounts when determining the amount of self-employment income received monthly;
- at least four consecutive recent pay amounts when determining the amount of self-employment income received more often than monthly, such as semi-monthly, bi-weekly or weekly; and
- at least four consecutive weeks for self-employment income received daily.

The individual is not required to provide verification of self-employment income and expenses for more than two calendar months before the interview date for income received monthly or more often.

If the advisor informed the household to maintain accurate self-employment records and receipts after certification, the household must provide them before being recertified unless:

- the records and receipts are not available because of a reason beyond the household's control, such as being lost in a fire or flood; or
- if due to a verified physical or mental disability, the applicant is unable to complete the task. Note: This requirement is not applicable if the self-employed person has not received TANF, SNAP, or Medical Program coverage for three consecutive months before reapplying.

Related Policy
Computation Methods, A-1323.4.6

A—1323.4.5 Allowable Costs of Producing Income

Revision 17-3; Effective July 1, 2017

All Programs

Allowable self-employment expenses are based on costs that can be deducted from federal income taxes according to the IRS Schedule C, Form 1040 - Profit or Loss from Business. There are certain self-employment expense types that are not allowed for SNAP.

Advisors must use an automatically calculated monthly expense amount generated by TIERS to determine eligibility if the IRS Schedule C, Form 1040 - Profit or Loss from Business is provided.

Allowable and Non-Allowable Self-Employment Expenses by Program

Expense Types	TANF and MAGI Programs	SNAP
Advertising	Allow	Allow

Car and truck expenses	Allow	Allow
Commissions and fees	Allow	Allow
Contract labor	Allow	Allow
Costs not related to self-employment	Non-allowed	Non-allowed
Costs related to producing income gained from illegal activities, such as prostitution and the sale of illegal drugs	Non-allowed	Non-allowed
Depletion	Allow	Non-allowed
Depreciation	Allow	Non-allowed
Employee benefit programs	Allow	Allow
Insurance	Allow	Allow
Interest	Allow	Allow
Legal and professional services	Allow	Allow
Net loss that occurred in a previous period	Non-allowed	Non-allowed
Office expense	Allow	Allow
Pension and profit-sharing plans	Allow	Allow
Rent or lease	Allow	Allow
Repairs and maintenance	Allow	Allow
Supplies	Allow	Allow
Taxes and licenses	Allow	Allow
Travel, meals, and entertainment	Allow	Non-

		allowed
Travel to and from place of business	Non-allowed	Non-allowed
Utilities	Allow	Allow
Wages	Allow	Allow
Other expenses	Allow	Allow

Note: When determining transportation costs, the individual may choose to use 53.5 cents per mile instead of keeping track of actual expenses.

Noncommercial Roomer/Boarder Payments

All Programs

If the household receives roomer or boarder payments, as explained in A-1323.4.3, Noncommercial Roomer/Boarder Payments, the cost of doing business is deducted from each monthly payment. Count the remainder as self-employment income.

For roomers, the cost of doing business is actual costs. For boarders, the cost of doing business is:

- the amount of the monthly SNAP allotment for the number of boarders (average of more than two meals a day); or
- two-thirds of a full allotment for the number of boarders (average of two meals a day or less); or
- the actual cost of providing room and meals if the actual cost exceeds the monthly SNAP allotment for the number of boarders.

Note: Each expense must be identified and verified when using actual costs.

Net Financial Loss

All Programs

A self-employment net financial loss must not be deducted from other types of household income. **Exception:** The loss may be deducted from other household income if:

- the loss results from a self-employment farming operation; and
- the household received or anticipates receiving annual gross income of $1,000 or more from the farming operation (from Step I, Line A, Page 3, Form H1049, Client's Statement of Self-Employment Income).

TANF

The farm loss amount may be deducted from other non-farm self-employment income during the budgetary (100 percent) needs test.

Any remaining farm loss amount may be deducted during the recognizable needs test.

Medical Programs

The farm loss amount may be deducted from other non-farm self-employment income during the federal poverty income level (FPIL) test.

Any remaining farm loss amount may be deducted after the work expense standard deduction and child/incapacitated care costs.

SNAP

The farm loss may be deducted from other non-farm self-employment income before applying the gross income test.

Any remaining farm loss may be deducted from other earned or unearned income after applying the 20 percent earned income deduction.

A—1323.4.6 Computation Methods

Revision 15-4; Effective October 1, 2015

All Programs

There are four computation methods for self-employment income that may be used to calculate monthly income amounts for budgeting purposes:

- annual,
- monthly,
- daily, and
- anticipated.

Annual Computation Method

For this method, the individual must have been self-employed for at least the past full year.

The self-employment income projection period, usually 12 months, is the period of time the household expects the income to support the family. A projection period should be established for households that receive self-employment income that is intended to support the household for:

- the year, but is received less frequently than monthly, such as farm income that may only be received a few times per year when crops or livestock are sold; or
- a specific period in time, but is received less frequently than monthly.

The projection period should be determined at application when the individual reports self-employment income received less often than monthly. **Note:** For Medicaid EDGs, if the individual is eligible for prior Medicaid, the prior months are not included in the 12-month projection period.

The following steps are used to determine the projection period for self-employment income:

1. Determine whether the self-employment is annual or seasonal, since that will determine the length of the projection period.
    - Annual – intended to support the household for at least the next full 12 months. The projection period is 12 months whether the income is received yearly or less often than monthly.
    - Seasonal – intended to support the household for less than 12 months since it is available only during certain months of the year. The projection period is the number of months the self-employment is intended to provide support.
2. Determine the first month of the projection period. It is always the first month the household receives benefits, unless the individual will begin working in a future month. In this situation, use the month the self-employment begins as the first month of the projection period.

Once the projection period is established, it must not be changed. The projection period remains the same until the:

- individual no longer supports the household through self-employment;
- 12-month or seasonal period ends; or
- EDG is denied, and the individual misses one full month's benefits before reapplying.

Exception: When there is a new source of self-employment income received less often than monthly, and the individual expects the income to support the household for the year or a specific period of time, establish a projection period for the months that the individual states the income is intended to cover. Since this projection period covers income from a new source, at redetermination, ensure that the income and circumstances still fit with the annual computation method criteria. Until the household has 12 months of income history, the projection period is conditional and may be changed as may the type of computation method used to calculate self-employment income.

In determining the monthly figure to use for new self-employment income when calculating a budget amount:

- the monthly computation method is used if there are two full representative months of self- employment income received less often than monthly; and
- the daily computation method is used if there are less than two full representative calendar months of self-employment income received less often than monthly.

On an active EDG, when an individual reports a new source of self-employment, the first month of the projection period is the change effective month.

Monthly Computation Method

The monthly computation method is used in two situations:

1. If the frequency is known and consistent, the appropriate conversion factor is used when calculating self-employment income and/or expenses. Conversion factors are not used when income is received on any other basis, such as daily or irregularly.

If the frequency is …	use the conversion factor …
weekly	4.33
bi-weekly	2.17
semi-monthly	2

2. If the individual has at least two full representative calendar months of self-employment income and the source or the frequency is unknown and inconsistent, each month's self-employment income should be totaled and deducted from the allowable expenses for each corresponding month.

Daily Computation Method

The daily computation method is used when:

- there are less than two full representative calendar months of self-employment income; and
- the source or frequency of the income is unknown or inconsistent (income received irregularly, not on a weekly, bi-weekly or semi-monthly basis).

The daily method is used until there are at least two representative calendar months of income. Once there are two full representative calendar months, the monthly computation method is used.

Anticipated Self-Employment Method

The anticipated method to calculate self-employment income is used when:

- there is no income history on which to base an average, and the individual will receive the income on a known and consistent basis; or
- there is a change that will make the current or actual self-employment income non-representative.

Anticipated means the individual knows who will pay, when they will pay, and how much will be paid. If the individual knows the source, but not the amount and/or frequency, the daily computation method in A-1323.4.7, Determining Net Self-Employment Income, should be used.

A—1323.4.7 Determining Net Self-Employment Income

Revision 15-4; Effective October 1, 2015

All Programs

Annual Computation Method

The following steps are used to determine net self-employment income when using the annual computation method:

1. Determine the projection period.
2. Determine the total gross self-employment income for the past year.
3. Determine the total allowable expenses for the past year.
4. Determine the yearly net income by subtracting the total allowable expenses from the total gross income.
5. Determine the monthly net income by dividing the total yearly net income by the number of months of earnings history used.

If the self-employment income is annual and no substantial changes are expected, the income should be projected for 12 months. If the self-employment income is seasonal and no substantial changes are expected, the income should be projected for the seasonal period.

Monthly Computation Method

The following steps are used for the monthly computation method:

1. Determine the total monthly gross self-employment income.
2. Determine the total allowable expenses for each corresponding month.
3. Subtract the total allowable expenses from the total gross self-employment income for the corresponding month.

4. Look at the net monthly income and determine which months are representative of future earnings and project over the length of the certification period.

Note: If the frequency is known and consistent, the appropriate conversion factor should be used in Step 1 and Step 2.

Daily Computation Method

The following steps are used for the daily computation method:

1. Determine the total gross income earned from the day the self-employment began through the interview date.
2. Determine the number of days the income was received. The day self-employment begins is the day any part of the self-employment activity occurs (for example, buying supplies, working, earning income, etc.).
3. Divide the total gross income by the number of days in the period the income was received.
4. Multiply the daily income by 30 to get the monthly estimate of gross self-employment income.
5. Determine the total verified self-employment expense paid from the day the self-employment began through the interview date.
6. Determine the number of days the expense was to cover. Use the same number of days used to calculate income.
7. Divide the total expense amount by the number of days in the period.
8. Multiply the daily expense deduction by 30 to get the monthly estimate of the expense.
9. Subtract monthly expenses from gross monthly income to determine net monthly self-employment.

Anticipated Self-Employment Method

The following steps are used for the anticipated self-employment method:

1. Determine how often the individual will be paid and the amount.
2. Multiply the pay amount by the appropriate frequency to determine the projected monthly amount:
   - Weekly: amount x 4.33
   - Bi-weekly: amount x 2.17
   - Semi-monthly: amount x 2

     Note: If the income amounts will fluctuate, a pay period average should be determined and multiplied by the appropriate conversion factor.
3. Projection should be made over the length of the certification period.

Related Policy
How to Project Income, A-1355
Length of Certification, A-2324

A—1323.4.8 Changes in Annual or Seasonal Self-Employment Income

Revision 15-4; Effective October 1, 2015

All Programs

When an individual reports a change in self-employment income during the certification period, it should be considered part of the normal fluctuations of the business if the current budget already includes fluctuations as significant as the change that the individual is reporting, and the budget is not revised. If a reported change is not part of the normal fluctuations of the business, the income and expenses should be re-evaluated and the change considered substantial if it results in a change to the average monthly net self-employment income of more than $25. If the change results in a change of $25 or less, benefits should not be adjusted.

If a 12-month income projection period was previously established, the period should not be changed, unless it has expired or the individual reports no longer supporting the household with self-employment income. Even if the income or expense changes resulted in a different projected self-employment income, the projection period is the same.

If the income projection period has expired, a new projection period should be established with required verifications, even if the individual indicates no changes in the business.

Note: When the individual reports a change in self-employment income that is not received annually or seasonally, the policy in B-631, Actions on Changes, should be followed.

A—1323.4.9 Rebudgeting Income and Expenses

Revision 15-4; Effective October 1, 2015

All Programs

If the individual reports a substantial change in annual or seasonal self-employment income, the income and expenses must be rebudgeted using the following method for actual income and expenses received.

Actual income from the beginning of the projection period through the month before re-evaluation should be used. The following steps are used to rebudget income in this situation.

1. Determine the actual income for the months from the beginning of the projection period through the month before re-evaluation.
2. Project the new income for the rest of the projection period.
3. Add the income from Step 1 and 2 to determine the annual or seasonal amount.
4. Divide the total from Step 3 by 12 or the number of months in the seasonal period to get the new monthly average.
5. Compare the new monthly amount to the previous average. If the change is substantial, budget the new amount over the remainder of the projection period.

A—1323.5 Wages, Salaries, Commissions, and Tips

Revision 15-4; Effective October 1, 2015

All Programs

The actual gross amount of all wages, salaries, commissions, bonuses, and tips count as earned income before deductions such as flexible fringe benefits, cafeteria plans and employee retirement contributions are withheld from the amount.

Wages held by the employer at the request of the employee and garnished wages are counted as income in the month the household would otherwise have been paid. If, however, an employer holds the employee's wages as a general practice, this money counts as income in the month it is paid.

An advance counts in the month it is received. When an advance is repaid, the payback amount is deducted from the gross pay, and the remainder is budgeted as the countable gross amount.

Related Policy
How to Project Income, A-1355
Budgeting Options for SNAP Households, A-1355.1

A—1323.5.1 Federal Tax Refunds and Earned Income Tax Credits (EIC)

Revision 15-4; Effective October 1, 2015

All Programs

Households with tax dependents and earnings below levels established by the Internal Revenue Service (IRS) are potentially eligible to receive EIC payments from the IRS.

EIC money is included in an individual's:

- paycheck (advance EIC payments) before the individual files an income tax return, or
- IRS refund after the individual files an annual income tax return.

Federal tax refunds and EIC payments are exempt as income.

Related Policy
Federal Tax Refunds and Earned Income Tax Credits (EIC), A-1232.2

A—1323.5.2 Flexible Fringe Benefits

Revision 15-4; Effective October 1, 2015

All Programs

Fringe benefit plans allow the employee to choose from benefit components such as insurance, extra vacation time, and payments to third parties for medical bills or child care. These are also called "cafeteria plans."

Under some plans, employers may:

- withhold wages to pay for benefits selected by the employee; or
- offer benefit credits in addition to wages, which the employee can use to purchase benefits.

Some plans may pay the remaining unused credit as part of the employee's wages.

TANF and SNAP

If the employer …	the advisor must count …
withholds the employee's wages to purchase benefits,	the held wages as earnings in the pay period that the employee would have normally received them.
provides credit in addition to wages,	as earnings only the portion that is paid directly to the employee. If the employer pays the unused credit in cash, the advisor must follow the steps below to determine countable excess income. 1. Determine the total amount of gross wages/salary. 2. Add the benefit credit amount to the wages/salary from Step 1. 3. Subtract the cost of fringe benefits up to the amount of the benefit credit from the amount in Step 2. 4. The remaining income from Step 3 is the countable gross earned income for the EDG.

Medical Programs

Flexible fringe benefits are exempt.

A—1323.5.3 Income from Tips

Revision 15-4; Effective October 1, 2015

All Programs

Household members who are employed in service-related occupations (beauticians, waiters, delivery staff, etc.) are likely to earn tips in addition to wages. Tips are counted as earned income.

Tip income is added to wages before applying conversion factors.

Note: Tips are not considered as self-employment income unless related to a self-employment enterprise.

A—1323.5.4 Vacation Pay

Revision 15-4; Effective October 1, 2015

TANF and SNAP

If an individual receives vacation pay …	the payment is considered …
during or before termination of employment,	earned income.
after termination of employment in one lump sum,	a liquid resource in the month received.
after termination of employment in multiple checks,	unearned income.

Medical Programs

Vacation pay is counted as unearned income.

Related Policy
Lump-Sum Payments, A-1242 and A-1331

A—1323.6 Temporary Census Income

Revision 10-2; Effective April 1, 2010

All Programs

Exempt wages.

A—1324 Government Payments

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Government payments are counted unless exempted in this section or by other policy in A-1300, Income.

Medical Programs

Government payments are exempt.

A—1324.1 Adoption Assistance

Revision 15-4; Effective October 1, 2015

All Programs

Adoption assistance payments are exempt.

Note: A person receiving adoption assistance in a TANF budget or a certified group is exempt.

Related Policy
Who Is Not Included, A-222, No. 8

A—1324.2 Crime Victim's Compensation Payments

Revision 15-4; Effective October 1, 2015

All Programs

Crime victim's compensation payments are provided from the funds authorized by state legislation to assist a person who:

- was a victim of a violent crime;
- was the spouse, parent, sibling, or adult child of a victim who died as a result of a violent crime; or
- is the guardian of a victim of a violent crime.

The Office of the Attorney General (OAG) distributes the payments monthly or in a lump sum. These payments are exempt.

Related Policy
Crime Victim's Compensation Payments, A-1232.1

A—1324.3 Government Disaster Payments

Revision 15-4; Effective October 1, 2015

All Programs

Federal disaster payments and comparable disaster assistance provided by states, local governments, and disaster assistance organizations are exempt if the household is subject to legal penalties when the funds are not used as intended (including temporary employment of six months or less for disaster-related work, paid under the Workforce Innovation and Opportunity Act and funded by the National Emergency Grant).

Examples:

- Payments by the Individual and Family Grant Program or Small Business Administration to rebuild a home or replace personal possessions damaged in a disaster.
- Payments from the Federal Emergency Management Agency (FEMA) to assist with rent.

Related Policy
Government Disaster Payments, A-1232.4

A—1324.4 Government Housing Assistance

Revision 15-4; Effective October 1, 2015

All Programs

See A-1326.3, Energy Assistance, for energy or utility payments.

TANF and Medical Programs

The value of government housing or rental subsidies, whether cash, two-party check, in-kind, or vendor-paid, are exempt.

SNAP

The following payments are counted:

- cash payments;
- vendor payments paid from state or local government funds unless exempt as shown below; and
- vendor payments paid from state or local funds for transitional housing for the homeless.

The following payments are exempt:

- in-kind payments; and
- federally funded vendor or two-party check payments.

A—1324.5 Transitional Living Allowance

Revision 15-4; Effective October 1, 2015

All Programs

Transitional living allowances (TLA) are exempt. The Texas Department of Family and Protective Services (DFPS) distributes TLA to a foster child who:

- is under age 21;
- has completed the preparation for adult living (PAL) classes; and
- has left foster care or is transitioning out of foster care.

Payments:

- are received for a maximum of 12 months;
- cannot exceed $500 a month;
- cannot total more than $1,000; and
- are intended for expenses other than ongoing room and board.

Related Policy
Transitional Living Allowance, A-1232.5

A—1324.6 In-Home and Family Support Program (IH/FSP) Payments

Revision 15-4; Effective October 1, 2015

All Programs

IH/FSP payments are from funds authorized by state legislation to assist persons with disabilities so they can live in the community. These payments are distributed by the Texas Department of Aging and Disability Services (DADS) to eligible individuals with:

- physical disabilities, who may receive grants of up to $1,200 annually with a maximum lifetime amount of $3,600; or
- intellectual disabilities, or eligible children newborn through age 3 with a developmental delay, who may receive grants of up to $2,500 annually.

These grants are available to purchase services, equipment, home modifications, or other items related to the individual's disability. State law requires that, to the extent possible, these funds be disbursed in a manner that does not interfere with the applicant's eligibility for TANF, SNAP or Medicaid.

TANF

If a household member receives one IH/FSP payment during the year, the policy in A-1244, Reimbursements, applies.

If a household member receives more than one payment:

- any portion of the payment that is a reimbursement for expenses not included in the standard of need or for medical needs that are not paid by Medicaid is deducted; and
- the budgeting policy in A-1356, Income Received Less Often Than Monthly, and resource policy in A-1243, Payments Exempt as a Resource While Being Considered Income, apply.

SNAP

If a household member receives one IH/FSP payment during the year, the policy in A-1244 applies.

If a household member receives more than one payment:

- a deduction for any portion of the payment that is a reimbursement for expenses other than normal living expenses is allowed; and
- the budgeting policy in A-1356 and the resource policy in A-1243 apply.

Notes:

- Medical expenses are considered as other than normal living expenses.
- A medical deduction for any part of an expense that is reimbursed is not allowed.

Medical Programs

IH/FSP payments are exempt.

A—1324.7 National and Community Services Act (NCSA)

Revision 15-4; Effective October 1, 2015

All Programs

The NCSA established a corporation to administer paid volunteer service programs. The corporation provides funds, training, and technical assistance to states and communities to develop and expand human, education, environmental, and public safety services.

The corporation oversees programs created under the Domestic Volunteer Service Act (DVSA) of 1973 such as:

- Volunteers in Service to America (VISTA),
- Retired and Senior Volunteer Program (RSVP),
- Foster Grandparents, and
- Senior Companion Program.

The corporation also administers programs established in 1993 that include:

- AmeriCorps,
- Learn and Serve, and
- National Senior Service Corps (Senior Corps).

For programs established in 1973:

Payments, living allowances, and stipends are exempt.

For programs established in 1993:

Payments except OJT payments are exempt.

OJT payments for adults are counted as earned income. A child's OJT payment is exempt if the child is under:

- age 19; and
- under parental control of another household member.

Exception: OJT payments received by AmeriCorps volunteers are exempt.

Medical Programs

Advisors must use the exceptions for counting a child's OJT income in the MAGI household income as explained in A-1341, Income Limits and Eligibility Tests, Medical Programs, **Step 3**.

SNAP

Payments under Title V of Public Law 106-501, the Community Service Employment Program for Older Americans (formerly known as the Senior Community Service Employment Program), are exempt.

A—1324.8 Native and Indian Claims

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Exempted payments made to Native Americans under various public laws include, but are not limited to, the following:

- Distributions from Native Corporations made under the Alaska Native Claims Settlement Act (ANCSA) (Public Law [PL] 92-203 and Section 15 of PL 100-241).

- Funds distributed per capita or held in trust by the Indian Claims Commission for members of Indian tribes, as follows:
  - Grand River Band of Ottawa Indians (PL 94-540);
  - Income to certain tribal members from land held in trust by the United States government (PL 94-114, Section 6);
  - Income resulting from provisions of PL 92-254; and
  - Red Lake Band of Chippewa (PL 98-123, Section 3) or Assiniboine Tribe of the Fort Belknap Indian Community, and the Assiniboine Tribe of the Fort Peck Indian Reservation (PL 98-124, Section 5).
- Funds distributed by the Secretary of Interior to tribal members from:
  - tribal trust funds on a per capita basis (PL 98-64); or
  - judgment funds from claims against the United States and held in trust or distributed on a per capita basis (PL 93-134, as amended by 97-458).
- Payments by the Indian Claims Commission to the:
  - Passamaquoddy Tribe, the Penobscot Nation, and the Houlton Band of Maliseet Indians or any of their members [Maine Indian Claims Settlement Act of 1980, PL 96-420, Section 9(c)].
  - Confederated Tribes and Bands of Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation (PL 95-433).
  - Seneca Nation or its members (Seneca Nation Settlement Act of 1990, PL 101-503).
  - Blackfeet, Gros Ventre, and Assiniboine tribes of Montana (PL 97-408).
  - Saginaw Chippewa of Mississippi [PL 99-123, Section 6(b)(2)].
- Payments to the Turtle Mountain Band of Chippewa, Arizona (PL 97-403).
- Payments to heirs of deceased Indians made under the Old Age Assistance Claims Settlement Act (PL 98-500).

Exception: Money given to Native Americans from gaming revenues (such as from casino profits, race tracks, lotteries, etc.) is not exempt under these laws. Gaming revenues are counted as unearned income.

Medical Programs

AI/AN disbursement income is exempt and not counted under MAGI only if the individual claiming that income type has verified his or her AI/AN status and provided verification of the income source, as explained in A-1370, Verification Requirements, for Medical Programs.

AI/AN disbursements include:

- distributions from Alaska Native corporations and settlement trusts;
- distributions from property held in trust, in the boundaries of a prior federal reservation;
- distributions and payments from rents, leases, rights of way, royalties, usage of rights, or using natural resources from land under the supervision of the Secretary of the Interior or rights to off-reservations hunting, fishing, gathering, or natural resource usage;
- payments from ownership/usage rights to items that are religious, spiritual, traditional, or cultural or rights that support subsistence/traditional lifestyle according to tribal law or custom; and
- student financial assistance from the Bureau of Indian Affairs education program.

A—1324.9 Nutrition Programs

Revision 15-4; Effective October 1, 2015

All Programs

The following amounts are exempt:

- the value of food assistance under the Child Nutrition Act of 1966 and under the National School Lunch Act; and
- benefits received under Title VII, Nutrition Program for the Elderly, of the Older American Act of 1965.

A—1324.10 One-Time Grandparent Payments

Revision 15-4; Effective October 1, 2015

All Programs

One-Time Grandparent payments are exempt as income.

A—1324.11 One-Time Temporary Assistance for Needy Families (OTTANF)

Revision 15-4; Effective October 1, 2015

All Programs

OTTANF is exempt as income.

A—1324.12 Payments to Vietnam Veterans' Children

Revision 03-7; Effective October 1, 2003

A—1324.12.1 Payments to Vietnam Veterans' Children Born with Spina Bifida (Public Law 104-204)

Revision 15-4; Effective October 1, 2015

All Programs

These VA payments made to Vietnam veterans' children who are born with spina bifida are exempt.

A—1324.12.2 Payments to Children of Women Vietnam Veterans Born with Certain Birth Defects (Public Law 106-419)

Revision 15-4; Effective October 1, 2015

All Programs

VA payments made to the children of women Vietnam veterans who are born with a birth defect are exempt.

Related Policy

Payments to Children of Women Vietnam Veterans Born with Certain Birth Defects (Public Law 106-419), A-1232.7.2

A—1324.13 Payments to Victims of Nazi Persecution

Revision 15-4; Effective October 1, 2015

All Programs

Payments made to individuals because of their status as victims of Nazi persecution are exempt.

A—1324.14 Payments to World War II Filipino Veterans and Spouses

Revision 15-4; Effective October 1, 2015

All Programs

Under the American Recovery and Reinvestment Act of 2009 (Division A, Title X, Section 1002), some World War II Filipino veterans who served in the military forces of the Government of Commonwealth of the Philippines, and their spouses, are authorized to receive one-time lump-sum payments of up to $15,000.

These payments are exempt.

A—1324.15 Relocation Assistance

Revision 15-4; Effective October 1, 2015

All Programs

The following payments are exempt if provided under:

- Title II of the Uniform Relocation Assistance and Real Property Acquisitions Act of 1970;
- Title I of Public Law 100-383 (these payments are made to Aleuts or individuals of Japanese ancestry [or their heirs] who were relocated during World War II); or
- Public Law 93-531 to members of the Navajo or Hopi Tribes.

A—1324.16 Retirement, Survivors and Disability Insurance (RSDI)

Revision 15-4; Effective October 1, 2015

All Programs

The benefit amount, including the deduction for the Medicare premium, less any amount that is being recouped for a prior RSDI overpayment, is counted as unearned income.

Note: If DFPS is the payee and the child gets Foster Care Medicaid:

- **No Cash**, the RSDI income is counted; or
- **With Cash**, the RSDI income is exempt.

See A-1326.15, Income Legally Obligated to Children in Department of Family and Protective Services (DFPS) Conservatorship, for more information on foster care types of assistance.

Note: SSA may deposit RSDI benefits into a Direct Express card debit account. See www.ssa.gov/pubs/10073.html.

TANF

RSDI or other income of SSI recipients is exempt.

Related Policy
Debit Accounts, A-1231.2

A—1324.17 Supplemental Security Income (SSI)

Revision 17-1; Effective January 1, 2017

TANF

The income of an SSI recipient is exempt.

If the SSI recipient contributes to a member of the TANF unit, the contributions policy in A-1326.1.1, Contributions from Noncertified Household Members, applies.

Exception: All of the SSI benefits are exempt when the SSI recipient meets one of the following criteria.

- The SSI recipient would otherwise be an eligible member of the TANF unit.
- The SSI recipient would otherwise be someone whose income is "applied" to the TANF unit.
- A TANF-certified member is the SSI recipient's payee.

Note: This policy applies to people who cannot get SSI financial assistance because of earnings but who continue to get SSI Medicaid.

SNAP

Counted as unearned income. The following amounts are deducted if the amount is being:

- recouped for an SSI overpayment; or
- collected by a qualified organization providing representative payee services, up to the lesser of 10 percent of the monthly benefit amount or:
  - $50 for SSI benefits based on alcoholism and/or drug abuse (SSI/DAA); or
  - $25 for non-SSI/DAA benefits.

Notes:

- Advisors must verify with SSA that the qualified organization is authorized to collect a fee for representative payee services. The advisor must also verify with the qualified organization the amount collected for representative payee services.
- If DFPS is the payee and the child gets Foster Care Medicaid:
  - **No Cash**, the SSI income is counted; or
  - **With Cash**, the SSI income is exempt.

A-1326.15, Income Legally Obligated to Children in Department of Family and Protective Services (DFPS) Conservatorship, includes more information on foster care types of assistance.

Note: SSA may deposit SSI benefits into a Direct Express card debit account. See www.ssa.gov/pubs/10073.html.

Medical Programs

SSI is exempt. Count the other income of an SSI recipient unless the income is exempt.

Related Policy
Plan for Achieving Self-Sufficiency (PASS), A-1326.8
Debit Accounts, A-1231.2

A—1324.18 Temporary Assistance for Needy Families (TANF)

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

TANF benefits are exempt from income.

SNAP

The TANF benefit amount (after recoupment) counts as unearned income.

Retroactive or restored TANF or refugee cash assistance payments are exempt as income. These payments should be considered lump-sum payments and counted as a resource.

Note: TANF benefits may be deposited into an Electronic Benefit Transfer (EBT) cash debit account and made accessible to recipients via an EBT card.

Exception: The recommended grant amount continues to be counted when the TANF grant is lowered for one or more of the following reasons:

- a Personal Responsibility Agreement (PRA) penalty;
- a recoupment for a TANF intentional program violation (IPV);
- a disqualification for IPV or noncooperation with a TANF requirement (unless the individual is disqualified in SNAP for the same offense); or
- an active TANF EDG is denied because of:
  - the noncooperation disqualification of an individual;
  - failure to sign Form H1073, Personal Responsibility Agreement;
  - PRA noncooperation; or
  - noncooperation with an audit or investigation.

SNAP benefits must not be increased in an existing certification period when TANF benefits are forfeited because of a noncooperation penalty. In situations where the TANF is denied:

- the full TANF benefit is counted until the next SNAP certification period begins; and
- the benefit continues to count when a SNAP certification period is extended.

In situations where there is a break in SNAP benefits of less than a month, the TANF continues to count through the next certification period when the:

- individual received or will receive SNAP in the month of the PRA noncooperation, and either the first or second noncooperation month is also the first month of a new SNAP certification period; or
- file date of the SNAP application and the TANF PRA noncooperation date are the same month, and SNAP benefits do not prorate to less than $10 in the month of application.

Note: This policy does not apply to other types of TANF disqualifications or denials or to denied TANF applications.

Examples:

During the SNAP certification period January – June, the date of noncooperation is February 1. The first noncooperation month is February, and the second noncooperation month is March. The TANF grant is denied in April. The TANF grant continues to count in the SNAP budget through June.

At a SNAP redetermination when there is a certified TANF EDG, the household fails to comply with TANF PRA requirements and is denied effective with March benefits. The date of noncooperation is January 1. The first noncooperation month is January, and the second noncooperation month is February. The SNAP application file month is January. When the SNAP redetermination is untimely in January:

- because the last benefit month was December, the TANF **counts** in the ongoing SNAP budget since there is not at least a one-month break in SNAP benefits.
- and the last benefit month was November, the TANF **does not count** in the forfeit and ongoing months because there is a break in SNAP benefits of one month or more. The TANF grant received in January, the month of redetermination, must be counted.
- because the last benefit month was December, and the SNAP benefit prorates to zero for the application month, the application month is considered a break in benefits of at least one month. The TANF grant **does not count** in the forfeit or ongoing months.

When the SNAP redetermination is a new application or the individual was receiving SNAP in a different household, the TANF **does not count** in the forfeit or ongoing months. However, the TANF grant received in January, the month of application, must be counted.

A—1324.18.1 TANF Annual School Subsidy Payment

Revision 15-4; Effective October 1, 2015

All Programs

TANF annual school subsidy payments are exempt.

A—1324.19 Unemployment Compensation

Revision 15-4; Effective October 1, 2015

All Programs

Unemployment insurance benefits (UIB) are:

- deposited into a debit account and accessible to claimants via the UIB debit card;
- deposited directly into a personal checking or savings account; or
- issued through a mailed paper check.

The gross UIB benefit, less any amount being recouped for a UIB overpayment, counts as unearned income.

Exception: The gross amount counts if the household agreed to repay a SNAP overpayment through voluntary garnishment.

Related Policy
How to Project Income, A-1355
Debit Accounts, A-1231.2
Payments Exempt as a Resource While Being Considered Income, A-1243

A—1324.20 Veterans Benefits

Revision 15-4; Effective October 1, 2015

All Programs

The VA provides payments to veterans with disabilities and/or their spouses/dependents and to spouses/dependents of deceased veterans. VA benefits are not subject to federal or state income tax or child support garnishment.

Three basic VA benefit programs are described in this section:

- Pension,
- Disability Compensation, and
- Dependency and Indemnity Compensation (DIC).

VA Pension

VA pension payments are made to certain veterans with disabilities based on financial needs. Low-income veterans who either have a disability or are age 65 and older may be eligible for a VA pension if they have 90 days or more of active military service with at least one day during a period of war. Payments are made to bring the veteran's total income, including other retirement or Social Security income, to a level set by Congress. Recipients must re-qualify each year to continue to receive payments. There is a similar pension benefit available for surviving spouses and dependent minor children of such deceased veterans.

VA Disability Compensation

VA disability compensation is a payment made to a veteran with a service-related disability. Eligibility is not based on financial need. The amount of the payment varies with the percentage of the veteran's disability and the number of the veteran's dependents living in or out of the home. The payment can also be made to a spouse, child or parent of a veteran because of the service-related death of the veteran.

Dependency and Indemnity Compensation

DIC is a monthly benefit paid to eligible survivors of active duty service members and survivors of those veterans whose deaths are determined by VA to be service-related. This payment is a flat monthly payment, regardless of other income. The payment is payable for the life of the spouse, provided the spouse does not remarry before age 57; however, should a remarriage end, DIC benefits can be reinstated. This payment is adjusted annually for cost-of-living increases and is non-taxable. VA adds a monthly transitional payment to the surviving spouse with minor children for the first two years of DIC entitlement or until the last child turns age 18, whichever occurs first. See http://benefits.va.gov/Compensation/current_rates_dic.asp for current payment amounts.

Veterans with certain disabilities may be eligible for additional special monthly compensation such as:

- Aid and Attendance and Housebound payments, which are an allowance to veterans and dependents who are in need of regular aid and attendance by another person, or a veteran who is permanently housebound; and
- reimbursement for unusual medical expenses.

TANF and SNAP

The gross benefit less any amount recouped or suspended for VA overpayment is counted as unearned income, except as described below for reimbursement for medical and attendant care expenses.

These special compensation payments that are intended to cover medical and attendant care expenses are exempt. These payments are exempt as reimbursement as explained in A-1332, Reimbursements.

Apportioned VA payments are a direct payment of the dependent's portion of the VA benefit to a dependent spouse or child not living with the veteran. Apportioned VA payments are unearned income to the dependent spouse or child not living with the veteran.

Other Types of Veterans Benefits

- Military retirement payment — A payment made to an individual who retired from active duty military service after at least 20 years of service. Military retirement is not a VA program, but is paid by the Defense Finance and Accounting Service in Cleveland (DFAS-CL). The gross payment is counted as unearned income.
- Survivor Benefit Plan (SBP) — Active duty members are automatically enrolled in this program. Surviving spouses and/or children of service members who die while on active duty may be entitled to SBP payments made by DFAS-CL. SBP payments are equal to 55 percent of what a member's retirement pay would have been had the member been retired at 100 percent disability. An SBP payment is reduced by the amount of payments provided under the VA DIC program.

At retirement, retirees may choose to purchase the SBP. In this case, the SBP pays retired military members' eligible survivors an inflation-adjusted monthly income. Basic SBP for a spouse pays a benefit equal to 55 percent of the retired individual's pay. Eligible children may also be SBP beneficiaries while they are dependents of the retired individual, either alone or added to spouse coverage. Any VA DIC paid to a spouse is subtracted from SBP payments, although VA DIC payments to or for children do not affect SBP payments. SBP premiums are refunded to the survivor if the monthly VA DIC amount is greater than the SBP monthly annuity.

The gross amount of any SBP payment is counted as unearned income.

- VA educational assistance programs — Different programs provide education assistance, including vocational rehabilitation. The policy in A-1322.1, Educational Assistance, applies.

Medical Programs

All veterans benefits are exempt from income

A—1324.21 DFPS Relative Caregiver Reimbursement Program Payments

Revision 15-4; Effective October 1, 2015

All Programs

One-time integration payments are exempt from income.

Flexible support payments are exempt from income.

Related Policy
DFPS Relative Caregiver Reimbursement Program Payments, A-1232.13

A—1324.22 Healthy Marriage Development Program Payments

Revision 15-4; Effective October 1, 2015

All Programs

A payment received for completing the Healthy Marriage Development Program is exempt. The advisor must document as required by policy in A-1380, Documentation Requirements.

A—1325 Income from Property

Revision 02-8; Effective October 1, 2002

A—1325.1 Dividends and Royalties

Revision 15-4; Effective October 1, 2015

All Programs

Dividends count as unearned income. Exception: Dividends from insurance policies are exempt as income.

TANF and SNAP

Royalties count as unearned income, less any amount deducted for production expenses and severance taxes.

Medical Programs

Royalties count as unearned income. For allowable expenses, see A-1420, Types of Deductions.

A—1325.2 Payments for Oil, Gas, and Mineral Rights

Revision 15-4; Effective October 1, 2015

All Programs

Payments for oil, gas, and mineral rights count as unearned income.

A—1326 Other

Revision 08-1; Effective January 1, 2008

A—1326.1 Cash Gifts and Contributions

Revision 18-1; Effective January 1, 2018

TANF and SNAP

Cash gifts and contributions count as unearned income unless they:

- are made by a private, nonprofit organization on the basis of need; and
- total $300 or less per household in a federal fiscal quarter. The federal fiscal quarters are January to March, April to June, July to September, and October to December.

If these contributions exceed $300 in a quarter, the excess amount counts as income in the month received.

Exception: Contributions from noncertified household members are budgeted according to policy explained in A-1326.1.1, Contributions from Noncertified Household Members.

Medical Programs

Count cash support only if:

- it is given from a taxpayer to his or her tax dependent;
- it is given by a taxpayer who is someone other than the receiver's spouse or parent; and
- the total amount exceeds $50 a month.

For example, a person gives $100 a month to her nephew and plans to claim her nephew as her tax dependent. This cash support will count for her nephew because the she is a taxpayer giving an amount to her tax dependent. She is not her nephew's parent or spouse, and the amount exceeds $50 a month.

Related Policy
Energy Assistance, A-1326.3
Lump-Sum Payments, A-1242 and A-1331
MyGoals Payments, A-1326.27

A—1326.1.1 Contributions from Noncertified Household Members

Revision 15-4; Effective October 1, 2015

TANF and SNAP

If a noncertified person(s) lives in the home with a TANF/SNAP unit and shares household expenses (no landlord/tenant relationship), any payments the noncertified person makes to the unit for common household expenses (including food, shelter, utilities, and items for home maintenance) are exempt. If a noncertified household member makes additional payments for use by a certified member, it is a contribution.

If a noncertified household member makes payments to a certified member under a formal or informal landlord/tenant relationship, countable income is determined according to the roomer/boarder policy in A-1323.4.3, Noncommercial Roomer/Boarder Payments.

Medical Programs

For contributions from noncertified household members, advisors must follow the policy explained in A-1326.1, Cash Gifts and Contributions, for Medical Programs.

A—1326.1.2 Gifts from Tax-Exempt Organizations

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Gifts from tax-exempt organizations are exempt if the gift is for a child with a life-threatening condition and the amount of the gift is:

- less than $2,000 annually, and

- not converted to cash.

If the gift is converted into cash or exceeds $2,000 a year, the conversion or the excess counts as unearned income in the month of receipt and is exempt as a resource in the months that follow.

Medical Programs

See A-1326.1, Cash Gifts and Contributions, for Medical Programs.

A—1326.2 Child Support

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Payments obtained on behalf of a child count as unearned income. See A-1326.2.1, Counting Child Support, for when to count for Temporary Assistance for Needy Families. Payments are considered as child support if:

- a court ordered the support, or
- the child's caretaker or the person making the payment states the purpose of the payment is to support the child.

Child support collections distributed through the Texas OAG may be received through warrants, direct deposits or the Texas Debit Card. Refer to A-1326.2.1 for the various methods and availability.

Child support payments may be received by a person in Texas through another state's Office of Attorney General. Several other states use debit accounts for the distribution of child support payments.

Note: If DFPS is the payee and the child receives Foster Care Medicaid:

- **With Cash**, child support is exempt.
- **No Cash**, the child support income is counted.

Advisors must contact DFPS child support representatives to verify the amount of child support and dates of disbursements because DFPS may not forward the total legally obligated amount. OAG inquiries are not used in this situation.

See A-1326.15, Income Legally Obligated to Children in Department of Family and Protective Services (DFPS) Conservatorship, for further information on foster care types of assistance.

Advisors must consider the following in determining child support:

- Gifts or donations as contributions are not considered child support. Gifts are items or money that only benefit the child for a specific purpose, such as a birthday present. These gifts or donations include (but are not limited to) clothes, toys, or personal items, or money to purchase clothes, toys, or personal items.
- Ongoing child support income is considered as income to the children, even if someone else living in the home receives it.
- Child support arrears is considered as unearned income to the caretaker.

If an absent parent is making child support payments but moves back into the home of the caretaker and child, the child support is not counted. The earnings and/or other income count as a regular household member.

If a caretaker receives current child support for a nonmember (or a member who is no longer in the home) but uses the money for personal or household needs, the amount counts as unearned income. The amount actually used for or provided to the nonmember for whom it is intended to cover is not counted.

If a single payment covers two or more children (including at least one who is not an applicant/recipient) and the support order does not specify a portion for each child, the payment is prorated among all of the children. When two or more children receive child support from the same father and one child receives Supplemental Security Income, the payment is always prorated.

Medical Programs

Child support is exempt.

A—1326.2.1 Counting Child Support

TANF and SNAP

For child support payments issued via …	funds are …
warrants,	mailed from Austin, Texas, the day after the disbursement date listed on the Texas Child Support Enforcement System (TXCSES) inquiry system. When determining availability, consider the distance the payment has to travel through the mail.
direct deposit/electronic transfers,	available two business days after the disbursement date listed on the TXCSES Web inquiry system.
Texas debit cards,	available two business days after the disbursement date listed on the TXCSES Web inquiry system.

Related Policy
How to Project Income, A-1355
Debit Accounts, A-1231.2

TANF

Applicants are not required to remit any child support received before the certification date. At application and prior to certification, the following procedures may be used to determine the countable child support to budget.

When determining count … …	
eligibility,	all child support already received and/or expected to be received each month, less the $75 disregard. If the countable child support plus other countable income is less than the TANF recognizable needs, proceed to determining the benefit amount.
benefits,	child support received from the beginning of the month through the date of certification, less the $75 disregard. **Exception:** For One-Time TANF, issue the full grant.

Note: If the applicant refuses to remit the child support after signing Form H1073, Personal Responsibility Agreement, prior to certification, a child support penalty is applied.

TANF recipients should be instructed to remit all child support received after the certification date to the OAG. See A-1124, TANF, for instructions on remitting child support payments to the state. Child support payments remitted to the OAG as required are not counted.

Child support received after certification is counted **if** the:

- individual receives an excess payment from the OAG; or
- legal parent keeps payments received directly from the absent parent instead of remitting them to the state.

A sanction is imposed for noncooperation. Child support payments are counted, less the $75 disregard deduction. The advisor must process a claim for any overissuance.

SNAP

Child support counts as unearned income. If a TANF individual remits child support to the state, only the portion the OAG sends to the individual is counted.

Computer Action on Disregard Payment

The OAG sends HHSC a monthly computer tape for all TANF individuals receiving OAG child support payments that month. Each month, the Texas Integrated Eligibility Redesign System (TIERS):

- updates the child support payment history file on SNAP data inquiry; and
- rebudgets any associated SNAP EDG not correctly budgeted. This rebudgeting results in an automated Form TF0001, Notice of Case Action, if rebudgeting results in adverse action.

TANF-State Program

Full child support payments are counted, less the $75 disregard deduction.

A—1326.2.2 Lump-Sum Child Support Payments

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Lump-sum child support payments received or anticipated to be received more often than once a year count as unearned income in the month received. Lump-sum child support payments received once a year or less frequently count as a resource in the month received. See A-1242, Lump-Sum Payments.

Lump-sum payments on child support arrears are received from the following sources:

- **IRS intercept program** — This occurs when the IRS intercepts the absent parent's tax refund to pay child support arrears.
- **Excess payment** — When the OAG sends a second excess payment to the individual, the advisor receives Form H1719, Notice of Excess Payment, with the date and the amount. See the glossary for more information.
- **OAG adjustments** — The advisor receives a PBS-OAGF1 Report, Clients Receiving a Lump Sum Adjustment from OAG-Possible Ineligibility. HHSC produces this report when the OAG makes adjustments to an EDG that result in a lump-sum amount being distributed to the individual. Adjustments may occur when federal distribution changes are implemented, court orders are modified, or EDG errors are corrected.

Lump-sum payments on current child support are received from the following sources:

- **Advance pay** — Advance pay occurs when the absent parent is current on obligated amounts and voluntarily pays an amount in advance of the obligated monthly amount. **Example:** The absent parent is obligated to pay $200 a month and is current on that amount. The absent parent loses his job and receives a severance payment of $2,000 and decides to pay $1,000 in advance to cover child support for the next five months. The payment to the individual counts as a resource in the month received.
- **Future pay** — Future pay occurs when the absent parent is current on obligated amounts and voluntarily and routinely pays an extra amount over the obligated amount. **Example:** The absent parent is obligated to pay $200 a month and is current on that amount. The absent parent pays $25 extra each month (or some months). The OAG releases the money as received. This payment counts as unearned income if the advisor can anticipate that it will be received more often than once a year.

Related Policy
Calculating Household Income, A-1350
TXCSES Menu Screens, C-832.2

A—1326.2.3 Medical Support Payments

Revision 15-4; Effective October 1, 2015

All Programs

When a court order is entered, it designates the amount of child support and/or medical support a parent receives on behalf of the children. Medical support is in the form of:

- health insurance, ordered in addition to child support; or
- a cash amount for the purpose of offsetting medical expenses.

TANF and SNAP

If the individual does not receive Medicaid and is responsible for paying medical expenses, the payments are considered a reimbursement and the policy for reimbursement in A-1332, Reimbursements, applies.

Cash medical support payments the individual receives and remits to Third Party Recovery (TPR) are not counted. Any of the cash medical support payment from the absent parent that the individual continues to keep counts as income.

Related Policy
Remitting Cash Medical Support Payments to the Third-Party Resources (TPR) Unit, A-861.5
TANF, A-1124
Reimbursements, A-1332

Medical Programs

Medical support payments are exempt.

If the individual has an open child support case with the OAG for children receiving Medicaid, the OAG processes medical support payments through an interface with HHSC/TPR, and the individual does not receive a direct payment. If an individual is not referred to the OAG for services and is receiving or begins receiving cash medical support payments, the individual is required to remit the payments to the TPR unit.

A—1326.3 Energy Assistance

Revision 15-4; Effective October 1, 2015

All Programs

Energy or utility payments and supplements are paid to or on behalf of the TANF, SNAP, and Medical Programs households from various governmental and private sources. The assistance may be in the form of cash, vendor, in-kind, and two-party check payments.

The chart below indicates when to exempt or count energy/utility assistance as TANF, SNAP, and Medical Programs income. **Note:** If an energy assistance payment is combined with other payments, only the energy assistance portion is exempt from income (if applicable).

Source	Type Payment	TANF	SNAP	Medical Programs
Federally-funded, state, or locally administered programs including CEAP, weatherization, Energy Crisis, and one-time payments for emergency repairs of a heating or cooling device (down payment and final payment)	• Vendor • In-kind • Two-party check • Cash	Exempt	Exempt	Exempt
Energy assistance received through HUD, U.S. Department of Agriculture's Rural Housing Service (RHS) or Farmer's Home Administration (FmHA)	• Vendor • In-kind • Two-party check • Cash	Exempt	Exempt	Exempt
State or local government-funded utility supplement or energy assistance payments (not federally-funded)	• Vendor • In-kind • Two-party check	Exempt	Exempt	Exempt
State or local government-funded utility supplement or energy assistance payments (not federally-funded) State or local government-funded utility supplement or energy assistance payments (not federally-funded)	• Cash	Exempt	Count	Exempt

Source	Type Payment	TANF	SNAP	Medical Programs
Private nonprofit organization	• Vendor • In-kind • Two-party check	Exempt	Exempt	Exempt
Private nonprofit organization	• Cash	Count per A-1326.1, Cash Gifts and Contributions	Count per A-1326.1	Exempt
State or federal regulated utility company, a municipal utility company, or a supplier of home heating oil or gas	• Vendor • In-kind • Two-party check	Exempt	Exempt	Exempt
State or federal regulated utility company, a municipal utility company, or a supplier of home heating oil or gas	• Cash	Exempt	Count	Exempt

A—1326.4 Foster Care and Permanency Care Assistance (PCA) Payments

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

Foster care or permanency care payments are exempt.

TANF

Do not include a person receiving foster care or permanency care payments in a TANF budget or certified group.

SNAP

If a foster parent or caregiver chooses to exclude a foster/PCA child/adult from the certified group:

- the foster care/PCA income for the foster/PCA child/adult who is excluded from the certified group is exempt; and
- all other income received by the excluded foster/PCA child/adult is exempt.

If a foster parent or caregiver chooses to include a foster/PCA child/adult in the certified group:

- the foster care/PCA income counts as unearned income for the foster/PCA child/adult;
- any other non-exempt income received by the foster/PCA child/adult is counted; and
- the foster care/PCA income under the foster/PCA child's/adult's name is budgeted for whom the payment is intended.

Related Policy
Who Is Not Included, A-222, No. 8

A—1326.5 In-Kind Income

Revision 15-4; Effective October 1, 2015

All Programs

In-kind income is exempt.

A—1326.6 Interest

Revision 17-1; Effective January 1, 2017

All Programs

Interest counts as unearned income unless specifically excluded.

Note: “Note interest” is one type of interest that is also counted as unearned income.

A—1326.7 Loans (Noneducational)

Revision 15-4; Effective October 1, 2015

All Programs

Financial assistance is considered a loan if:

- there is an understanding that the individual will repay the money; and
- the individual can reasonably explain how the loan will be repaid.

These loans are exempt from income. Contributions that are not considered loans must be considered as explained in A-1326.1, Cash Gifts and Contributions.

Note: See A-1234, Noneducational Loans, for policy on treating loans as a resource.

A—1326.8 Plan for Achieving Self-Sufficiency (PASS)

Revision 15-4; Effective October 1, 2015

All Programs

Any amount an SSI recipient deposits into a PASS account or uses toward completion of a PASS plan is exempt.

Note: If the PASS contribution is made from earned income, the advisor should enter the PASS income in the Employer – Employee Screen – Amount Totals – PASS Income. TIERS will deduct the PASS contribution from the gross earnings.

A PASS can be, but is not limited to, money that is:

- deposited into a savings account to purchase a vehicle for employment transportation;
- deposited into a savings account to start a new business; or
- used toward an educational program.

The PASS plan must be approved by the Social Security Administration.

The SSI recipient will receive a notice from SSA approving or disapproving the PASS plan. Advisors may use this notice as verification of the PASS plan.

Related Policy
Individual Development Accounts (IDAs), A-1231.3

A—1326.9 Pensions

Revision 15-4; Effective October 1, 2015

All Programs

A pension is any benefit derived from former employment (such as retirement benefits or a disability pension). A pension counts as unearned income.

A—1326.10 Trust Funds

Revision 15-4; Effective October 1, 2015

All Programs

Withdrawals or dividends that the household can receive from a trust fund (also referred to as trust payments) count as unearned income.

Related Policy
Trust Funds, A-1237

A—1326.11 Resettlement-Reception and Placement (R&P)

Revision 15-4; Effective October 1, 2015

All Programs

R&P payments are exempt.

A—1326.12 Refugee Cash Assistance (RCA)

Revision 15-4; Effective October 1, 2015

TANF

Individuals can receive RCA only if they are not eligible for TANF.

SNAP

RCA counts as income in the month received.

Medical Programs

RCA income is exempt.

A—1326.13 Match Grant

Revision 15-4; Effective October 1, 2015

TANF

Individuals can receive Match Grant only if they are not eligible for TANF.

SNAP

Follow the policy in A-1326.1, Cash Gifts and Contributions.

Medical Programs

Match Grant is exempt.

A—1326.14 Spousal Diversion and Dependent Allowance

Revision 15-4; Effective October 1, 2015

TANF and SNAP

The portion of income from a spouse or parent in a nursing facility that is diverted to the family members living in the community counts as unearned income.

The spousal diversion and dependent allowance are determined by the Medicaid for the Elderly and People with Disabilities worker processing the application for nursing facility coverage. When nursing facility coverage is approved and disposed, TIERS will add this income in the community family member's approved Texas Works (TW) EDGs upon running Eligibility. Advisors do not make Data Collection entries for this income.

Medical Programs

Spousal diversion payments are exempt.

A—1326.15 Income Legally Obligated to Children in Department of Family and Protective Services (DFPS) Conservatorship

Revision 15-4; Effective October 1, 2015

All Programs

DFPS has systems in place to become a payee for legally obligated income the child received prior to DFPS taking conservatorship. This income may include (but is not limited to) child support, RSDI and SSI.

Foster care (FC) types of assistance (TOA) are identified in TIERS Inquiry as:

- Foster Care – Federal Match – With Cash,
- Foster Care – No Federal Match – With Cash,
- Foster Care – No Federal Match – No Cash, and
- Foster Care – Federal Match – No Cash.

Federal Match identifies Medicaid paid by matched funds from the federal government. **No Federal Match** identifies state-paid Medicaid only without matching federal funds. **With Cash** types of assistance (with or without federal match) indicate that the foster parent receives FC financial assistance for an FC child in addition to FC Medicaid. **No Cash** indicates the foster parent does not receive an FC financial payment but DFPS provides FC Medicaid only.

When reviewing inquiry systems such as WTPY/SOLQ and OAG, and DFPS is identified as the payee for the legally obligated income:

- The legally obligated income for an FC child who is receiving FC **With Cash** is not counted since DFPS keeps the legally obligated income.
- Legally obligated income for the FC child who receives FC **No Cash** is counted since DFPS sends the legally obligated income to the foster parent.
- The legally obligated income is counted when a child is placed back in the home of the individual from whom the child was removed. DFPS remains the conservator of the child receiving FC **No Cash**, and the legally obligated income is not forwarded. The individual must inform the income source they are now the payee. If DFPS has not already provided the issuing agency this verification, that agency must verify with DFPS before changing the payee.
- FC and Adoption Assistance (AA) children placed in Texas from another state will receive a TOA **No Cash** from DFPS in Texas. However, the child may receive an FC or AA payment from the home state. When a child is receiving FC or AA in Texas and is from another state, the advisor must contact the home state to verify any countable legally obligated income.

Examples:

- A child receives SSI. DFPS removes the child from the custody of her mother. DFPS becomes the payee for the child's SSI.
- The child is placed with a foster parent. The child receives FC – Federal Match – With Cash. The foster parent chooses to include the child in the foster parent's SNAP household. The child is added to the foster parent's SNAP EDG. Since the child receives an FC payment, DFPS retains the child's SSI. The FC payment and SSI are not budgeted in the SNAP EDG because the FC payment is exempt income and DFPS keeps the SSI income.
- Months later, DFPS places the child with her great-aunt. The child now receives FC – Federal Match – No Cash. The child's great-aunt chooses to include the child in the great-aunt's SNAP household. The child is removed from the former foster parent's EDG and is added to her great-aunt's EDG and SNAP EDG. DFPS remains the payee for the child's SSI but sends it to her great-aunt. The SSI must be counted in the SNAP budget.
- Several months later, DFPS places the child back with her mother; however, DFPS retains conservatorship. The child continues to receive FC – Federal Match – No Cash. DFPS informs the SSA that the child now resides with her mother. The child's mother must inform SSA to have the child's SSI sent to her. The SSI must be counted in the SNAP budget.

Note: DFPS does not become the payee for children who receive adoption assistance.

A—1326.16 Welfare-to-work Income

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Welfare-to-work income is exempt.

Medical Programs

Welfare-to-work income is counted as earned income.

A—1326.17 Alimony (Spousal Support) Received

Revision 15-4; Effective October 1, 2015

All Programs

Alimony, also referred to as spousal support, is payments received from a spouse or former spouse under a divorce or separation decree.

Alimony received is counted as unearned income for the individual who received the payment.

A—1326.18 Annuity

Revision 15-4; Effective October 1, 2015

All Programs

An annuity is a series of payments paid under a contract and made at regular intervals over a period of more than one full year. Payments can be either fixed (under which one receives a definite amount) or variable (not fixed). An individual can buy the contract alone or with the help of an employer.

Annuity payments are counted as unearned income.

A—1326.19 Capital Gains

Revision 15-4; Effective October 1, 2015

Capital gains are profit from the sale of property or of an investment when the sale price is higher than the initial purchase price (for example, profits from the sale of stocks, bonds, or from the sale of real estate).

TANF and SNAP

Capital gains are exempt.

Medical Programs

Capital gains are counted as unearned income.

A—1326.20 Housing Allowance

Revision 17-4; Effective October 1, 2017

SNAP and TANF

Follow policy in A-1323.3, Military Pay Allotments and Allowances, or A-1324.4, Government Housing Assistance, for specific types of housing allowances. Housing allowances not addressed in A-1323.3 or A-1324.4 are counted as unearned income.

Medical Programs

Follow policy in A-1323.3, Military Pay Allotments and Allowances, or A-1324.4, Government Housing Assistance, for specific types of housing allowances.
Housing allowances provided as compensation for ordained, commissioned or licensed members of the clergy are excluded from MAGI budgeting if:

- the employing church or organization officially designates the payment as a housing allowance before it makes the payment;
- the total amount of the allowance does not exceed the total cost of renting or purchasing the home, including furnishings and utilities; and
- the amount of the allowance does not exceed the value of the services the individual provides as a member of the clergy. If the housing allowance exceeds the housing costs or value of services provided, count the excess amount as earned income.

Housing allowances not addressed in A-1323.3, A-1324.4, or considered a housing allowance for a clergy member are counted as unearned income.

A—1326.21 Life Estate

Revision 15-4; Effective October 1, 2015

All Programs

Life estate income is income an individual receives from ownership of property that an individual only possesses ownership of for the duration of one's life (for example, rental income).

Life estate income is counted as unearned income.

A—1326.22 Jury Duty Pay

Revision 15-4; Effective October 1, 2015

Jury duty pay is taxable income received from jury duty as compensation.

TANF and SNAP

Jury duty pay is exempt.

Medical Programs

Jury duty pay is counted as unearned income.

A—1326.23 Court Awards

Revision 15-4; Effective October 1, 2015

Court awards are taxable money that an individual receives as the result of a lawsuit (for example, compensation for lost wages or punitive damages awards).

TANF and SNAP

Follow policy in A-1331, Lump-Sum Payments.

Medical Programs

Court awards income is counted as unearned income.

A—1326.24 Canceled Debt

Revision 15-4; Effective October 1, 2015

Canceled debts are debts that have been canceled, forgiven, or discharged, and the canceled amount is included as countable income on federal income tax returns (for example, loan foreclosures or canceled credit card debt).

TANF and SNAP

Canceled debt income is exempt.

Medical Programs

Canceled debt income is counted as unearned income.

A—1326.25 Achieving a Better Life Experience (ABLE) Accounts

Revision 17-1; Effective January 1, 2017

Achieving a Better Life Experience (ABLE) programs allow individuals (beneficiaries) who become blind or disabled before age 26 to establish tax-free savings accounts for the designated beneficiary's disability-related expenses.

All Programs

Contributions to an ABLE account from individuals other than the designated beneficiary, and any distributions from an ABLE account, are not considered income to the designated beneficiary.

Income of the designated beneficiary, or an individual whose income is considered when determining eligibility, that is deposited into an ABLE account, remains countable income when determining eligibility.

TANF and SNAP

Interest and dividends earned on an ABLE account are exempt.

Medical Programs

Interest and dividends earned on an ABLE account are countable as unearned income.

Related Policy:

Achieving a Better Life Experience (ABLE) Accounts; A-1231.6

A—1326.26 School-Based Savings Accounts

Revision 17-1; Effective January 1, 2017

School-Based Savings Accounts are accounts set up by students or their parents at financial institutions that partner with school districts. The accounts are intended to help students save for higher education.

TANF and SNAP

Interest earned on School-Based Savings Accounts is exempt.

Medical Programs

Interest earned on School-Based Savings Accounts is countable as unearned income.

Related Policy

School-Based Savings Accounts, A-1231.7

A—1326.27 MyGoals Payments

Revision 18-1; Effective January 1, 2018

MyGoals payments are cash payments received by participants in the MyGoals for Employment Success demonstration project. The demonstration studies the impact of combining workforce development and financial payments on employment outcomes for recipients of the Housing and Urban Development, Section 8 Rental Assistance. Only residents within the jurisdiction of the Houston Housing Authority are selected to participate in the project.

All Programs

MyGoals payments are counted as cash contributions made by a private, nonprofit organization according to policy in A-1326.1, Cash Gifts and Contributions.

A—1330 Types of Payments

Revision 04-3; Effective April 1, 2004

A—1331 Lump-Sum Payments

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Lump sums received once a year or less are exempt, unless specifically listed as income. These sums are considered as a resource in the month received, and the policy in A-1242, Lump-Sum Payments, applies.

Note: Retroactive or restored payments are considered to be lump-sum payments and count as a resource. Any portion that is ongoing income is separated from a lump-sum amount and counted as income.

Example: A person receives a lump-sum payment in the amount of $4,950 from the SSA in the month of March. Effective that same month, the person receives his first monthly RSDI payment of $950, which is included in the $4,950 lump-sum payment. Staff must budget the $950 RSDI payment beginning with the month of March as an ongoing payment and consider the $4,000 as a lump-sum payment.

A lump-sum payment counts as income in the month received if the individual gets it or expects to get it more often than once a year.

Exceptions: Contributions, gifts, and prizes count as unearned income in the month received, regardless of frequency of pay.

If a lump sum reimburses a household for burial, legal, medical bills or damaged/lost possessions, the countable amount of the lump sum is reduced by the amount earmarked for these items.

Federal tax refunds and EICs are exempt as income.

Medical Programs

All lump-sum payments are counted as income in the month they are received.

Note: Award prizes are considered lump-sum payments and are counted in the month they are received.

Related Policy
Cash Gifts and Contributions, A-1326.1
Federal Tax Refunds and Earned Income Tax Credits (EIC), A-1232.2

A—1332 Reimbursements

Revision 15-4; Effective October 1, 2015

TANF

A reimbursement (not to exceed the individual's expense) is exempt if it is provided specifically for a past or future expense:

- that is not included in HHSC's standard of need, or
- for medical needs that are not paid by Medicaid.

If the reimbursement exceeds the individual's expenses, any excess counts as unearned income. A reimbursement to exceed the individual's expenses is not considered unless the individual or provider indicates the amount is excessive.

Note: A reimbursement for future expenses is exempt only if the individual plans to use it as intended.

SNAP

A reimbursement (not to exceed the individual's expense) provided specifically for a past or future expense other than a normal living expense is exempt.

If the reimbursement exceeds the individual's expenses, any excess counts as unearned income. A reimbursement is not considered to exceed the individual's expenses unless the individual or provider indicates the amount is excessive.

Note: A reimbursement for future expenses is exempt only if the individual plans to use it as intended.

Medical Programs

A reimbursement is exempt. Reimbursements include private insurance payments.

A—1333 Third-Party Beneficiary

Revision 15-4; Effective October 1, 2015

All Programs

Money an individual receives that is intended and used for maintenance of a nonmember is exempt.

If an individual receives a single payment for more than one beneficiary, the amount actually used for the nonmember is excluded up to the nonmember's identifiable portion or prorated portion, if the portion is not identifiable.

A—1334 Vendor Payments

Revision 15-4; Effective October 1, 2015

All Programs

Payments that a person or organization outside the household makes directly to the individual's creditor or person providing the service are exempt.

TANF and SNAP

Exception: Money legally obligated to the household, but which the payer makes to a third party for a household expense is counted as income.

Example: In a SNAP EDG, the absent parent is court-ordered to pay $400 a month. Instead, the absent parent pays $150 cash support and also pays $300 of the custodial parent's rent directly to the landlord for a total of $450. The $150 cash and $250 of the vendor-paid rent counts as child support, since that portion is legally obligated to the individual. The $50 amount over the legally obligated child support of $400 is considered an exempt vendor payment.

Related Policy
Cash Gifts and Contributions, A-1326.1
Child Support, A-1326.2

A—1334.1 Vendor Payments from State and Local Government Funds

Revision 15-4; Effective October 1, 2015

SNAP

All vendor payments made for a household with a migrant farm worker in the workstream that are paid with state or local government funds are exempt.

Vendor payments paid to other people with state or local government funds are counted unless the payment provides assistance for:

- medical expenses,
- child care, or
- expenses related to natural disasters (for example, fires or floods).

Note: Vendor payments paid with federal funds (for example, federally funded housing assistance) are exempt. Policy in A-1326.3, Energy Assistance, applies.

TANF and Medical Programs

Vendor payments from state and local government funds are exempt.

A—1340 Income Limits

Revision 08-1; Effective January 1, 2008

A—1341 Income Limits and Eligibility Tests

Revision 15-4; Effective October 1, 2015

TANF

There are two eligibility tests for TANF.

Budgetary Needs Test

The budgetary needs test is the first eligibility test for the household. This test applies to all households who have not received TANF in the last four months (in Texas or another state).

If an unmet need of less than 50 cents remains, the household is ineligible.

Recognizable Needs Test

The recognizable needs test is the final eligibility test for the household. This test applies to all applicant and certified households.

The recognizable needs test has two parts. Applicant households (those subject to the budgetary needs test) must pass both Part A and Part B. All other households must pass only Part B.

If an unmet need of one cent or more remains, the household is eligible.

Needs Tests Instructions

All countable earned and unearned income is included:

- Total the gross earned and unearned income for each individual.
- Add the amount of any applied income.
- Subtract the child support disregard, if applicable.

- Subtract the standard work-related expense (not to exceed the member's monthly earned income) for each member who qualifies for it and who has countable earnings.
- Subtract each member's allowable costs for dependent care (up to the maximum).
- Subtract any child support expense.
- Compare the net income to the budgetary needs amount in C-111, Income Limits. If the net income is 50 cents or more, the household passes the budgetary needs test.

Note: If there is a diversion amount and someone other than the individual with diversions has countable income (or two members with joint diversions both have countable income), each member's income/earned income deductions are computed separately until after subtracting the **actual** amount allowed to be diverted from each individual's income. Then the total net incomes are combined.

When two members have joint diversions, any amount of the diversion that exceeds one member's income can then be diverted from the other member's income.

- Subtract 1/3 of the net income for applicants with earned income who have not been active TANF in the last four months.
- Subtract 90 percent of the remaining earnings (up to a cap of $1,400). Allow this deduction for each employed household member who is eligible for it. The individual can receive this deduction for four months in a 12-month period. The four months do not have to be consecutive. **Note:** Do not count a month in which a full-family sanction is imposed as one of the 90 percent earned income deduction (EID) months.

Note: If there is a diversion amount and someone other than the individual with diversions has countable income (or two members with joint diversions both have countable income), each member's income/earned income deductions are computed separately until after subtracting the **actual** amount allowed to be diverted from each individual's income. Then the adjusted gross incomes are combined.

When two members have joint diversions, any amount of the diversion that exceeds one member's income can then be diverted from the other member's income.

For each household member with earnings, the deductions cannot exceed the individual's total income. This also applies when there is more than one household member with earnings and/or diverted income.

The adjusted income should be compared to the recognizable needs amount in C-111, Income Limits. If the adjusted income is one cent or more, the household passes the recognizable needs test.

The adjusted income is subtracted from the maximum grant amount in C-111 to determine the benefit amount.

Related Policy
Child Support Deductions, A-1421
$75 Disregard Deduction, A-1422
Dependent Care Deduction, A-1423
Diversions, Alimony, and Payments to Dependents Outside the Home, A-1424
Work-Related Expense ($120 and 20%), A-1425.1
1/3 Disregard for Applicants, A-1425.2
90% Earned Income Deduction, A-1425.3
Income Limits, C-111

SNAP

There are two eligibility tests for SNAP.

Gross Income Test

Gross income is the total countable income. This test applies to all households except those:

- with a member who is elderly or has a disability as specified in B-430, Households with Elderly Members or Members with a Disability; or
- that are categorically eligible.

To be considered categorically eligible, all household members must be approved for TANF or SSI, or a combination of TANF and SSI, or the household must meet resource criteria and have gross income below or equal to 165 percent FPIL for its size.

A household subject to the gross income test is ineligible if unrounded gross income exceeds the limit by one cent or more.

Note: For households with a deductible farm loss, the loss is subtracted before applying the gross income test.

Net Income Test

Net income is the gross income minus allowable deductions. This test applies to all households, except categorically eligible households.

Note: The net income test applies to a household with a member who is elderly or has a disability if the household's gross income exceeds 165 percent FPIL and the household does not meet categorically eligible requirements.

If a household's rounded income exceeds the net income limits, the household is ineligible. Fifty cents or more is rounded up; 49 cents or less is rounded down. The EDG is denied if net income results in zero allotment for the initial and ongoing months.

TIERS will assign the appropriate income test at Eligibility Summary after running Eligibility Determination Benefit Calculation (EDBC).

Related Policy
Maximum Income Limits, C-121
Benefits, A-2322

Medical Programs

For Medical Programs, MAGI financial eligibility is determined by comparing the applicable program income limit defined in C-130, Medical Programs, and the MAGI household income calculated using **Step 1** through **Step 5** below.

Advisors must use the following five steps in the specified order for **each individual applying for benefits** to determine MAGI financial eligibility for each individual.

Step 1 — Determine MAGI Household Composition

The MAGI household composition for the individual, as explained in A-240, Medical Programs, will be used to complete Steps 2, 3, 4, and 5.

Step 2 — Determine MAGI Individual Income

Identify and list all income, expenses, and overpayments for each individual in the MAGI household.

Form H1042, Modified Adjusted Gross Income (MAGI) Worksheet: Medicaid and CHIP, is used for each person included in the individual's MAGI household composition to list and calculate:

- earned income;
- unearned income;
- self-employment income;
- AI/AN disbursement;
- overpayments; and
- expenses.

Step 3 — Determine Whether Any Exemptions Apply to MAGI Household Income

If an individual meets one of the following exceptions for the taxable year in which Medicaid or Children's Health Insurance Program (CHIP) eligibility is requested, their MAGI individual income is not included when calculating MAGI household income (as explained in **Step 4**).

Exception 1:

An individual is a child who is:

- under age 19;
- included in the MAGI household composition of a parent; and
- not expected to be requiredto file a federal income tax return since the child's monthly income is below the monthly IRS income threshold listed in C-131.5, IRS Monthly Income Thresholds.

Exception 2:

An individual is a tax dependent who is:

- included in the MAGI household composition of the taxpayer claiming them as a tax dependent; and
- not expected to be required to file a federal income tax return since the tax dependent's monthly income is below the monthly IRS income threshold listed in C-131.5.

If an individual meets the criteria for Exception 1 or 2 and does not have any income, it is not necessary to determine whether the individual is expected to be required to file an income tax return, since there is no income to compare with the IRS income threshold. The advisor should move to **Step 4** at this point.

Note: Even if an individual's tax status is "non-taxpayer/non-tax dependent," the individual may be "expected to be required to file" a federal income tax return based on the IRS threshold amounts.

For individuals who are expected to be required to file a federal income tax return, all MAGI individual income from Step 2 counts in every household composition in which that individual is included.

If a child meets **Exception** 1:

- his or her income is excluded from the MAGI household income of every applicant or recipient whose MAGI household composition includes that child; and
- the child's income is exempt from his or her own MAGI household income.

If a tax dependent meets **Exception** 2:

- the tax dependent's income is excluded from the MAGI household income of the taxpayer who plans to claim that individual on a federal income tax return for the taxable year in which Medicaid or CHIP eligibility is requested; and
- this tax dependent's MAGI individual income counts in his or her own MAGI household income and counts in the MAGI household income of everyone else in whose MAGI household they are included.

If an individual meets the criteria for both exceptions — a child under age 19 included in the MAGI household composition of a parent **and** a tax dependent included in the MAGI household composition of the taxpayer — Exception 1 applies. Exception 1 is more beneficial for the child, because the child's income would then be exempt from the child's MAGI individual income.

Example: A child, age 9, lives with her mother, has no income, and her mother expects to claim the child on her federal income tax return. The child would meet Exception 1 and Exception 2. For the purposes of exempting the child's income, the child is considered a child under age 19 (Exception 1). Since the child has no income, there is no need to compare her income to the tax thresholds, because there is no income to exempt. If the child did have income under the threshold, it would be more beneficial to allow her Exception 1 so that her income would not be counted on her own MAGI household income.

Step 4 — Calculate MAGI Household Income

First, the MAGI individual income for each person included in the applicant's or recipient's MAGI household composition is calculated by:

- adding earned income, unearned income, self-employment income, and AI/AN disbursements (if AI/AN status is not verified as explained in A-1370, Verification Requirements, Medical Programs, or the income source is not verified);
- subtracting overpayments; and
- subtracting expenses.

	Person 1	**Person 2**	**Person 3**	**Person 4**
Total earned/unearned income				
Add	+	+	+	+
Total self-employment Income				
Add	+	+	+	+
Total AI/AN disbursement				
Subtract	-	-	-	-
Total recoupment of overpayments				
Subtract	-	-	-	-
Total expenses				

Equals = = = =

MAGI Individual Income

Second, the MAGI individual income for all persons included in the applicant's or recipient's MAGI household composition must be totaled. Anyone's income (as applicable) based on Exceptions 1 and 2 from Step 3 is exempt.

Add MAGI Individual Income + + + =

Third, the standard MAGI income disregard, listed in C-131.4, Standard MAGI Income Disregard, by MAGI household size, must be subtracted from the sum of the MAGI individual incomes to get the MAGI household income. The standard MAGI disregard is an income disregard equal to five percentage points of the FPIL. It is a standard amount based on the applicable household size across all Medical Programs that use MAGI rules to determine income.

Sum of MAGI Individual Incomes

Subtract -

Standard MAGI Disregard

Equals =

MAGI Household Income

Note: The standard MAGI income disregard is updated annually based on the annual updates to the FPIL.

Step 5 — Determine MAGI Financial Eligibility

The individual's eligibility is determined by comparing whether the applicant's or recipient's MAGI household income is less than or equal to the income limit of the applicable program based on FPIL and MAGI household size.

Steps 1 to 5 must be repeated for each individual applying for Medical Programs.

Related Policy
Income Limits, C-131
Guidelines for Providing Retroactive Coverage for Children and Medical Programs, C-1114
Who Is Included, A-241.1

A—1341.1 Grant Amount

Revision 15-4; Effective October 1, 2015

TANF

The TANF grant amount is the amount of the monthly benefit. The TANF grant is approximately 17 percent FPIL. The federal government periodically adjusts the FPIL.

After the household passes the recognizable needs test, the recommended grant amount is calculated. The advisor subtracts the household's adjusted gross income (rounded down to the nearest dollar) from the maximum grant amount allowed for the household's size and

composition. See C-111, Income Limits.

The minimum grant amount is $10. The household is eligible to receive the minimum grant if the recommended grant amount is less than $10.

Benefits of less than $10 are issued only for:

- supplemental payments; and
- payments made after processing a recoupment.

A—1350 Calculating Household Income

Revision 15-4; Effective October 1, 2015

All Programs

A household's income is computed to determine eligibility and benefit amount. Household income is computed by using:

- actual income (income that was already received), or
- projected income amounts (not received but expected).

Notes:

- Both actual income amounts and projected income amounts for the current month are used to determine eligibility and benefits.
- For households paid on a monthly or semi-monthly basis, income is counted for the month it is intended if the household receives:
  - the income in a different month because of a change in the mailing cycle or pay date; or
  - an additional or missed payment because of weekends or holidays.

Exception: A-1355.2, How to Use Texas Workforce Commission (TWC) Quarterly Wage Information to Budget Earned Income, may be used when using the TWC wage record to calculate income.

TANF

If a child lives with a married relative (not a parent) who wants to be the caretaker, eligibility and benefits are determined using:

- normal budgeting for the applicant's income, and
- stepparent budgeting for the income of the applicant's spouse.

Medical Programs

See A-1341, Income Limits and Eligibility Tests, for Medical Programs.

A—1351 Irregular and Unpredictable Income

Revision 15-4; Effective October 1, 2015

SNAP

Income that is irregular and unpredictable is exempt if both of the following conditions apply:

- The anticipated income will be less than or equal to $30 per household in a federal fiscal quarter; and
- The individual receives the income too infrequently or too irregularly to reasonably anticipate it. "Reasonably anticipate" means the individual knows:
  - who the income will come from,
  - in what month it will be received, and
  - how much it will be.

A—1352 Terminated Income

Revision 15-4; Effective October 1, 2015

All Programs

Terminated income counts in the month received. Actual income must be used and conversion factors are not used if terminated income is less than a full month's income.

Income is terminated if it will not be received in the next usual payment cycle.

Income is not terminated if:

- someone changes jobs while working for the same employer;
- an employee of a temporary agency is temporarily not assigned;
- a self-employed person changes contracts or has different customers without having a break in normal income cycle; or
- someone receives regular contributions, but the contributions are from different sources.

A—1353 How to Convert Income to Monthly Amounts

Revision 15-4; Effective October 1, 2015

All Programs

If actual or projected income is not received monthly, the income should be converted to monthly amounts using one of the following methods:

- Divide yearly income by 12.
- Multiply weekly income by 4.33.
- Add amounts received twice a month (semi-monthly).
- Multiply amounts received every other week by 2.17.

Note: A-1355.2, How to Use Texas Workforce Commission (TWC) Quarterly Wage Information to Budget Earned Income, can be used for converting TWC wages.

A—1353.1 Converting New Semi-Monthly Income

Revision 15-4; Effective October 1, 2015

All Programs

The following procedures should be followed if an individual has a new source of semi-monthly income and has not received enough checks to reliably project the income:

1. Determine the estimated number of hours the individual will work per week.
2. Estimate weekly gross income by multiplying the weekly estimated hours by the hourly wage.
3. Determine the monthly projected gross income by multiplying the estimated weekly gross income by 4.33.
4. To determine the semi-monthly income amount to enter on the income screen, divide monthly gross income by two.

A—1354 How to Budget Actual Income

Revision 15-4; Effective October 1, 2015

All Programs

Actual income is income that has already been received. Actual income is budgeted by:

- determining the actual income received in a past month; and
- converting the averaged amount to a monthly amount. See A-1353, How to Convert Income to Monthly Amounts, for instructions on how to convert income to a monthly amount.

Actual income should not be converted when:

- determining eligibility for three months prior Medicaid; or
- the income received from a new or terminated source is less than a full month's income.

Note: A-1355.2, How to Use Texas Workforce Commission (TWC) Quarterly Wage Information to Budget Earned Income, can be used for budgeting TWC wages.

A—1355 How to Project Income

Revision 15-2; Effective April 1, 2015

All Programs

Projected income is income a person has not received, but expects to get. To project income:

1. Evaluate the household's income and circumstances with the person.
2. Budget income in the month the person anticipates getting it. Budget:

- actual income received as of the interview date (or the date the information was requested), and
- income that can be reasonably anticipated for pay periods after the interview or information request date. "Reasonably anticipated" means the person knows:
  - the source of the income,
  - in what month the person will get the income, and
  - what amount of income the person will get.

3. When a person does not get income monthly but anticipates getting a full month's income, convert it to a monthly amount using conversion factors.
4. When a person gets an additional payment outside the regular payment cycle, convert the regular payments and add the additional payment to the converted amount.

Note: To determine the date income can be reasonably anticipated, use factors specific to the source of income, distance it has to travel through the mail, electronic transfers, weekends and holidays.

For people getting unemployment insurance benefits, determine the availability of funds in the account by adding one business day to the payment date listed on the Texas Workforce Commission Inquiry Benefit Payment screen, excluding weekends and holidays.

For child support payments disbursed through the Texas debit card, follow policy in A-1326.2.1, Counting Child Support.

Fluctuating Income

If income is ongoing, but the amounts fluctuate, it is best to anticipate income by averaging income from past pay periods. When using this method:

- Verify at least two pay amounts in the time period beginning 45 days before the file date through the interview date (or the date the EDG is being processed if an interview is not required).
- Continue to enter amounts for all pay periods in the required budget months, using either year-to-date (YTD) amounts or the average amount of received payments for any unverified pay dates.

If the household states the payments are representative of current income, use YTD amounts, if available, for missing pay periods and use the average amount of verified payments for other unverified pay periods in all budget months. Use more than two pay amounts if they are available, but do not pend to require more than two pay amounts when a person says the pay amounts are representative of current income and the statement is not questionable.

Exception: For Children's Medicaid, see policy in A-1371, Verification Sources.

Use a different method to anticipate income when someone has a new job, seasonal fluctuations occur, or expected changes (such as changes in work hours or rate of pay) cause too many past amounts to be unrepresentative of current income.

Different methods of anticipating future income are:

- asking the employer for an estimate,
- using less than the required number of pay periods when they are not all available,
- multiplying anticipated hours by the rate of pay, or
- other methods.

Always document the reason and calculations for the method used.

Example: When an applicant has paychecks, use the YTD amounts to find any missing pay amounts, if possible. In this situation, the gross pay on the checks is representative of current income.

Pay Date	Gross Pay Amount	YTD
05/11	(missing paycheck)	(missing paycheck)
05/25	$265.50	$4,675.93
06/09	(missing paycheck)	(missing paycheck)
06/23	$262.84	$5,199.18

You must have the checks before and after the missing paycheck. Take the YTD gross amount of the check prior to the missing paycheck and subtract it from the check received directly after the missing paycheck.

$5,199.18 YTD of check dated 06/23

−$4,675.93 YTD of check dated 05/25

$523.25 Difference of the YTD amounts

Then subtract the gross pay amount of the paycheck received after the missing paycheck from the difference of the YTD amounts.

$523.25 Difference of the YTD amounts

−$262.84 Gross pay amount of check dated 06/23

$260.41 Gross pay amount of check dated 06/09

Then add the three amounts together and divide by three to determine the average for the other missing pay period.

$265.50 Gross amount of 05/25

+$260.41 Gross amount of 06/09

+$262.84 Gross amount of 06/23

$788.75 ÷ 3 = $262.92 Average to use for check dated 05/11

Non-Fluctuating Income

All Programs (except TP 43, TP 44 and TP 48)

- Verify that a source of income (earned or unearned) does not fluctuate.
- Verify the frequency of the payment.
- Require gross pay from only one payment received in the 45 days before the file date through the interview date if the individual states the frequency and gross pay have not changed. Use this income amount for unverified pay periods in all budget months.

Exception: Do not apply this policy to sources of income that involve fluctuations in pay due to overtime, tips, commission, bonuses, hourly wages, etc.

Examples:

- At initial certification, a person gave proof he is paid a salary of $400 gross weekly, with no fluctuations. He is now being interviewed for a SNAP redetermination and has one pay stub dated within 45 days of the application file date showing earnings of $400 for the week. He states there have been no changes in his weekly gross pay or the pay frequency. One pay stub is acceptable proof in this example, because the pay amount and frequency were previously verified and the person stated the pay amount and frequency have not changed.
- Another person is being interviewed for a SNAP application and has one pay stub dated within 45 days of the application file date. She states she is paid once a week in the amount of $500 gross and that her pay does not fluctuate. The advisor calls and verifies with the employer the pay frequency and that the gross amount does not fluctuate. Once the advisor verifies the pay frequency and that income does not fluctuate, the advisor may accept the single pay stub as proof of gross pay and does not pend for other pay stubs unless the income is otherwise questionable.

A—1355.1 Budgeting Options for SNAP Households

Revision 15-4; Effective October 1, 2015

SNAP

If income is received more than once a month, monthly converted amounts are used to compute the monthly average. If the monthly income fluctuates, the household may choose to average its monthly income over the entire certification period. The advisor must determine the household's eligibility and benefits based on the average income.

Exception: The income of destitute households must not be averaged over the certification period.

A—1355.2 How to Use Texas Workforce Commission (TWC) Quarterly Wage Information to Budget Earned Income

Revision 18-1; Effective January 1, 2018

All Programs

The quarterly wage records displayed on TWC inquiry reflect wages earned in the quarter ending as late as one month before the current calendar month, however, since the wage records are updated quarterly, wages may be further in the past. TWC quarters are displayed as a number corresponding to the quarter of the year in which the wages were earned, as illustrated below:

- The first quarter is January through March and is displayed as a **1** and the corresponding year.
- The second quarter is April through June and is displayed as a **2** and the corresponding year.
- The third quarter is July through September and is displayed as a **3** and the corresponding year.
- The fourth quarter is October through December and is displayed as a **4** and the corresponding year.

Use the gross monthly amount determined from using TWC wage records, when applicable, is used in all of the following budget months:

- application; and
- ongoing.

Note: A-831.3, Income Computation, may be used when determining the budget for prior Medicaid months.

Staff must use the following chart to determine payment amounts when using TWC wage records to budget earned income.

Did the client receive 3 full months of income in this quarter?	**YES,** **then use one of the following calculations:**
	• **Weekly** – Divide the quarterly amount by the number of pay periods in the selected quarter. • **Bi-Weekly** – Divide the quarterly amount by the number of pay periods in the selected quarter. • **Semi-Monthly** – Divide the quarterly amount by 3 and then divide the monthly amount by 2. • **Monthly** – Divide the quarterly amount by 3. • **Quarterly** – Use the quarterly amount.
	NO, **then use one of the following calculations:**
	• **Weekly** – Divide the quarterly amount by 3 and then divide the monthly amount by 4.33. • **Bi-Weekly** – Divide the quarterly amount by 3 and then divide the monthly amount by 2.17. • **Semi-Monthly** – Divide the quarterly amount by 3 and then divide the monthly amount by 2. • **Monthly** – Divide the quarterly amount by 3. • **Quarterly** – Use the quarterly amount.

Note: TIERS uses the calculations in the chart above to derive the Calculated Payment value on the "TWC Inquiry" section of the **Employment Payments** screen.

Prior to using TWC quarterly wage information as a verification source for earned income, staff must use the preferred methods of verification for the applicable program.

TANF and SNAP

The following sources continue to be the preferred methods of wage verification if they are available without having to pend the EDG to obtain them:

- the most recent consecutive check stub(s);
- Form H1028, Employment Verification; or
- TALX, income verification system.

If these preferred sources of verification are not available during the interview, or when processed if no interview is required, and it would be necessary to pend for wage verification, the TWC quarterly wage information should be used as verification as explained below.

Using TWC Quarterly Wage Information as Verification of Earned Income

1. Did the person receive pay for all pay periods in all months of the most recent quarter posted from the current employer, and none of the months includes leave without pay or a change in work hours from full-time to part-time?	**Yes– Continue**	**No** – Pend for other wage verification
2. Is the person still employed by the employer listed on the most recent TWC quarter?	**Yes– Continue**	**No** – Pend for other wage verification

3. Is the person's pay rate the same now as it was for each month of the most recent quarter reported to TWC?	**Yes– Continue**	**No** – Pend for other wage verification
4. After discussion with the individual, do they agree that the result is representative of anticipated future gross wages per pay period? **Note:** The advisor must convert the income to the frequency the person receives the income before discussing with them whether the earnings shown in TWC records are representative of current and/or future earnings.	**Yes – Use TWC wage record as verification**	**No** – Pend for other wage verification

Note: Tip income not included on a person's wage statement should continue to be verified by having the person provide a signed and dated statement, as required by A-1370, Verification Requirements.

Medical Programs

If the client-reported income is not reasonably compatible with electronic data sources as explained in A-1370, Verification Requirements, Medical Programs, and the advisor would need to pend for verification of earned income, determine if the TWC quarterly wage information can be used as verification of earnings. The TWC wage record may be used as a verification source if the following conditions are met:

- the current employer listed on the Medicaid application/redetermination form matches the employer listed on the most recent TWC wage record, and
- all household members for whom the household is applying are eligible based on the TWC quarterly wage information.

Convert the quarterly wage data to monthly income amounts, as described above.

If the income reported on the application/redetermination form makes the household ineligible, then policy in A-1370 does not require the verification of earnings. If a member is ineligible based on the TWC data but appears eligible based on wages reported on the application form, request other income verification.

Note: If the TWC quarterly wage data is older than the verification used in the current SNAP budget, use the SNAP budget to determine eligibility for Medicaid applications/renewals.

A—1356 Income Received Less Often Than Monthly

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

If income is received less often than monthly, the income is prorated over the period covered.

SNAP

If income is received less often than monthly, the income:

- counts in the month received, or
- is prorated over the period the income is intended to cover (at the individual's option).

Exception: Income of destitute farm workers is not prorated.

A—1357 Computing Benefits by EDG Action Type

Revision 14-1; Effective January 1, 2014

All Programs

Action Type	Budgeting
Application	• For past months, use the actual amounts for the entire month and use the appropriate conversion factor. For three months prior, use the actual amounts received for the entire month but do not use a conversion factor. • For the interview month, use a combination of actual amounts (amounts that have already been received) and projected amounts for amounts that have not been received yet, based on policy in A-1355, How to Project Income. • For future months, project amounts. • For TWC, see A-1355.2, How to Use Texas Workforce Commission (TWC) Quarterly Wage Information to Budget Earned Income.
Untimely redetermination – interview after the last benefit month	• For past months, use the actual amounts for the entire month and use the appropriate conversion factor. For three months prior, use the actual amounts received for the entire month but do not use a conversion factor. • For the interview month, use a combination of actual amounts (amounts that have already been received) and projected amounts for amounts that have not been received yet, based on policy in A-1355, How to Project Income. • For future months, project amounts. • For TWC, see A-1355.2, How to Use Texas Workforce Commission (TWC) Quarterly Wage Information to Budget Earned Income.
Untimely redetermination – interview during the last benefit month	• For the new certification period, project amounts. • For TWC, see A-1355.2, How to Use Texas Workforce Commission (TWC) Quarterly Wage Information to Budget Earned Income.
Timely redetermination	• For the new certification period, project amounts. • For TWC, see A-1355.2, How to Use Texas Workforce Commission (TWC) Quarterly Wage Information to Budget Earned Income.
Changes	Project amounts.
Claims/Restored benefits	Use actual amounts.

A—1358 How to Budget Expenses

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Only household expenses expected during the certification period should be considered to determine eligibility and benefits.

Expenses should be projected using the most recent month's bills and any anticipated increases or decreases. The household may choose to average expenses if they are anticipated to fluctuate or occur less often than monthly.

If the individual is billed for expenses weekly, biweekly or semi-monthly, the income conversion factors found in A-1353, How to Convert Income to Monthly Amounts, may be used to determine monthly expenses.

Medical Programs

Budgeting MAGI expenses is explained in A-1411, Rules That Apply to Deductions, Medical Programs.

A—1359 How to Determine Spend Down

Revision 05-1; Effective January 1, 2005

A—1359.1 Determining Eligibility/Spend Down for the Application and Following Months

Revision 15-4; Effective October 1, 2015

TP 56 and TP 32

Children and pregnant women with unpaid medical bills must first be determined ineligible for Medicaid or CHIP before being considered for TP 56 or TP 32.

TP 56 and TP 32 use MAGI rules to determine financial eligibility as explained in A-1341, Income Limits and Eligibility Tests, Medical Programs, with the following exception.

Exception: When calculating MAGI household income in **Step 4** for TP 56 and TP 32, the only income that is included for the applicant or recipient is income from the following individuals, if these individuals are in the applicant's or recipient's MAGI household composition:

- The applicant;
- The applicant's parents, if the applicant is under age 19; and
- The applicant's spouse (if applicable).

Informing individuals about spend down is explained in A-1532.1, Spend Down EDGs.

A—1359.2 Determining Eligibility/Spend Down for Three Months Prior

Revision 15-4; Effective October 1, 2015

TP 56 and TP 32

Children and pregnant women must be determined ineligible for Medicaid or CHIP before being considered for TP 56 or TP 32 coverage for three months prior to the application month and must have:

- unpaid medical bills during the prior month(s), or
- received Medicaid services from the Texas Department of State Health Services during the prior months.

Advisors must determine financial eligibility for TP 56 and TP 32 for the three months prior to the application month by following the MAGI rules as explained in A-1359.1, Determining Eligibility/Spend Down for the Application and Following Months.

Children and pregnant women may be determined eligible for TP 56 or TP 32 coverage for any month in the three months prior to the application month. Advisors must notify the applicant of the eligibility determination for each month.

A—1359.3 Corrections to a TP 56 EDG

Revision 15-4; Effective October 1, 2015

TP 56

The following procedures are used to notify the Medically Needy Clearinghouse (MNC) when:

- a correction must be made to a TP 56 EDG with spend down; and
- the Clearinghouse has not processed the EDG.

The claims administrator at 1-800-252-8263 is the contact entity to speak with someone concerning a Medicaid EDG with spend down. Advisors should have access to the following information concerning the EDG before calling:

- EDG name;
- EDG number;
- advisor's name;
- advisor's employee number and mail code;
- advisor's telephone number; and
- all information about the change.

A—1360 Determining Countable Income in Special Household Situations

Revision 15-4; Effective October 1, 2015

A—1361 Alien Sponsor's Income

Revision 16-2; Effective April 1, 2016

TANF, SNAP, TP 08, TP 43, TP 44, TP 48, TP 40, TP 07, TP 20, TP 56, TP 70, TA 84 and TA 85

Count the income of the alien's sponsor and spouse (if the spouse also signed an affidavit of support). See Glossary for the definition of an alien sponsor.

Do not apply this policy to sponsored aliens who:

- are children under age 18;
- are ineligible for benefits (examples include those who are disqualified from getting benefits or those considered non-members, such as students who do not meet SNAP student eligibility criteria);
- have become naturalized U.S. citizens;
- have worked or can receive credit for 40 quarters of work;
- have a deceased sponsor;
- have a sponsor who is a member of the alien’s household/MAGI household composition;
- are refugees, parolees, asylum grantees, Amerasians, victims of severe trafficking or Cuban/Haitian entrants;
- are battered alien spouses of U.S. citizens or of legal permanent residents, children of battered aliens, or parents of battered children, if (1) HHSC determines the battery is substantially related to the need for benefits, and (2) the battered person does not live with the batterer; or

  Notes:
  - Do not deem the sponsor's income for 12 months for these battered aliens, starting the month the alien is certified for any benefit. Do not assign a new 12-month period if the alien reapplies after denial of benefits. After the first 12 months, continue exempting the sponsor's income from deeming if (1) a court or the U.S. Citizenship and Immigration Services (USCIS) recognize the battery, (2) HHSC determines the battery has a substantial connection to the need for benefits, and (3) the alien does not live with the batterer.
  - Use the following list of circumstances as a guide in making the substantial connection between the battery and the need for benefits. Determine if the battered alien needs the benefits:
    - to become self-sufficient after leaving the abuser;
    - to escape the abuser and/or the community in which the abuser lives;
    - to ensure the battered alien's safety;
    - to replace financial support lost as a result of the separation from the abuser;
    - because of the loss of a job or reduced earnings resulting from the battery or cruelty;
    - because the battered alien needs medical attention or mental health counseling or now has a disability due to the battery;
    - because the battered alien lost the home, and the separation from the abuser jeopardizes the battered alien's ability to care for the children;
    - to reduce nutritional risks;

        - to get medical care for a pregnancy resulting from sexual assault or abuse; or
        - to replace medical coverage or health care services.
- are indigent. Only use this criterion if the alien does not meet one of the other exceptions noted in this list. Deem only the amount the sponsor will give the alien for a 12-month period starting the date HHSC makes the indigence determination. Each determination is renewable for additional 12-month periods.

  Each time a determination of indigence is made, send a memo with the name, address, Social Security number and date of birth, of both the indigent alien and the indigent alien's sponsor, to Texas Works Policy Section, 909 W. 45th St., Bldg. 2, Mail Code 2115, Austin, TX 78751. Before sending the memo, tell the alien that state office must report the sponsor to the Attorney General for failure to give support as required on the sponsor affidavit. Allow the sponsored alien to choose to have the sponsor's income deemed if the alien does not want state office to send this report.

TANF, TP 08, TP 43, TP 44, TP 48, TP 40, TP 07, TP 20, TP 56, TP 70, TA 84 and TA 85

This policy does not apply to:

- sponsored aliens whose sponsors get TANF or SSI, or
- the dependent child of a sponsor or sponsor's wife.

TP 43, TP 44 and TP 48

When determining eligibility for a child whose parent is a sponsored alien and required member of the budget group, count the income of the parent's sponsor.

Exception: Do not count the income of the parent's sponsor if the parent meets one of the sponsored alien exceptions in this section under the All Programs label.

SNAP

This policy does not apply to:

- sponsored aliens whose sponsors get SNAP as a member of the same household, or
- organizations or groups that sponsor aliens.

A—1361.1 Budgeting the Individual Sponsor's Income

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

Consider all of the sponsor's gross countable income as available to the alien's household, minus only the following deductions:

- The lesser of:
    - 20 percent of the total gross monthly earned income (including net self-employment earned income); or
    - $175.
- The budgetary needs (100 percent) figure of a one- or two-parent caretaker TANF EDG for the sponsor's family size. For Medical Programs, use the appropriate income limits figure for the sponsor's family size. Include all members of the household whom the sponsor claims or could claim as tax dependents. **Note:** For TANF, see A-1424, Diversions, Alimony, and Payments to Dependents Outside the Home, to determine:
    - whether to use the needs allowance of an adult or a child; or
    - the needs amount for more than two adults.
- The total amount the sponsor pays to a claimed tax dependent living outside the home.
- Total alimony or child support the sponsor pays to persons living outside the home.

Count the remaining amount as unearned income for the alien.

SNAP

Consider all of the sponsor's gross countable income as available to the alien's household, minus only the following deductions:

- 20 percent of the sponsor's total monthly gross earned income (including net self-employment earned income).
- An amount equal to the gross income limit for a household including the sponsor, the spouse, and any others claimed or who could be claimed as tax dependents (even if living outside the home). Do not include people who live with the sponsor but cannot be claimed as

tax dependents.

Compare the computed countable income with the actual contributions that the alien received from the sponsor and spouse.

Budget the higher of the two amounts as unearned income to determine the alien's eligibility and benefits.

A—1361.2 Prorating the Sponsor's Income

Revision 01-7; Effective October 1, 2001

All Programs

If several aliens are sponsored, prorate the remaining income evenly among all the aliens who apply for or receive benefits.

A—1361.3 Budgeting the Organization Sponsor's Income

Revision 01-7; Effective October 1, 2001

TANF

An alien sponsored by an organization is not eligible for TANF unless the alien:

- can prove the organization no longer exists; or
- provides income and resource information for the organization.

If the alien provides income and resource information, contact Texas Works Policy Section, state office, for special budgeting procedures.

A—1362 Disqualified Members

Revision 16-2; Effective April 1, 2016

TANF

The income of a disqualified legal parent, including a disqualified second parent, is counted. Procedures in A-1362.1, TANF — Budgeting for a Legal Parent Disqualified for Alien Status, Failure to Prove Citizenship, Noncompliance with the Unmarried Minor Parent Domicile Requirement or State Time Limits, or A-1362.2, TANF — Budgeting for a Household Member Disqualified for Noncompliance with SSN, TPR, Failure to Timely Report a Certified Child's Temporary Absence, Intentional Program Violation, Being a Fugitive or a Felony Drug Conviction, apply.

The income of a disqualified child who is a required member of the certified group is counted. Procedures in A-1362.2 apply.

The income of other noncertified children is not counted.

SNAP

All income, except a prorated portion, is counted for a person disqualified for one of the following reasons:

- The applicant failed to provide or apply for a Social Security number.
- The applicant is an ineligible alien (including an alien awaiting sponsor information or proof of sponsor information).
- The applicant is waiting for verification of a questionable claim of U.S. citizenship.
- An able-bodied adult without dependents (ABAWD) has received the maximum months of benefits without meeting the SNAP ABAWD work requirement.

All income, unless otherwise exempt, is counted for a member disqualified for:

- intentional program violation;
- Employment and Training (E&T) noncompliance;
- felony drug convictions; or
- being a fugitive.

Disqualified people are considered household members although they are not allowed to participate.

Medical Programs

Calculate the MAGI household income for each individual applying for Medical Programs using the steps explained in A-1341, Income Limits and Eligibility Tests, Medical Programs.

A—1362.1 TANF — Budgeting for a Legal Parent Disqualified for Alien Status, Failure to Prove Citizenship, Noncompliance with the Unmarried Minor Parent Domicile Requirement or State Time Limits

Revision 15-4; Effective October 1, 2015

TANF

For EDGs with a legal parent who is disqualified for one of the reasons above and who has income, advisors should follow the budgeting process below to determine the amount of the legal parent's income to count against the needs of the remaining certified group before applying the two needs tests.

1. Determine the legal parent's countable monthly gross earned income.
2. Subtract the standard $120 work-related expense deduction from earned income.
3. Add the disqualified parent's unearned income to the net earned amount and subtract the following three amounts:
    - The monthly amount the parent actually pays to a person living outside the home whom the parent can claim as a tax dependent or is legally obligated to support.
    - The monthly amount of alimony and child support payments the parent actually makes to persons outside the home.
    - The budgetary needs amount for the parent and other noncertified members in the home whom the parent can claim as tax dependents or is legally obligated to support (including SSI recipients). Use the needs figure applicable to the number of noncertified members (including the parent with income). **Note:** See A-1424, Diversions, Alimony, and Payments to Dependents Outside the Home, to determine:
        - whether to use the needs allowance of an adult or a child, or
        - the needs amount for more than two adults.

    Exception: Do not include the needs of a dependent who is disqualified for a reason other than citizenship.
4. Count the remaining income against the needs of the certified group.

Note: If a noncertified stepparent with income also lives in the home, complete the steps in A-1366.2, Stepparent Budgeting Procedures, before completing this process.

A—1362.2 TANF — Budgeting for a Household Member Disqualified for Noncompliance with SSN, TPR, Failure to Timely Report a Certified Child's Temporary Absence, Intentional Program Violation, Being a Fugitive or a Felony Drug Conviction

Revision 15-4; Effective October 1, 2015

TANF

The same budgeting procedures used for a certified household member are used for TANF, except the needs of the disqualified member are not included.

Exception: If the household member is not a required member of the certified group, the non-required member's needs are removed. Additionally, the non-required member's income and resources do not count against the remaining members of the certified group.

If the member has expenses for which income must be diverted, the policy in A-1424, Diversions, Alimony, and Payments to Dependents Outside the Home, should be followed.

A—1362.3 SNAP — Budgeting for Members Disqualified for Citizenship, SNAP ABAWD Work Requirement or Noncompliance with Social Security Number Requirements

Revision 16-2; Effective April 1, 2016

SNAP

- All of the disqualified person's countable income should be totaled.

  Notes:
  - Income of an alien's sponsor is not applied to a sponsored alien who is disqualified.
  - If a disqualified member receives TANF, the disqualified member's pro rata share of the TANF grant is counted, and each TANF recipient's portion of the grant is entered as TANF income.
- The disqualified person's countable income is divided by the number of household members, including the disqualified member. This determines the pro rata share of income.
- All pro rata shares of income are counted, except those of a disqualified member(s).

Earned Income Deduction — The EID is deducted from the part of the disqualified member's earned income that is counted in the household.

Standard Deduction — The appropriate standard deduction amount is applied only for eligible household members.

Dependent Care, Child Support Expense, Shelter Expense and Homeless Shelter Standard Deductions — These expenses billed to or paid by the disqualified member are divided equally among all SNAP household members, including the disqualified member. All pro rata shares are included in the household budget, except those of disqualified members. The allowable pro rata share is entered under an eligible SNAP household member.

Note: If only the disqualified member has income, the expenses must be considered to be paid by that member.

Utility or Telephone Deductions — The appropriate utility or telephone standard is allowed. Utility or telephone deductions are not prorated.

Medical Deduction — The actual medical expense or the standard medical deduction is prorated among all household members, and the pro rata share for a disqualified member's medical bills (including situations in which the disqualified member is billed for or pays the medical bills of a remaining eligible household member) is not allowed.

Note: If only the disqualified member has income, the expenses must be considered to be paid by that member.

Unlimited Excess Shelter Deduction — This deduction is allowed even if the disqualified member is the only elderly member or member with disabilities in the household.

Income Test and Household Size — The disqualified member is not considered in determining the household's income limits or the amount of the household's allotment.

Example of Procedures for Budgeting TANF Income of Households with Members Disqualified for Citizenship/Alien Status Who Are Eligible for TANF but Not SNAP

A household consists of a husband and wife and their four children. The husband and wife are lawful permanent residents, and their four children are U.S. citizens. The husband is unemployed, and the household receives a TANF-State Program grant of $294. Both the husband and wife are eligible for TANF but are disqualified aliens for SNAP.

For TANF/SNAP EDGs, TIERS will automatically prorate the TANF income for the SNAP budget, using the following formula.

Step	Action

Step	Action
1	Divide the TANF grant by the number of TANF-certified household members to arrive at the pro rata share for each member. $294 ÷ 6 = $49 (each member's pro rata share of the grant).
2	Multiply the pro rata shares of the grant by the number of TANF recipients who also are eligible for SNAP benefits. $49 x 4 = $196
3	Divide the disqualified person's pro rata share of the TANF benefits by the total number of SNAP household members, including the disqualified member(s). Count the pro rata share of TANF attributed to all eligible SNAP household members. $49 ÷ 6 = $8.17 x 4 = $32.68 (countable share of the husband's TANF) $49 ÷ 6 = $8.17 x 4 = $32.68 (countable share of the wife's TANF)
4	Determine the total countable TANF by adding the countable amounts from Steps 2 and 3. $196 (children's share) + $65.36 = $261.36.

A—1362.4 SNAP — Budgeting for Persons Disqualified for Intentional Program Violations, SNAP Employment Services Noncompliances, Felony Drug Convictions or Being a Fugitive

Revision 15-4; Effective October 1, 2015

SNAP

Income — All income of a disqualified member counts unless it is otherwise exempt.

Income Deductions — All income deductions and expenses of a disqualified member are allowed.

Standard Deduction — The disqualified member is not included in the household size when applying the standard deduction.

Shelter/Medical Deductions — Appropriate shelter and medical deductions are allowed even if the disqualified person is the only elderly person or person with disabilities in the household.

Although the household can receive uncapped shelter deductions, the household must still pass both the gross and net income tests if the disqualified person was the only elderly member or member with disabilities in the household.

Income Test and Household Size — The disqualified member is not included in determining the household income limits or the amount of the household's allotment.

A—1363 Diverting Income

Revision 15-4; Effective October 1, 2015

TANF

Income is diverted if a caretaker, second parent, minor parent, or married minor has countable income and:

- pays alimony or child support to persons outside the home;
- makes payments to persons outside the home whom the individual can claim as tax dependents or has a legal obligation to support; or
- there are noncertified persons living in the home whom the individual can claim as tax dependents or has a legal obligation to support, including SSI recipients and children receiving TP 19 SSI Medicaid.

This process should also be completed if a noncertified stepparent lives in the home and only the legal parent has income, or they both have income and the stepparent's income does not meet all of the stepparent's and the noncertified dependent's needs in A-1366.2, Stepparent

Budgeting Procedures. If both the stepparent and legal parent have income, the budgeting process in A-1366.2 should be completed before this process.

Line 1 – **Payments to Dependents Outside Home** — The actual amount of any payments made to persons living outside the home whom the parent can claim as tax dependents or is legally obligated to support.

Line 2 – **Alimony and Child Support Payments** — The actual amount of alimony or child support payments the parent makes to persons outside the home.

Line 3 – **100 Percent Needs Amount** — The budgetary (100 percent) needs figure for all noncertified members in the home whom the legal parent can claim as tax dependents or is legally obligated to support including SSI recipients, except do not include the needs of a parent/dependent who is disqualified for a reason other than citizenship/alien status, state time limits or the unmarried minor parent domicile requirement. Use the single parent caretaker needs figure if there is a noncertified stepparent in the home, or a second legal parent in the home who receives SSI or is disqualified for citizenship/alien status, state time limits or noncompliance with the unmarried minor parent domicile requirement. See A-1424, Diversions, Alimony, and Payments to Dependents Outside the Home, to determine:

- whether to use the needs allowance of an adult or a child, or
- the needs amount for more than two adults.

Line 4 – **Maximum Amount to Be Diverted** — The total of lines 1, 2 and 3 (except if A-1366.2 is also completed, follow instructions in A-1366.2 to enter remaining needs). This is the **maximum** amount of diversions that can be deducted from the individual's total income. The **actual** amount diverted in any needs test may be less, since the diverted amount cannot exceed the individual's total income and be deducted from income of another household member unless they will be filing a joint tax return or they are married.

TIERS will complete this process based on the entries on the Relationship page.

Related Policy
Diversions, Alimony, and Payments to Dependents Outside the Home, A-1424

A—1364 Migrant Farm Workers in the Workstream

Revision 02-3; Effective April 1, 2002

SNAP

Migrant farm workers are people who have moved into a county looking for work cultivating crops, canning, or packing. The household must include at least one migrant farm worker to be classified as a migrant household.

A—1364.1 Guidelines for Determining Income of Migrant Workers

Revision 15-4; Effective October 1, 2015

All Programs

- Income should not be anticipated merely because there is work available in the area.
- Everyone in an area may not be employed, even if work is available.
- Future income counts only when the amount and month of receipt is known.
- The effect of future migrations must be considered since these migrations might interrupt the expected income.
- The grower, not the crew chief, is considered as the source of income.
- Travel advances and wage advances must be distinguished. If a travel advance is a reimbursement for travel expenses, the advance does not count as income. Wage advances for travel expenses count as income if the migrant worker has a written contract from the prospective employer that states the travel advance is a wage advance that will be deducted from wages earned later.
- The income of a student under age 18 must be separated from the rest of the migrant household's income. If the student's earnings or amount of work performed cannot be distinguished from that of other household members, the total income is divided equally among the working members, and the child's share is excluded.

A—1365 Unmarried Minor Parent Income

Revision 15-4; Effective October 1, 2015

TANF

The following steps should be followed when determining eligibility for households with an unmarried minor parent.

Note: Minor parent budgeting procedures are not used when determining eligibility for married minor parents.

1. Determine which of the following situations describes the household:

Situation	Household Composition
A	minor parent minor parent's child deprived due to absence minor parent's legal parent(s) minor parent's minor siblings
B	minor parent minor parent's child deprived due to absence minor parent's legal parent and stepparent minor parent's minor siblings
C	minor parent minor parent's child deprived due to absence minor parent's legal parent and stepparent minor parent's minor siblings minor parent's legal parent's and stepparent's mutual child
D	minor parent legal parent of minor parent's child (not married to minor parent) minor parent's mutual child minor parent's legal parent(s) minor parent 's minor siblings
E	minor parent legal parent of minor parent's child (not married to minor parent) minor parent's mutual child minor parent's child deprived due to absence minor parent's legal parent(s) minor parent's minor siblings

2.

If the household situation is described in situation …	and the legal parent's choice to apply for TANF is …	include in the certified group …	using these budgeting procedures …
A minor parent minor parent's child deprived due to absence minor parent's legal parent(s) minor parent's minor siblings	yes,	all household members. Include the minor parent's child if the caretaker or payee requests that the child be certified. Treat the minor parent as a child.	count income according to TANF guidelines for exempt and countable income. If the household is ineligible, process the minor parent's application using "A" "no" if the minor parent wants to apply.

If the household situation is described in situation …	and the legal parent's choice to apply for TANF is …	include in the certified group …	using these budgeting procedures …
-	no,	the minor parent and minor parent's child deprived due to absence.	apply the legal parent's income using stepparent budgeting procedures (divert for the legal parent's and siblings' needs). Treat the minor parent's income according to adult caretaker policies.
B			
minor parent minor parent's child deprived due to absence minor parent's legal parent and stepparent minor parent's minor siblings	yes,	all members except the stepparent. Also include the stepparent if the legal parent is incapacitated (A-221, Who Is Included, No. 7). Include the minor parent's child if the caretaker or payee requests that the child be certified. Treat the minor parent as a child.	apply the stepparent's income if the stepparent is not included in the EDG. Follow the budgeting procedures in A-1366, Stepparent EDGs. If the household is ineligible, process the minor parent's application using "B" "no" if the minor parent wants to apply.
-	no,	the minor parent and minor parent's child deprived due to absence.	apply the minor parent's legal parent's income using stepparent budgeting procedures (divert for the needs of the legal parent, stepparent, and siblings). Do not count the stepparent's income. Treat the minor parent's income according to adult caretaker policies.
C			
minor parent minor parent's child deprived due to absence minor parent's legal parent and stepparent minor parent's minor siblings minor parent's legal parent's and stepparent's mutual child	yes,	all household members. Include the minor parent's child if the caretaker or payee requests that the child be certified. Treat the minor parent as a child.	count income according to TANF or TANF-State Program guidelines for exempt and countable income. If the household is ineligible, process the minor parent's application using "C" "no" if the minor parent wants to apply.
-	no,	the minor parent and minor parent's child deprived due to absence.	follow the budgeting procedures in "B" "no" (also divert for the legal parent's and stepparent's mutual child).

If the household situation is described in situation …	and the legal parent's choice to apply for TANF is …	include in the certified group …	using these budgeting procedures …
D minor parent legal parent of minor parent's child (not married to minor parent) minor parent's mutual child minor parent's legal parent(s) minor parent's minor siblings	yes,	all household members except the other parent of the minor parent's mutual child. Include the minor parent's child if the caretaker or payee requests that the child be certified. Treat the minor parent as a child.	apply the income of the minor parent's child's noncertified other parent using stepparent budgeting procedures (divert for the needs of the other parent; also, divert for the other parent's mutual child's needs if the child is not included in the grant). If the household is ineligible, process the minor parent's application using "D" "no" if the minor parent wants to apply.
-	no,	the minor parent, minor parent's mutual child, and the other parent of the minor parent's mutual child.	apply the minor parent's legal parent' s income using stepparent budgeting procedures (divert for the legal parent's and the siblings' needs). Treat the minor parent's and second parent's income according to adult caretaker policies.
E minor parent legal parent of minor parent's child (not married to minor parent) minor parent's mutual child minor parent's child deprived due to absence minor parent's legal parent(s) minor parent's minor siblings	yes,	the same household composition policies as "D" "yes."	follow the budgeting procedures in "D" "yes." If the household is ineligible, process the minor parent's application using "E" "no" if the minor parent wants to apply.
-	no,	the minor parent, minor parent's mutual child, and the other parent of the minor parent's mutual child. Also, include the minor parent's child deprived due to absence.	follow the budgeting procedures in "D" "No."

Notes:

- If the minor parent lives with both parents, allow the caretaker EDG with second parent needs figure when diverting their income.

- If the income of the minor parent's parent is diverted, do not count their resources. Refer to A-1247, Resources of Stepparents, for stepparents.
- When the parents of the minor parent apply for TANF and the diverted amount from the minor parent's stepparent is a negative number, divert the remaining amount from the minor parent's legal parent's income.

  Do **not** carry over any remaining diversion amount to other household members' income.

A—1366 Stepparent EDGs

Revision 15-4; Effective October 1, 2015

TANF

A stepparent's income is always considered when determining financial eligibility for the certified group.

Stepparent budgeting procedures are used when a minor parent and the minor parent’s children living with the minor parent's parent are applying for TANF and they meet the criteria in A-221, Who Is Included, No. 6.

If the legal parent and stepparent live in the home and have mutual children, the household members cannot be separated. Both parents' income is budgeted using legal parent budgeting procedures.

Related Policy
New TANF Spouse's Earnings, A-1368

A—1366.1 How to Determine Budgeting Procedures in Stepparent EDGs

Revision 15-4; Effective October 1, 2015

TANF

The stepparent is included in the grant only if the stepparent wants to be included and:

- the stepparent is the only parent in the home, or
- both the legal parent and stepparent are in the home and the legal parent has a disability (according to procedures in A-1050, Deprivation Based on Incapacity).

If the stepparent is **included** in the grant, the stepparent's income and resources count as a legal parent's would be counted. The usual earned income deductions are allowed.

If the stepparent is **not included** in the grant, the stepparent's income is budgeted using the stepparent budgeting procedures in A-1366.2, Stepparent Budgeting Procedures, to determine the amount of monthly income to be applied to the certified group. These budgeting procedures should be followed even if the stepparent does not meet TANF citizenship requirements.

A—1366.2 Stepparent Budgeting Procedures

Revision 15-4; Effective October 1, 2015

TANF

The amount of the stepparent's income that is counted to meet the certified group's needs must be determined before applying either needs test, using the following process:

1. Total the stepparent's countable gross earned income.
2. Deduct the stepparent's work-related expenses ($120).
3. Add the stepparent's unearned income to the net earned amount.

4. Deduct the stepparent's actual support payments for tax dependents outside the home and monthly expenses for alimony or child support. Deduct an amount equal to the budgetary needs (100 percent) of a single parent caretaker EDG for the stepparent and the stepparent's noncertified tax dependents living in the home (do not include the needs of a dependent that is disqualified for a reason other than citizenship).

   Note: See A-1424, Diversions, Alimony, and Payments to Dependents Outside the Home, to determine:
   - whether to use the needs allowance of an adult or a child, or
   - the needs amount for more than two adults.
5. Apply the stepparent's remaining income to the certified group as unearned income.

Notes:

- Count the stepparent's applied income only from the date of marriage.
- Use stepparent budgeting procedures when a minor parent and the minor parent's children living with the minor parent's parent are applying for TANF and they meet the criteria in A-221, Who Is Included, No. 6.

See A-1363, Diverting Income, for the budgeting process when only the legal parent has income or the legal parent and stepparent have income.

A—1366.3 Budgeting Procedures in Stepparent EDGs When Both Parents Have Eligible Children for Whom They Want to Apply

Revision 15-4; Effective October 1, 2015

TANF

The following steps are used to determine eligibility and benefits for TANF:

1. Test eligibility for each parent's EDG individually as separate cases. Consider only the income and circumstances of the caretaker and children for whom the caretaker is applying. Do not apply the stepparent's income in this initial step.
2. If both applicants are eligible, work the TANF as separate cases for each EDG group. Do not divert or apply income from either parent.
3. If both EDGs are ineligible, deny them both.
4. If one EDG is ineligible and the other eligible, deny the ineligible EDG and rebudget the eligible EDG. Consider the ineligible parent a stepparent and apply the ineligible parent's income using stepparent budgeting procedures.

Notes:

- Divert income for an ineligible child from only one parent when budgeting for step 1 and step 3. Divert income from both parents for the same child only when they will be filing a joint tax return or they are married.
- If the household includes eligible mutual children, the household members cannot be separated. Budget both parents' income using legal parent budgeting procedures.

A—1367 Strikers

Revision 15-4; Effective October 1, 2015

All Programs

A striker is anyone who participates with one or more other employees in a work slow-down or stoppage. This includes a stoppage resulting from the expiration of a collective bargaining agreement.

A striker's status ends only when the striker returns to the job, retires, quits, is locked out, or is fired, regardless of the length of the strike.

A person is not a striker if the person is:

- exempt from work registration on the day before the strike for any reason other than employment;
- not participating in the strike, but cannot work because of the strike;

- afraid to cross the picket line because of threatened harm; or
- locked out of the job by an employer, including an individual who was on strike before the lock-out.

A—1367.1 Eligibility of Strikers

Revision 15-4; Effective October 1, 2015

TANF, TP 08 and TA 31

A family is not eligible for TANF, TP 08 and TA 31 for any month in which the caretaker or second parent is participating in a strike.

SNAP

A household with a striker is ineligible for SNAP unless the household:

- was eligible immediately before the strike; and
- is still eligible.

Pre-Strike Eligibility

The income of all household members (including the striker) is used as of the day before the strike. If the household is ineligible, the household is denied.

If the household was eligible before the strike, current eligibility should be computed.

Current Eligibility

1. The striker's income on the day before the strike should be compared with the striker's current income (including union benefits and part-time jobs). The higher of the two incomes counts.
2. The striker's income is added to the current income of other household members.

   If the household is not currently eligible, the household is denied.

   If the household is eligible based on both current and pre-strike income, the household is eligible if it meets all other eligibility criteria. Other eligibility criteria are considered the same as income. The household must be eligible currently and before the strike.

TP 40, TP 43, TP 44, TP 48, TP 33, TP 34, TP 35 and TP 36

This policy is not applicable to these programs.

A—1368 New TANF Spouse's Earnings

Revision 15-4; Effective October 1, 2015

TANF

The earnings of a TANF recipient's new spouse are excluded for six months, beginning the month after the date of the marriage if the total gross income of the budget group does not exceed 200 percent FPIL for the family size. This applies to both ceremonial and common law marriages.

The following individuals are included in the budget group:

- the caretaker or payee of the TANF-certified group;
- the new spouse of the TANF caretaker or payee;
- each dependent of the TANF caretaker or payee and the new spouse who meets the TANF age and relationship requirements and lives in the household; and
- anyone who would be a required member if not disqualified or ineligible such as an SSI recipient or ineligible alien.

If the household fails to provide verification of the marriage, the income exclusion is not allowed. The amounts previously excluded count after six months.

A—1370 Verification Requirements

Revision 15-4; Effective October 1, 2015

All Programs

- All countable income must be verified at initial application, redetermination and when a household reports a change.

  Exception: Verification is not required if the amount reported makes the household ineligible.

Verification of earned and unearned income is not required for any pay amount that is older than two months before the interview date.

Related Policy
Verification and Documentation, C-900

- Verify a child meets the criteria listed in A-1323.1, Children's Earned Income, before exempting the child's earned income.
- Verify interest income at the periodic redetermination if it's from a new source or the amount has changed more than $50. Otherwise, accept the person's statement of the amount.
- Verify tip income not included on an individual's wage statement by having the individual give a signed and dated statement.
- Verify all loans or contributions (cash or vendor payments) to determine the countable amount.
- Verify whether the person got vacation pay before or after a job ended. If the person got vacation pay after the job ended, verify whether the person got the vacation pay in a lump sum or multiple checks.
- If all attempts to verify income are unsuccessful because the payer fails or refuses to give information and no other proof can be found, use the best available information to determine the budget amount.
- Verification used for SNAP or TANF in a TIERS EDG is acceptable for the other program unless it is inconsistent with other information or is otherwise questionable. Verification used for Medicaid can be used for SNAP or TANF unless policy specifically says otherwise for a specific type of verification. Verification used for SNAP or TANF also can be used for Medicaid unless policy specifically says otherwise for a specific type of verification.
- For strikers, contact union and company officials to:
  - find out the probable length of the strike; and
  - verify the striker's wages from the company, the striker's benefits and any help the striker is getting from the union.
- For self-employment, see A-1323.4.4, Determining the Amount of Self-Employment Income.
- For self-employment that has ended, use a collateral source as verification. Use a person's statement only if a collateral source is not available. Refer to C-940, Documentation, for requirements when an alternate method is used rather than a preferred source.
- Verify the death of an alien's sponsor.

TANF and SNAP

The following steps are used to get income information on employable household members who have no prior certification history or who have had a month or more break in certification or when adding a new member.

Step	If yes …	If no …
1. For the month of application or two months before, did any household member have any earned or unearned income that ended?	Verify and document the: • source, • final gross amount and date received, • reason the income ended, and • end date. **Go to Step 2.**	**Go to Step 2.**
2. Is the household claiming no income?	If the claim is questionable, follow policy in A-1700, Management, or verify per C-920, Questionable Information.	**STOP.**

TANF

The date of marriage between a TANF recipient and the new spouse must be verified and used to determine the six-month period in which the new spouse's earnings can be excluded as income.

TP 08

The following must be verified to establish eligibility for TP 07:

- increase in gross earnings; and
- date the earnings/hours increased.

If verification is not readily available, the individual's statement may be accepted, unless questionable.

If the household gives earnings information sufficient to determine ineligibility for TP 08, but does not give proof of the earnings, the household members should be transferred to TP 07 if they meet the eligibility requirements in A-842, TP 07 Transitional Medicaid.

TANF and Medical Programs

If a person at application claims to have a disability or is caring for a child with disabilities, at the first redetermination, the advisor must verify the person has applied with the Social Security Administration for RSDI/SSI.

SNAP

- A change may be processed based on best available information if:
  - an increase in earnings results in a decrease in benefits,
  - the person fails to give information, and
  - the advisor can compute benefits based on the information provided.
- A person's statement that the person does or does not have a sponsor may be accepted unless the sponsor status is questionable.

  If sponsor status is questionable, the household has two options:
  - The aliens may contact USCIS and get Form G-641, Application for Verification of Information from Immigration and Naturalization Service Records, to show proof of sponsor status.
  - The household may participate without the alien member.
- A disqualified person's income must be verified the same as any other member.
- For strikers, advisors should contact union and company officials to find out the probable length of the strike and to verify the striker's wages from that company, the striker's benefits or any help the striker is getting from the union.

  The services of people or organizations involved in a strike or lock-out must not be used to interview applicants participating in the strike or lock-out. HHSC does not give these people or organizations access to Lone Star Cards, personal identification number (PIN) packets or other documents; nor does it use the facilities of these people or organizations in certifying strikers.
- Combat pay included in any income made available to the household by an absent military person must be verified as well as the combat zone to which the person is deployed. **Note:** The military person's leave and earning statement (LES) is often sent directly to the family, or the deployed military person can mail it to the family back home. The advisor can use the military person's LES to verify the amount of combat pay, if any is being received, and to verify deployment to a designated combat zone.

  The advisor can also verify deployment to a combat zone by requesting that the household provide the orders issued to the military person, or the advisor can contact the financial office at the local base.
- Migrant income can be verified through sources such as Employment Services, Farm Labor bureaus, Rural Manpower Development, Farmer's Cooperative Service, growers' associations, Migrants' Service organizations, county agents, and individual growers and crew chiefs.

  If the household states the migrant workers work for various growers or crew chiefs, the household should be given a calendar form with space for recording each day's income and hours worked. The household should get the grower or crew chief's signature for validation and present the form at the next interview.
- Additional proof of income should not be requested when reactivating a SNAP EDG at redetermination that was denied for failure to provide information. The original proof of income the person gave at the interview date should be accepted, unless the household reports a change in income.
- For streamlined reporting (SR) households, the individual's statement as to whether the household exceeded the income limit during the original SR certification should be accepted. If verification of current earnings shows household income does not exceed 130 percent FPIL and there is no indication the household exceeded 130 percent FPIL during the original SR certification period, it is not necessary to verify all income between the original SR certification period and the current certification.
- If the person began employment during the original SR certification period and reports it at the SR redetermination, the start date of the job should be verified, but it is not necessary to verify all actual income from the start date. If the household's current income exceeds 130 percent FPIL, the person should be asked to estimate the household's monthly income for the previous months. If the person's estimate of the income exceeds 130 percent FPIL, the person's statement should be accepted, and an overpayment referral should be submitted. The amount of the overpayment and the overpayment date can be estimated using the policy in B-730, How to File an Overpayment Referral. The Office of Inspector General (OIG) verifies all actual income and recalculates the overpayment.
- If a member of the SR household has earned or unearned income that ends during the certification, the last terminated income should be verified at the next redetermination.
- If a member of the SR household changes jobs several times during the certification period, then at redetermination, the advisor must verify termination of the last job and the job the household member had at the start of the previous SR certification period.

Related Policy
Required Verification for SNAP, C-912

Medical Programs

Advisors may only request additional financial verification or documentation from applicants or clients if:

- acceptable verification is not available through electronic data sources; or
- information obtained electronically is not reasonably compatible with the individual's statement of income provided on the application or at redetermination.

Income from electronic data sources is considered reasonably compatible with income reported by an individual when both the income reported by the individual and electronic data is at or below the applicable income limit.

The system will determine whether an applicant's or client's income is reasonably compatible with available electronic data sources.

If the applicant's or client's statement of income is not determined to be reasonably compatible with electronic data, income must be verified using other acceptable verifications explained in A-1371, Verification Sources.

An individual's statement of income would not be reasonably compatible with electronic data if:

- the applicant's or client's statement of income is above the applicable FPIL;
- the applicant's or client's statement of income is below the applicable FPIL, but electronic data indicate that income may be above the applicable FPIL;
- the applicant or client has unverified countable expenses that need to be verified in order for the individual to be determined income-eligible;
- the applicant or client did not provide sufficient information to calculate a monthly income (the individual must provide the income type, income frequency, and income amount);
- the applicant or client has provided more income sources than are available from electronic data;
- the applicant or client has unverified countable income other than earned income, RSDI, or unemployment; or
- TIERS is unable to access a third-party system to acquire electronic data, or electronic data was insufficient to complete reasonable compatibility.

When determining ongoing eligibility, the household is not required to provide verification of earned or unearned income of any pay amount that is older than two months before the interview date or the date the action is initiated when an interview is not required.

Advisors must not require an individual to provide additional verification if:

- verification is available through TWC inquiry, the Birth Verification System (BVS), The Work Number income information from the Data Broker System, or other automated systems that are acceptable verification sources and accessible to the advisor, or if the individual indicates that verification is readily available in the electronic case record; and
- the information is sufficient to establish current eligibility.

Note: Because a Data Broker report cannot be requested for children under age 16, advisors may request additional verification from the client if earned income is reported by a child under age 16 who did not meet an exception explained in A-1341, Income Limits and Eligibility Tests, for Medical Programs, **Step 3**, and other electronic data sources are unavailable.

If the applicant reports that someone living at that physical address receives AI/AN income and includes an amount, but does not provide the name of the individual receiving the AI/AN income, advisors must pend for missing information, and:

- if the applicant fails to provide the missing information by the final due date, the EDG will be denied for failure to provide information.
- if the applicant provides the name of the individual receiving the AI/AN income, but does not provide verification for the income type, the income will be counted instead of being exempt. However, the EDG will not be denied for failure to provide information. The applicant will still be eligible for exemptions from cost-sharing if they are eligible for CHIP.

If the applicant indicates someone is eligible to receive services from Tribal/Indian Health Services, but the name of the individual receiving services is not included, advisors must pend for the name. If the name is not provided by the final due date, the EDG will not be denied, but the exemption will not be allowed for cost-sharing if the applicant is eligible for CHIP.

TP 40

After certification, a TP 40 EDG must not be denied for failure to provide proof of income unless income verification was postponed at certification.

A—1371 Verification Sources

All Programs

Alien Sponsor's Death

- copy of death certificate;
- Birth Verification System record;
- doctor's statement;
- Social Security claim number or evidence of receipt of widow's or survivor's benefits from the deceased person's Social Security number;
- U.S. Department of Veterans Affairs or military service records
- Indian census record;
- statement from funeral director;
- records from the hospital or other institution where the person died; or
- insurance company records.

Alternate Sources for Alien Sponsor's Death

- newspaper death notice/obituary;
- state or local public assistance records (including burial payment records);
- lodge, club or other organization records;
- police records;
- statement from clergy; or
- "In Memoriam" card.

Contributions

- statement from the person or agency giving the money to or making the payment for the individual;
- contribution check or copy of check;
- canceled check from the person making the contribution; or
- proof of payment records for MyGoals cash payments.

Earned Income

- Use The Work Number income information from the Data Broker System.
- Have the employer fill out Form H1028, Employment Verification. Make sure the employer completed all items and the information is consistent. Resolve any discrepancies.
- View at least two pay amounts in the time period starting 45 days before the file date through the interview date (or the date the EDG is being processed if an interview is not required). Verify and document any breaks in pay periods. Do not use pay stubs as the only source of verification if the person:
  - began employment in the application or interview month;
  - reported new employment after certification;,
  - ended employment in the application month; or
  - ended employment in the two months before application (TANF and SNAP only).
- Contact the employer.
- Use TWC wage records — see A-1355.2, How to Use Texas Workforce Commission (TWC) Quarterly Wage Information to Budget Earned Income.
- Use Form H2583, Choices Information Transmittal, if the form is complete and indicates the employer verified the information.

Other Income

- check or copy of check;
- statement from the bank paying dividends and interest (accept the person's statement on periodic reviews and timely recertifications);
- statement from the company or union providing pensions or union benefits; or
- Form H1050, Check Verification

Other Government Benefits

- current award notice, letter or official statement;
- check or copy of check;
- agency contract/record; or
- a Texas Department of Family and Protective Services advisor/representative statement.

RSDI

- check or copy of check;
- current award notice, letter or statement from the SSA;
- WTPY/SOLQ;
- direct deposit slip;
- computer inquiry to Bendex file, if it is consistent with the person's statement
- Form H1050;
- online verification from https://www.ssa.gov/employer/ssnv.htm; or
- SSA Form 1610, Public Assistance Agency Information Request (if no other source is readily available)

Self-employment

- IRS Schedule C, Form 1040 – Profit or Loss from Business;
- previous year's IRS tax return or business records (for self-employment income received less often than monthly);
- most recent business records and receipts;
- Form H1049, Client's Statement of Self-Employment Income, completed and signed by the individual;
  statement of estimated earnings;
- Tax Guide for Small Business; or
- receipts for goods/services provided.

Note: Use Form H1049 alone only if collateral contacts or documentary information cannot otherwise verify the income and expenses.

Unemployment Compensation

- check or copy of check;
- current award notice, letter or statement from TWC;
  former employer;
- TWC inquiry; or
- statement from TWC verifying the primary wage earner's application for unemployment insurance benefits.

Note: Other forms of verification must be used in conjunction with Form B-11, Benefits Claim Determination.

All Programs (except TP 33, TP 34, TP 35, TP 43, TP 44 and TP 48)

Application for SSI/RSDI

- Receipt from the SSA; or
- WTPY/SOLQ

TANF and SNAP

Child Support

- C-820, Data Broker; C-825.14.1, OAG Child Support Data; C-832, Office of the Attorney General (OAG) Inquiry; C-833, TXCSES Web Child Support Portal Inquiry;
- check or copy of check;
- county clerk records;
- canceled checks (three months if possible);
- wage withholding statements;
- withholding statements from unemployment compensation;
- written statement from the parent providing support; or
- current court records such as court order, court support agreement, or divorce or separation papers.

Educational Grants, Scholarships or Loans

- Statement, letter or records from:
  - schools;
  - organizations, clubs or agencies providing benefits; or
  - Veterans Affairs (for veteran's educational benefits).

SSI

- check or copy of check;
- current award notice, letter or written statement from the SSA;
- computer inquiry to SDX file (this source also provides sufficient proof of other types of income available to an SSI recipient);
- direct deposit slip;
- online verification from https://www.ssa.gov/employer/ssnv.htm; or

- WTPY/SOLQ.

Veterans Benefits

- a current award notice, letter or statement from VA or DFAS-CL;
- contact with a VA representative at 1-800-827-1000;
- contact with a DFAS-CL representative at 1-800-321-1080; or
- Form H1240, Request for Information from Bureau of Veterans Affairs and Client's Authorization

Workers' Compensation

- Current award notice letter or statement from:
  - claims adjuster;
  - attorney; or
  - insurance company; or
  - check or copy of check.

TANF

Ceremonial Marriage

- marriage license or certificate;
- church records;
- statement from clergy; or
- family Bible records.

Common Law Marriage

- Declaration of Informal Marriage filed with the county clerk;
- sworn statement signed by both spouses; or
- Form H1057, Declaration of Informal Marriage.

Medical Programs

Determining whether client-reported income is reasonably compatible with electronic data sources is the preferred method of wage verification for Medical Programs. Reasonable compatibility is explained in A-1370, Verification Requirements, Medical Programs.

TP 33, TP 34, TP 35, TP 43, TP 44 and TP 48

In addition to the verification sources listed for All Programs, the following are also accepted for earned and unearned income:

- paycheck stub issued in the last 60 days;
- most recent tax return;
- most recent Social Security statement or check;
- proof of self-employment; or
- letter from an employer verifying current income and frequency of payment.

Related Policy
Questionable Information, C-920
Providing Verification, C-930

A—1380 Documentation Requirements

Revision 15-4; Effective October 1, 2015

All Programs

Exempt Income — Requires documentation that includes:

- why it is exempt; and
- the name and address or telephone number of the income source.

Terminated Income — Requires documentation of:

- any income that terminated in the application month; and
- vacation pay received before or after termination, including the dates received.

Income — Requires documentation of the:

- date of each income statement or stub used;
- date income is actually received;
- date income is anticipated using factors such as distance it has to travel through the mail, direct deposit/electronic transfers, weekends and holidays;
- name and address or telephone number of the income source;
- gross amount of income;
- frequency of receipt (such as weekly, every two weeks, semimonthly, monthly); and
- calculations used.

Notes:

- If other means are used to verify earned income, the information should be documented comparable to that listed above. The payback amount and gross amount used in the budget for advances should be documented according to policy in A-1323.5, Wages, Salaries, Commissions, and Tips.
- If using TWC quarterly wage records, advisors must complete the appropriate screens in TIERS.

Fluctuating Income — Requires documentation regarding:

- the reason for income fluctuations; and
- why a pay period was included or excluded in the projection. If a pay period is not representative of future earnings, the advisor must document the reason it is not representative.

Income Computations — Requires document verification and computation of household income:

- at the initial application;
- when a change is reported; and
- at each subsequent application/redetermination.

  Note: All sources, amounts, dates, and computations must be recorded.

Other Income — Requires documentation of the method used to verify income other than earned and TANF. This documentation includes the:

- type of income;
- check or document seen;
- date on the check or document;
- amount recorded on the check or document;
- date the income was verified; and
- computation performed to determine the total income.

Self-Employment — Requires documentation of:

- the method for averaging income;
- deductions for the costs of doing business;
- the number of hours engaged in the enterprise; and
- other factors used to determine the amount of income.

  Notes:
  - Document the reason if Form H1049, Client's Statement of Self-Employment Income, is the only source of verification.
  - Provided the income is entered as self-employment income in TIERS, a statement informing the self-employed individual to keep self-employment records and receipts for verification purposes for future recertifications will appear on Form TF0001, Notice of Case Action. Otherwise, add the statement to the individual's notice and document that the self-employed person was given this information in writing.

Alien Sponsor's Income — Requires documentation that an indigent alien, exempt from deeming requirements, was informed that state office is required to report the indigent alien's sponsor to the OAG. If the alien does not want this report sent to the OAG, the advisor must document that the alien chose to have the sponsor's income deemed.

TANF and SNAP

Terminated Income — Requires documentation of any income that terminated in the two months before the application month, including:

- source;
- gross amount of final check and date received;
- reason for termination; and
- date of termination.

TANF and Medical Programs except TP 33, TP 34, TP 35, TP 43, TP 44, TP 45 and TP 48

Requires documentation of the household's plan to pursue income to which it is entitled, including time allowed to pursue the income.

Requires documentation of an individual who no longer claims to have a disability or be caring for a child with disabilities, when they reapply after they were denied for failure to follow the agreed plan to apply for SSI/RSDI.

TANF

Requires documentation of the months during the six-month period in which the earnings of a new spouse of a TANF recipient will be excluded.

Requires documentation of the individual's decision not to apply for SSI, when the individual is not required to pursue it because the individual is physically or mentally unable to complete the application process and HHSC fails or is unable to provide assistance needed to complete the SSI application process.

Requires documentation of an individual's decision to no longer claim a Choices exemption for disability or caring for a child with disabilities when the individual has failed, without good cause, to apply for SSI/RSDI.

Related Policy
Documentation, C-940
The Texas Works Documentation Guide

TWH, A-1400, Deductions

Revision 18-1; Effective January 1, 2018

A—1410 General Policy

Revision 15-4; Effective October 1, 2015

All Programs except TP 45

Certain deductions may be allowed when determining countable income.

TANF

Households may be allowed the following deductions:

- work-related expense deduction (up to $120);
- 90 percent earned income deduction;
- dependent care;
- diversions; and
- $75 disregard.

SNAP

Households may be allowed the following deductions:

- 20 percent earned income deduction for households with earnings;
- standard deduction;
- medical costs for household members who are elderly or have a disability;
- dependent care;

- child support paid to or for non-household members;
- homeless shelter standard;
- excess shelter costs; and
- Plan for Achieving Self-Sufficiency (PASS).

Medical Programs except TP 45

Households may be allowed the following Modified Adjusted Gross Income (MAGI) deductions:

- standard MAGI income disregard;
- alimony paid;
- educational expenses/student loan interest;
- moving expenses;
- tuition or GI Bill deduction;
- educator expenses;
- expenses of fee-basis government officials, expenses of performing artists, and expenses of reservists;
- health savings account;
- deductible part of self-employment tax;
- self-employed individual retirement account (IRA), simple IRA, and qualified plan deductions;
- self-employed health insurance;
- penalty on early withdrawal;
- IRA deduction; and
- domestic production activities deduction.

TP 45

Since there is no income test, deductions are not considered as a factor in determining eligibility for TP 45.

A—1411 Rules That Apply to Deductions

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Actual amounts (amounts that have already been billed) are used for the interview month, and amounts that have not been billed may be projected.

- The following expenses are not deducted:
  - expenses paid to another member of the same Eligibility Determination Group (EDG);
  - expenses paid by a reimbursement, an exempt vendor payment or in-kind benefit (**Exception:** For the Supplemental Nutrition Assistance Program [SNAP], see A-1428.1, Allowable Medical Expenses, and A-1429.3, Utility Allowances); or
  - past-due balances, late charges or finance charges. **Exception:** For SNAP, expenses such as property tax that are averaged over the period between scheduled billings or over the period the expense is intended to cover are allowable even if the expense is paid or past due when reported.
- The most recent month's bills are used to project expenses, and unexpected changes should be considered during the certification period.
- Only household expenses expected during the certification period should be considered.
- The income conversion factors are used to determine monthly expenses if expenses are billed weekly, biweekly or semi-monthly.

Deductions must not be allowed if:

- verification of the expense is required;
- the household fails to provide required verification; and
- the advisor is not able to verify the expense directly using other automated systems that are acceptable verification sources and accessible to the advisor or through another method.

Note: The EDG must not be denied for failure to provide the verification.

SNAP

- An expense is allowed, regardless of when or if the household intends to pay it.
- If expenses are not averaged, the expenses should be deducted in the month the expense is billed (or the month it becomes due if no bill is sent). **Exception:** See A-1428.4, Change in Medical Expenses During Certification.

- A deduction for expenses that are legally due monthly is allowed even when the household pays them in advance.
- Households may choose to average expenses that fluctuate or occur less often than monthly. These expenses are averaged over the:
  - interval between scheduled billings, or
  - period the expense is intended to cover if there is no scheduled billing.

    Note: If the individual reports a change, the average is recalculated.

- If the individual agrees with the provider to make installment payments for an allowable one-time expense, the individual can choose to have the agreed upon payments budgeted as the amount due in a given month.

Medical Programs except TP 45

MAGI rules allow certain expenses to be deducted from the individual's income in order to determine the MAGI individual income.

- For all MAGI expenses that have been verified using last year's federal income tax return, take the expense amount from the federal income tax return and divide that amount by 12 to determine the monthly expense amount for use for applicant or recipient.
- For the alimony paid expenses verified using other acceptable verification sources, use the actual amount verified for the MAGI alimony paid expense.

A-1411.6.23 MyGoals Payments

Revision 18-1; Effective January 1, 2018

MyGoals payments are cash payments received by participants in the MyGoals for Employment Success demonstration project. The demonstration studies the impact of combining workforce development and financial payments on employment outcomes for recipients of the Housing and Urban Development, Section 8 Rental Assistance. Only residents within the jurisdiction of the Houston Housing Authority are selected to participate in the project.

MyGoals payments are counted as cash contributions made by a private, nonprofit organization according to policy in A-1326.1, Cash Gifts and Contributions.

A—1420 Types of Deductions

Revision 12-3; Effective July 1, 2012

A—1421 Child Support Deductions

Revision 15-4; Effective October 1, 2015

TANF

Diversion policy in A-1424, Diversions, Alimony, and Payments to Dependents Outside the Home, applies.

SNAP

Advisors should deduct child support payments (current or arrears) that a household member is legally obligated to pay and that member or another household member:

- actually pays **to** an individual outside the SNAP household; or
- actually pays **for** an individual outside the SNAP household; or
- makes to a child support agency.

A—1421.1 Allowable Child Support Deductions

Revision 15-4; Effective October 1, 2015

SNAP

Allowable child support payments may be in the form of:

- cash support;
- medical support; or
- payments to third parties.

To be an allowable deduction, these payments must be ordered by a court or administrative authority and be equal to or less than the household's child support obligation.

Payments for alimony or spousal support are not deductible.

A—1421.2 Budgeting Child Support Deductions

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Child support collected through a tax intercept is not an allowable child support deduction.

A child support payment may be owed by one household member but paid by another member. The child support expense for the household member paying the expense is allowed.

If the household member with the legal obligation or the household member paying the legal obligation leaves the home, the household's eligibility for the deduction must be redetermined.

SNAP

A child support deduction for households that pay legally obligated child support is allowed. For current support, a deduction up to and including the legally obligated amount is allowed. For arrears, only the amount a household member actually pays is allowed.

For households with new obligations, the anticipated amount is budgeted if the household member can reasonably explain the basis for future payment. For households with previous payments, the amount (not to exceed the legal obligation) is averaged and projected over the certification period. Any other anticipated changes that would affect the payment should be considered.

In some instances, an employer may charge the absent parent a processing fee for garnishing wages or the custodial parent may use the services of a private collection agency, which may charge the absent parent a fee for collecting child support. The processing fee is not an allowable expense. Only the legally obligated amount a household member pays is allowed as a deduction, regardless of whether a processing fee is added or subtracted from the gross amount of the child support.

If a household member pays child support in advance, the household is eligible for the child support deduction. The individual is allowed the option of deducting the entire amount in the month paid or averaging the amount over the period of time it is intended to cover.

If legally obligated child support is paid by a household member who is disqualified due to ...	then ...
intentional program violation, employment sanction, felony drug convictions or being a fugitive,	deduct the entire amount of eligible child support paid.
alien status, citizenship, Social Security number or 18-50 work requirement,	prorate the amount of eligible child support paid by the disqualified member. Deduct all but the disqualified member's share.

The full child support expense is deducted when another household member pays the legally obligated child support on behalf of a disqualified member.

A—1422 $75 Disregard Deduction

Revision 15-4; Effective October 1, 2015

TANF

Up to $75 of child support received before the certification date may be deducted.

Related Policy
Child Support, A-1326.2

A—1423 Dependent Care Deduction

Revision 15-4; Effective October 1, 2015

TANF

The maximum dependent care deduction is up to and including:

- $200 a month for each child under age 2,
- $175 a month for each child age 2 or older, and
- $175 a month for each adult with disabilities.

An earned income deduction is allowed for the actual cost of unreimbursed payments up to and including the maximum amount when the individual incurs an expense for:

- the care of a child or adult with disabilities (even when the child or adult with disabilities is not included in the certified group); and/or
- transportation of a child to and/or from day care or school.

The expense must be both necessary for employment and incurred by an employed person who is included in the Temporary Assistance for Needy Families (TANF) budget group or would be included except the person is disqualified for a reason listed in A-1362.2, TANF — Budgeting for a Household Member Disqualified for Noncompliance with SSN, TPR, Failure to Timely Report a Certified Child's Temporary Absence, Intentional Program Violation, Being a Fugitive or a Felony Drug Conviction. The expense for household members meeting these requirements is allowed, even if there are other adults in the household who could care for the children.

The deduction in the budgetary and recognizable needs tests is allowed.

SNAP

A deduction is allowed for the actual cost of unreimbursed payments when the individual incurs an expense for the care of a child or adult with disabilities, or the transportation of a child or adult with disabilities to and/or from day care or school. The deduction is allowed if the expense is necessary for a household member to:

- seek or continue employment;
- attend training; or
- go to school.

The expense for household members who meet one of the above conditions is allowed, even if there are other adults in the household who could care for the children. These expenses are deducted from earned or unearned income. The individual's expense may be considered necessary for employment, training or school attendance if the child or adult with disabilities lives with the individual at least one day a month. The child/adult with disabilities does not have to be a certified member of the SNAP household.

Related Policy
Disqualified Members, A-1362

A—1424 Diversions, Alimony, and Payments to Dependents Outside the Home

Revision 15-4; Effective October 1, 2015

TANF

The following deductions from the income of a caretaker, second parent, or minor parent are allowed before either of the two needs tests are applied (after earned income deductions in the budgetary and recognizable needs tests):

- budgetary needs amount for a family size equal to the number of noncertified persons in the home whom the legal parent can claim as tax dependents or is legally obligated to support (including Supplemental Security Income [SSI] recipients and children receiving TP 19 SSI Medicaid). The needs figure applicable to the number of noncertified members is used.

  An amount for the needs of a dependent who is disqualified for a reason other than citizenship, alien status, time limits, or unmarried minor parent domicile requirement is not diverted.
- actual amount of child support and alimony a household member pays to persons outside the home.
- actual amount of a household member's payments to persons outside the home whom a household member can claim as tax dependents or is legally obligated to support.

When two household members are married or filing a joint tax return, any portion of their joint diversion amount that exceeds one person's income can be deducted from the other person's income.

Step 3 on Form H1100, Addendum Income Worksheet, should be completed to allow this deduction.

Medical Programs

Alimony paid by members of the MAGI household composition may be deducted.

A—1424.1 Determining the Needs Figure

Revision 15-4; Effective October 1, 2015

TANF

The following table may be used when diverting for the needs of noncertified tax dependents in the home.

If the tax dependent is a ...	then use the budgetary needs figure for ...
• parent, • spouse (including spouse of child), or • child age 19 or older,	an adult.*
child under age 19,	a child.

* If the number of persons whose needs are diverted includes more than two adults, use the chart figure for two adults and the number of children from the column labeled Caretaker EDGs With Second Parent. If there are a total of three adults, add an additional amount from the chart for the family size of one ($313); or if there are a total of four adults, add an additional amount from the chart for a family size of two ($498). Continue the pattern depending upon whether the number of additional adults is an odd number (5 = $498 + $313) or an even number (6 = $498 + $498).

When diverting for an 18-year-old child who turns age 19 during one of the budget months, the budgetary needs figure of an adult is used beginning with the month after the child turns age 19.

A—1425 Earned Income Deductions

Revision 15-4; Effective October 1, 2015

TANF

Earned income deductions are the:

- standard work-related expense (up to $120);
- 1/3 earned income disregard for applicants;
- 90 percent earned income deduction; and
- dependent care costs.

An applicant or recipient does not qualify for deductions if:

- income is gained from illegal activities, such as prostitution and selling illegal drugs.
- the individual did not notify the Texas Health and Human Services Commission (HHSC) timely about a new job or increased earnings without good cause. Allow the deduction for ongoing budgets, but do not allow it when determining an overpayment or supplemental budgets. Count the months it should have been budgeted as used months based on when the change would have been effective if the individual had reported it timely.
- individual voluntarily quits a job without good cause within the 60 days prior to the:
  - application file date, or after filing but before certification; or
  - household addition request date, or after the request but before being added. Deductions are not allowed until the next complete review.

    Deductions beginning with the Texas Integrated Eligibility Redesign System (TIERS) effective month are allowed when processing the next complete review.

SNAP

A 20 percent deduction of all gross earned income is allowed. See B-752, Determining Claim Amounts, for exceptions.

A—1425.1 Work-Related Expense ($120 and 20%)

Revision 15-4; Effective October 1, 2015

TANF

A work-related expense deduction of up to $120 a month (not to exceed the person's monthly earnings) is allowed from the earned income of each employed household member:

- whose needs are included in the budget or certified group; or
- who is a disqualified member.

In TANF, this deduction is allowed in the budgetary and recognizable needs test.

SNAP

Allow a 20 percent deduction of all gross earned income.

A—1425.2 1/3 Disregard for Applicants

Revision 15-4; Effective October 1, 2015

TANF

Applicant households that must pass the 100 percent budgetary needs test are also required to pass Part A of the 25 percent recognizable needs test. This Part A test allows the standard work-related deduction ($120) and a disregard of 1/3 of the remaining income. If the

applicant fails this test, the household is ineligible for TANF.

Note: For this purpose, an applicant household is one that has not received TANF in any state in the four months before applying.

A—1425.3 90% Earned Income Deduction

Revision 15-4; Effective October 1, 2015

TANF

Applicant households that pass Part A of the recognizable needs test and all other households must pass Part B of the test (see A-1341, Income Limits and Eligibility Tests). After subtracting the standard work-related expense, 90 percent of the remaining earnings (up to a cap of $1,400) is subtracted. This deduction is allowed for each employed household member who is eligible for it. The individual can receive this deduction for four months in a 12-month period. The four months do not have to be consecutive. **Note:** A month in which a full-family sanction is imposed is not counted as one of the 90 percent earned income deduction (EID) months.

The 12-month period is a fixed period that begins with the first month the 90 percent deduction is used. The first month that counts as a used month is the first month the individual receives a cash benefit that includes the 90 percent deduction. This period is referred to as the 90 percent EID eligibility period.

If the individual has not used all four months of the deduction within the 90 percent EID eligibility period, a new fixed 12-month period and four new months of the 90 percent EID are allowed after the first 12-month period ends. The new 12-month period begins with the first month that the individual uses the 90 percent deduction again.

If the household member received the 90 percent deduction for four months in a 12-month period, the member may not receive it again until:

- TANF is denied and remains denied for one full benefit month; and
- 12 calendar months have passed since the denial. This 12-month period is known as the 90 percent EID ineligibility period and begins with the first full month of denial after the individual used the fourth month of the 90 percent deduction.

A—1425.3.1 Who Is Eligible for the 90% Earned Income Deduction

Revision 15-4; Effective October 1, 2015

TANF

A household member is eligible to receive the 90 percent EID if:

- the individual has not previously received the deduction for four months in the individual's 12-month period; and
- the individual's needs:
  - are included in the certified group; or
  - would be included except the individual is disqualified for noncompliance with child support, Social Security number (SSN), Choices, third-party resource (TPR) requirements, intentional program violation (IPV), or for reasons other than alien/citizenship status, TANF state time limit policies, and the TANF unmarried minor parent domicile requirement.

TIERS default settings automatically allow the 90 percent EID for eligible EDG members. The 90 percent EID page appears by choosing the screen from the left navigation bar. The effective begin and end dates are used to allow the deduction for specific months.

An individual may decline use of the deduction even if it results in EDG denial without its use. The individual may decline at any time, but the deduction may not be removed retroactively. Any removal from the budget will take effect according to timely change processing for future months.

If the client wishes to decline the deduction, the client answers "yes" to the questions, "Does individual decline the TANF 90 percent earned income deduction?" and "Does individual decline the FMA 90 percent earned income deduction?" on the 90 percent Earned Income Deduction – Details screen. TIERS requires answers for both questions.

A—1425.3.2 Who Is Not Eligible for the 90% Earned Income Deduction

Revision 15-4; Effective October 1, 2015

TANF

An individual is not allowed the deduction if any of the situations listed in A-1425, Earned Income Deductions, apply to the individual.

An individual is not allowed the deduction if the member's needs are not included in the EDG because the member is disqualified due to:

- alien/citizenship status;
- TANF state time limits policies; or
- TANF unmarried minor parent domicile requirement.

The deduction is not allowed if the individual has already received the 90 percent deduction for four months in a 12-month period. When the 90 percent ineligibility period ends, the deduction is not allowed again until the individual obtains new employment. The new employment must begin after the 90 percent ineligibility period ends.

A—1425.3.3 Removing the 90% Earned Income Deduction

Revision 15-4; Effective October 1, 2015

TANF

After the individual receives the 90 percent deduction for four months in a 12-month period, the deduction ends. TIERS automatically removes the deduction and rebudgets the EDG for the appropriate month based on advisor entries.

A—1426 Reserved

Revision 15-4; Effective October 1, 2015

A—1427 Homeless Shelter Standard

Revision 15-4; Effective October 1, 2015

SNAP

The homeless shelter standard shown in C-121.1, Deduction Amounts, is budgeted for any month the household:

- meets the definition of a homeless household;
- has any amount of out-of-pocket shelter expenses; and
- chooses the standard.

Households that choose the homeless shelter standard are not entitled to any other shelter deductions or utility standards.

Note: Advisors must ensure that the household has out-of-pocket shelter expenses before allowing the deduction.

A—1428 Medical Deduction

Revision 15-4; Effective October 1, 2015

SNAP

A medical deduction is allowed for households with a member who meets the definition of elderly in B-431, Definition of Elderly, or of having a disability in B-432, Definition of Disability, if the:

- member who is elderly or has a disability incurred the expense; and
- medical expenses exceed $35 a month. If two or more people in the household qualify for a medical deduction, combine the medical expenses. If an applicant has been or will be reimbursed for a medical expense, deduct only the nonreimbursed amount.

Expenses that the household is still legally obligated to pay are allowed for someone who was a household member:

- immediately before entering the hospital or nursing home; or
- when the member died.

A—1428.1 Allowable Medical Expenses

Revision 17-3; Effective July 1, 2017

SNAP

Deductions are allowed for the following medical expenses:

- medical care provided by a licensed practitioner or other qualified health professional (e.g., registered dietician);
- dental care provided by a licensed practitioner or other qualified health professional;
- psychotherapy care provided by a licensed practitioner or other qualified health professional;
- rehabilitation care provided by a licensed practitioner or other qualified health professional;
- hospitalization provided by a facility recognized by the state;
- outpatient treatment provided by a facility recognized by the state;
- nursing care provided by a facility recognized by the state;
- nursing home care provided by a facility recognized by the state;
- diapers for children with disabilities;
- incontinence pads for elderly or adults with disabilities;
- drugs prescribed by a licensed practitioner (including insulin);
- over-the-counter medication (including aspirin, ibuprofen, medicated creams, etc.) when approved by a licensed practitioner or other qualified health professional;
- medical supply costs (including rental) are deductible with a prescription/approval;
- sickroom equipment costs (including rental) are deductible with a prescription/approval;
- adaptive aids;
- health insurance policy costs (including dental insurance, vision insurance, etc.);
- hospitalization insurance policy costs (including hospital indemnity insurance, etc.);
- Medicare premiums and cost-sharing/deductibles;
- spend down expenses incurred by Medicaid recipients;
- Medicaid Buy-In for Children (MBIC) premium payments;
- dentures;
- hearing aids;
- prostheses;
- service animals. Cost of securing and maintaining any animal trained to serve the needs of a person with disabilities, such as a guide dog or dog to help the hearing impaired. This includes dog food and veterinarian bills;
- eyeglasses prescribed by a qualified health professional;
- lodging costs to obtain medical services;
- care costs. Cost of maintaining an attendant, home health aide, child care provider or housekeeper necessary because of age or illness. In addition to wages, deduct an amount equal to a one-person SNAP allotment if the applicant furnishes a majority of the attendant's meals. If the applicant has attendant care costs that could qualify under both medical and dependent care deductions, consider the cost a medical expense;
- repayment of a loan used to pay medical expenses; or
- transportation costs (such as trips to the doctor, hospital, therapy, drug store, or paying someone to drive the individual for medical services, etc.).

Note: When determining transportation costs, the individual may choose to use 53.5 cents per mile instead of keeping track of actual expenses.

Deductions are not allowed for the following medical expenses:

- the costs of policies that do not specifically cover medical costs (such as income maintenance or lump sums for death or dismemberment) are not allowable;
- food supplements that can be purchased with SNAP, such as Ensure and baby formula, even if prescribed by a physician;
- paid or past due expenses billed prior to the initial certification period (that is, before the person was receiving SNAP); or
- herbal products.

A—1428.2 Budgeting Medical Deductions

Revision 15-4; Effective October 1, 2015

SNAP

Households that have a member who is eligible for a medical expense are eligible for a deduction using either the standard medical expense (SME) or actual medical expenses.

At ...	then budget ...	and verify ...
application, if the household has medical expenses greater than $35 and less than or equal to $137 a month,	the SME,	the household has medical expenses greater than $35.
application, if the household has medical expenses greater than $137 a month,	actual medical expenses,	the actual monthly medical expense(s). If the household chooses not to provide verification of expenses exceeding $137, then allow the SME instead of actual expenses. The household must provide proof of expenses exceeding $35.
redetermination, if: • the household already has actual medical expenses greater than $35 and less than or equal to $137, and • there is no change, or there is a change in the amount but the monthly medical expense is still greater than $35 and is less than or equal to $137,	the SME,	N/A, no verification is required.
redetermination, if the household does not already have the SME budgeted and the household states an eligible member has medical expenses greater than $35 and less than or equal to $137,	the SME,	the household has medical expenses greater than $35.
redetermination, if the household does not already have actual medical expenses budgeted and the household states an eligible member has medical expenses greater than $137,	actual medical expenses,	the actual monthly medical expense(s). If the household chooses not to provide verification of expenses exceeding $137, then allow the SME instead of actual expenses. The household must provide proof of expenses exceeding $35.
redetermination, if: • the household has actual medical expenses greater than $137 already budgeted, and • there is a change in the monthly amount of more than $25,	• the SME if the new total is greater than $35 and less than or equal to $137, or • actual medical expenses if the new total exceeds $137,	the change in medical expenses.

When the expense ends, the advisor must end date the expense record in TIERS.

TIERS will subtract $35 from the SME or actual medical expenses to determine the net amount of the medical deduction.

If a member is disqualified for:

- SNAP Employment and Training (E&T), a felony drug conviction, IPV, refusal to cooperate with the quality control review process, or being a fugitive, and is billed for or pays medical expenses — the full deduction is allowed; or
- SSN noncompliance, citizenship requirements, alien status, or the 18-50 work requirement, and is billed for or pays medical expenses for the disqualified member's own expenses or the medical expenses of another household member who is elderly or has a disability — the expense or the standard medical deduction is prorated among all household members and the pro rata share for individuals disqualified for SSN noncompliance, citizenship requirements, alien status, or the 18-50 work requirement is not allowed. The full medical deduction is allowed if the medical expenses are paid by an eligible household member.

If the disqualified person has the only income, the expenses are considered to be paid by that person.

The following information describes how the SME or actual medical expenses are prorated in the event a disqualified member pays for some or all of the allowable medical expenses.

Eligibility for the SME or actual medical expenses is determined based on verified medical expenses of all aged members or members with disabilities (including a disqualified member). The SME is used if the total verified medical expenses are greater than $35 and less than or equal to $137. The household may claim actual expenses if the total verified expenses exceed $137.

If ...	then ...	and ...
the household is eligible for the SME,	prorate the SME among all household members,	use the eligible household members' portion of the SME in the budget. (In TIERS, enter the amount each member actually pays, and TIERS prorates accordingly.)
the household is eligible for actual medical expenses,	prorate the portion paid by the disqualified member among all household members,	add the eligible household members' prorated portion to the actual amount of medical expenses any eligible member pays and use this amount in the budget. (In TIERS, enter the amount each member actually pays, and TIERS prorates accordingly.)

Example 1 (SME): The household consists of three eligible members with total verified monthly medical expenses of $75 and one member who is disqualified due to citizenship. The disqualified person pays for half of the medical expenses, and an eligible person pays for the other half. The household is eligible for the SME because the total verified monthly medical expenses are $75 (greater than $35 but less than $137). The SME is prorated among the eligible members, because the disqualified member pays for part of the medical expenses.

$137 / 4 = $34.25
$34.25 x 3 = $102.75

In TIERS, a medical expense of $37.50 ($75/2) is entered for both the disqualified person and for the eligible member, which is the amount of monthly medical expenses each member actually pays, and TIERS will budget a prorated SME of $102.75.

Example 2 (Actual Medical Expenses): The household situation is the same as Example 1, except that the monthly amount of verified medical expenses is $200. The disqualified member pays $100 of the medical expenses. The household is eligible for the actual amount of medical expenses. The amount the disqualified member pays is prorated and added to the portion paid by the eligible member to determine the total amount of the medical deduction.

$100 / 4 = $25
$25 x 3 = $75
$75 + $100 = $175

The following amounts are entered in TIERS:

- $100, for the eligible member; and
- $100, for the disqualified member (TIERS will prorate the allowable amount to $75).

Finally, $35 must be subtracted from the total deduction to determine the net amount of the medical deduction (TIERS does this as a final step).

A—1428.2.1 Determining Allowable Costs for Individuals with a Medicare Prescription Drug Plan Part D

Revision 15-4; Effective October 1, 2015

SNAP

If the applicant is enrolled in Medicare Drug Plan Part D, the individual's prescription costs are budgeted following normal rules by reasonably anticipating the individual's unreimbursed out-of-pocket expenses.

Note: The household may opt for the SME.

A—1428.3 Budgeting Options

Revision 15-4; Effective October 1, 2015

SNAP

When averaging the medical expenses, the SME is budgeted for each month of the certification period, as long as the household's allowable averaged monthly medical expense is greater than $35. If the expense recurs monthly or more often, and the medical expense exceeds $35 and is less than or equal to $137 a month, the SME is budgeted for each month of the certification period. When allowable medical expenses for the household exceed the SME, the actual medical expenses are budgeted. The following chart is used to determine when to budget the SME or actual medical expenses.

If the expense ...	then budget the ...
recurs less often than monthly and the amount averaged for each month is less than or equal to $35,	actual amount of verified actual medical expense in the month billed, or use the SME in the month billed if the medical expense is greater than $35 and less than or equal to $137.
recurs less often than monthly and the amount averaged for each month is greater than $35 and less than or equal to $137 a month,	SME for each month of the certification period.
recurs less often than monthly and the amount averaged for each month is greater than $137,	averaged amount of actual verified medical expenses for each month. Budget the SME only if the household chooses to use the SME or fails to provide enough verification to qualify for actual medical expenses.
occurs one time and the amount averaged over the certification period is less than or equal to $35 a month,	actual amount of verified medical expenses in the month billed, or use the SME in the month billed if the medical expense is greater than $35 and is less than or equal to $137.
occurs one time and the amount averaged over the certification period is greater than $35 and less than or equal to $137 a month,	SME for each month of the certification period.
occurs one time and the amount averaged over the certification period is greater than $137 a month,	averaged amount of the actual medical expenses for each month. Budget the SME only if the household chooses to use the SME or fails to provide enough verification to qualify for actual medical expenses.

Note: A deduction is allowed for payments made on a monthly payment plan set up before the expense became past due.

A—1428.4 Change in Medical Expenses During Certification

Revision 15-4; Effective October 1, 2015

SNAP

SNAP households are not required to report changes in medical expenses during the certification period.

Households should be advised that a new one-time expense or change in a recurring medical expense that is reported and verified timely may be budgeted in the certification period.

If the household voluntarily reports a change in medical expenses and the change is reported and verified timely, the advisor must consider the newly reported change to determine if the individual should consider switching from the SME to actual expenses.

A medical expense, paid or unpaid, is reported timely if it is reported before it becomes past due to the provider:

- anytime during the certification period, or
- at the next redetermination.

A one-time medical expense reported and verified too late to budget in the current certification period may be deducted in the first month of the next certification period or averaged over the next certification period.

When the household timely reports and provides timely verification of a paid or unpaid expense (one-time medical expense or recurring) at the redetermination interview:

- the expense is deducted in the first month of the new certification period, or
- averaged over the new certification period.

When a change in medical expenses is reported during the certification period by a ...	then ...
household member or the authorized representative,	follow the procedures in B-600, Changes, for both increases and decreases in benefits.
source other than a household member or the authorized representative,	act on the change if it is considered to be verified at the time of receipt and the change can be made without contacting the household for additional information or verification. **Note:** If the change would require contact with the household, do not act on the change until the household is recertified.

A—1428.5 Switching Between Actual Medical Expenses and the Standard Medical Expense

Revision 15-4; Effective October 1, 2015

SNAP

Households may switch between actual expenses and the SME at redetermination. Households may also switch at an incomplete review if changes in medical expenses are reported and it is to the household's advantage to switch from the SME to actual medical expenses.

A—1429 Shelter Costs

Revision 15-4; Effective October 1, 2015

SNAP

A deduction is allowed for all households that incur a shelter expense using the following rules:

- Monthly shelter costs that exceed 50 percent of the income remaining after other deductions may be deducted.
- The shelter deduction cannot exceed the maximum shown in C-121.1, Deduction Amounts, unless there is a member of the household who is elderly or has a disability as defined in B-430, Households with Elderly Members or Members with a Disability.
- The uncapped deduction is not allowed for households that only receive a medical deduction for a former member.
- A deduction is allowed only for charges for the shelter the household currently occupies. **Exceptions:**
  - If a required household member is employed in another city and maintains a residence there, shelter costs are allowed for both the regular residence and the residence maintained where the member is employed. The household may claim one of the utility allowances.
  - See A-1429.2, Shelter Deductions for an Unoccupied Home.
- Households sharing shelter costs are both entitled to a shelter deduction for their share.
- Shelter expenses paid by an exempt vendor payment or reimbursement are not deductible. **Exception:** A deduction for utility expenses as noted in A-1429.3, Utility Allowances, is allowed.

- One of the utility allowances/standards is allowed.

  Note: The utility and telephone standards for households with disqualified members or households sharing utility expenses must not be prorated.
- Property taxes that are averaged as explained in A-1411, Rules That Apply to Deductions, are deducted, even if the expense is paid or past due when reported.

A—1429.1 Allowable Shelter Costs

Revision 15-4; Effective October 1, 2015

SNAP

Allowable costs include:

- Rent, mortgage payments and other continuing charges leading to ownership of the property, such as mandatory maintenance and homeowner association fees, are allowed.

  Notes:

  Costs to repay a loan are allowable shelter costs only if the lender places a lien on the property as a result of the loan. The loan may be for home repair/improvement or for purposes unrelated to the home, but the payments due are considered a mortgage if the loan results in a lien on the property.

  Maintenance fees must be mandatory as a condition for the continuation of residence for renters and homeowners. The fees must be a required fee payment, not a requirement to maintain the property.

- Taxes and insurance on the shelter, but not its contents, are allowed. The cost of insurance for the shelter and the contents are allowed if they cannot be separated.
- Charges for fuel, utilities, sewage, and garbage collection are used to determine whether the household may be eligible for one of the utility expense deductions found in A-1429.3, Utility Allowances.
- Expenses related to a telephone, including a cell phone, are used to determine whether the household may be eligible for a standard telephone deduction.
- Unreimbursed expenses for the repair of a home damaged by a natural disaster are allowed.

Note: Shelter costs do not include one-time deposits.

A—1429.2 Shelter Deductions for an Unoccupied Home

Revision 15-4; Effective October 1, 2015

SNAP

The actual shelter costs are budgeted for a home (excluding utility costs) unoccupied because of employment or training, illness (including receiving medical treatment), natural disaster or casualty loss (fire, flood, state of disrepair, etc.), if the:

- household intends to return to the home;
- current occupants are not claiming the same shelter costs the owner is claiming for SNAP purposes; and
- home is not leased or rented.

The household may claim both the shelter costs of its current residence and the cost of the unoccupied home, and a single utility standard (if the household is eligible for one), but no more than the maximum excess shelter deduction (if applicable).

A—1429.3 Utility Allowances

Revision 15-4; Effective October 1, 2015

The appropriate utility allowance is determined at application, redetermination, and when the individual reports a change in utility expenses.

A—1429.3.1 Standard Utility Allowance (SUA)

Revision 15-4; Effective October 1, 2015

SNAP

The SUA is budgeted in the amount shown in C-121.1, Deduction Amounts. No other expenses related to utilities are allowed when using the SUA. The SUA is allowed for households that:

- have or anticipate out-of-pocket heating or cooling costs separate from their rent or mortgage payments during the next 12 months; or
- reasonably anticipate receiving a vendor or direct payment from CEAP or the Energy Crisis Program funded under the Low Income Home Energy Assistance Act (LIHEAA) in any of the next 12 months, even if they do not have an out-of-pocket expense.

Notes:

- Cooling costs are limited to the cost related to the operation of an air conditioning system, an evaporative cooler (or swamp box) or window unit air conditioner(s). A fan is **not** considered a cooling cost for the purposes of qualifying for the SUA.
- When households share heating or cooling costs and a meter (whether they live together or not), each household is eligible for the SUA.

A—1429.3.2 Basic Utility Allowance (BUA)

Revision 15-4; Effective October 1, 2015

SNAP

The BUA is budgeted in the amount shown in C-121.1, Deduction Amounts, for households that incur utility expenses other than just a telephone expense but do not have heating or cooling costs separate from their rent or mortgage payments. No other expenses related to utilities are allowed when using the BUA.

When households share utility costs other than a telephone but do not have heating or cooling costs (whether they live together or not), each household is eligible for the BUA.

A—1429.3.3 Determining the Appropriate Utility Allowance

Revision 15-4; Effective October 1, 2015

SNAP

The following chart may be used as a guide to determine the appropriate utility allowance the household is eligible to receive.

If the individual ...	then the household is eligible for the ...
owns or is buying their home and is billed for utilities that include heating or cooling costs ...	SUA
owns or is buying their home and is billed for utilities that do **not** include heating or cooling costs ... (**Example:** The household does not have air conditioning and cools their home with fans and uses a cooking stove for heating.)	BUA
receives LIHEAA payments, such as CEAP or Energy Crisis ...	SUA

If the individual ...	then the household is eligible for the ...
rents and is billed for utilities from an individual meter for heating or cooling costs ...	SUA
rents from a landlord who lives in a separate residence and the landlord bills the household a standard amount for the heating/cooling costs ...	SUA
lives in public housing and is billed only for excess heating or cooling costs ...	SUA
shares the expense and a meter with another household who lives in a separate residence on the same property and the other household is billed for the utilities that include heating and cooling costs ...	SUA
lives together in the same residence with a friend or family member and the individual: • shares the heating/cooling expenses with the friend or family member (even if the friend or family member is billed for the utilities that include heating/cooling costs); • pays the cooling bill and the friend or family member pays the heating; • pays the friend or family member a set amount for the utilities that include heating and/or cooling costs separate from the rent ...	SUA
lives together in the same residence with another household and the individual shares the utility expenses that do not include heating or cooling costs separate from the rent ...	BUA
lives together in the same residence with another household who pays for the heating/cooling costs and the individual is only responsible for the water bill ...	BUA
pays only the telephone expense and all other utility expenses are included in the shelter costs ...	telephone standard
lives together in the same residence with other households who share the heating, cooling or other utility costs and the individual is only responsible for the telephone bill ...	telephone standard
lives with a disqualified member and the household pays heating or cooling costs ...	SUA
lives with a disqualified member and the household pays non-heating or non-cooling costs ...	BUA

A—1429.4 Telephone Standard

Revision 15-4; Effective October 1, 2015

SNAP

The telephone standard is budgeted as shown in C-121.1, Deduction Amounts, for households that have a telephone expense (including a cell phone) and do not claim the BUA, SUA or the homeless shelter standard.

A—1430 Standard Deduction

Revision 15-4; Effective October 1, 2015

SNAP

The standard deduction is budgeted as shown in C-121.1, Deduction Amounts, for each household.

Medical Programs except TP 45

All households receive the standard MAGI income disregard listed in C-131.4, Standard MAGI Income Disregard, by MAGI household size. This disregard is equal to five percentage points of the Federal Poverty Income Limit (FPIL) and is applied when calculating MAGI household income, as explained in A-1341, Income Limits and Eligibility Tests, Medical Programs, Step 4.

A—1440 Verification Requirements

Revision 15-4; Effective October 1, 2015

All Programs except TP 45

If an individual fails to provide a required verification of a deduction, do not deny the EDG. Disallow the deduction. If the individual subsequently provides verification of the deduction, use report of change guidelines to budget the deduction.

TANF

Dependent care must be verified at application, complete review, or if the amount changes.

The following amounts must be verified at application, complete review, or if the amount changes:

- actual amount of child support and alimony paid to persons outside the home, and
- actual amount of payment to persons outside the home whom a person can claim as tax dependents or is legally obligated to support.

SNAP

Dependent care expenses must be verified at application, recertification, and when the individual reports a change in dependent care if verification can be obtained during the interview. If verification cannot be obtained during the interview, the individual's statement may be accepted without verification if the household states the total dependent care expense for the EDG does not exceed $300 a month and it is not questionable. The EDG is pended only if the expense claimed is questionable or exceeds a total of $300 a month.

The following amounts must be verified:

- household's legal obligation to pay child support:
  - by viewing a court order, administrative order, legally enforceable separation agreement, other official document; or
  - using a collateral contact with access to an official document.
- amount of the child support obligation.
- actual amount of child support paid by viewing:
  - Attorney General or county registry collection and distribution records,
  - canceled checks,
  - wage withholding statements,
  - withholding information from unemployment compensation, or
  - statements from the custodial parent regarding direct payments or third-party payments the household pays or expects to pay on behalf of the custodial parent.

  Note: Documents used to verify the household's legal obligation to pay child support are not acceptable verification of the household's actual payments.
- medical expenses. See A-1428.2, Budgeting Medical Deductions.
- rent or mortgage costs if the expense is questionable or if a regional requirement. If the requested proof is not provided, the expense is not allowed.
- shelter cost of an unoccupied home at initial application, changes, and recertifications.

Medical Programs except TP 45

All MAGI expenses must be verified at application, complete review, or if the amount changes.

A—1441 Verification Sources

Revision 18-1; Effective January 1, 2018

TANF and SNAP

Dependent Care

- statement or a current bill from provider;
- current receipts; or

- income tax return.

Child Support Paid by Household – Verifying Amount of Child Support Paid

- attorney general collection and distribution records;
- county clerk records;
- cancelled checks;
- wage withholding statements;
- withholding statements from unemployment compensation; or
- statement from the custodial parent regarding direct payments or third-party payments paid on their behalf.

TANF and Medical Programs except TP 45

Alimony

- divorce decree;
- court order;
- court records; or
- statement from the individual who is receiving the alimony.

TANF

Dependents Outside the Home

- previous year tax records;
- bank records;
- copies of money orders;
- cancelled checks; or
- statement from the individual who is receiving the payments.

SNAP

Medical Expenses

- bills (or copies of bills) from providers of health insurance, services and products;
- statements from providers;
- health insurance policies;
- statement from a qualified health professional indicating that over-the-counter medication, medical equipment or supplies are prescribed; or
- State Online Query (SOLQ) or Wire Third-Party Query (WTPY) to verify Medicare Part B premiums.

Note: If the person receiving SNAP is covered by insurance, the statement from providers needs to show the balance due after insurance pays.

Child Support Paid by Household – Verifying Legal Obligation

- court order;
- administrative order;
- legally enforceable separation agreement;
- divorce decree;
- attorney general child support enforcement records; or
- county clerk records.

Mortgage

- statement from mortgage company or bank;
- cancelled checks; or
- mortgage receipt.

Rent

- statement from landlord or apartment manager;
- rent receipt;
- cancelled checks; or
- current lease contract showing the payment amount. **Note:** A common practice of leasing companies is to show the monthly market amount on the first page of a lease, not the actual payment amount of the lease.

Property Taxes

- tax bill;
- cancelled check;
- statement from tax office employee; or
- county tax office websites.

Home Insurance

- insurance company bill;
- cancelled check; or
- statement from an insurance company employee.

Utilities

- utility company bill;
- cancelled checks; or
- statement from utility company employee.

Medical Programs except TP 45

An applicant's or recipient's federal income tax return from the previous year is the only valid verification source that can be used to verify all MAGI expenses except for alimony paid.

Note: A federal income tax return from the previous year is valid verification for MAGI expenses until the client files a new federal income tax return but no later than April 15 of the following year. If a person files an extension and submits proof of an extension, the previous year's federal income tax return is valid until October 15. If an applicant or recipient does not file federal income taxes, he or she will not be able to provide verification and, therefore, will not be able to claim any MAGI expenses other than alimony paid.

Related Policy
Questionable Information, C-920
Providing Verification, C-930

A—1450 Documentation Requirements

Revision 15-4; Effective October 1, 2015

All Programs except TP 45

Documentation is required for the following:

- the type of deduction allowed;
- the person for whom a deduction is allowed and how the person qualifies;
- the source/provider to whom a deduction expense is paid (name, address and/or telephone number);
- date and amounts paid; and
- calculations used to determine monthly amounts.

TANF and SNAP

Documentation is required for the following:

- the reason a household qualified for a dependent care deduction when it is questionable or not obvious; and
- justification for not allowing earned income deductions.

TANF

The relationship of the child care provider to the child must be documented.

SNAP

Documentation is required for the following:

- if the individual chose the SME when the individual's expenses exceed the SME; and
- an explanation of standard deductions —
    - document why the household did not qualify for a utility deduction; or

- why one of the utility standards (standard utility allowance, basic utility allowance, telephone standard) was budgeted.

Exception: Utility service providers' names and addresses are not required documentation.

Related Policy
The Texas Works Documentation Guide

TWH, A-1500, Reminders

Revision 18-1; Effective January 1, 2018

A—1510 General Reminders

Revision 15-4; Effective October 1, 2015

All Programs

Before certifying applicants and recertifying recipients, staff must:

- Ensure that the applicant completes each item and signs and dates the application or renewal form.

  Note: If the applicant indicates changes during application or renewal processing or the interview, document the nature of the change and when the individual expects the change to occur. Individuals on TP 08, TP 43, TP 44 and TP 48 complete the administrative renewal process explained in B-122.4, Medical Program Administrative Renewals, and may not be required to provide a signed renewal form.
- Give the applicant Form H1019, Report of Change. Explain that the applicant must report changes within 10 days after the household knows about the change. Indicate the appropriate reporting requirement on page 1.
- Refer the applicant to other programs the applicant might be eligible for, such as family planning; Supplemental Security Income (SSI); Women, Infants and Children (WIC); and Social Security. Refer individuals who are elderly or have disabilities and who are ineligible for Medical Programs for families and children to the Texas Health and Human Services Commission (HHSC) Medicaid for the Elderly and People with Disabilities (MEPD) programs. **Note:** If individuals indicate they need services that Texas Works does not provide and the advisor does not have a resource number, the individual should be advised to call 2-1-1 for information and referral services.
- Inform the applicant of the right to appeal any HHSC action that affects the applicant's eligibility or amount of benefits.
- Check for unpaid overpayments from prior certifications.
- Inform applicants that the information they provide is subject to verification by third parties.

TANF

Staff must:

Explain federal and state time limits on Temporary Assistance for Needy Families (TANF) benefits. Inform the individual that a Choices noncompliance penalty makes the individual ineligible for a TANF state time limit hardship exemption during the individual's five-year freeze-out period. Explain that members need to be employed or apply for other possible sources of income. Encourage individual independence.

Explain the requirement to seek other income for which the individual is potentially eligible, as explained in A-1311.1, Requirement to Pursue SSI/RSDI, and A-1311.1.1, SSI/RSDI Application Assistance. Provide Form H1859, Social Security Administration Benefits for People with Disabilities Receiving TANF, and explain that the individual must apply for and provide verification by the next TANF redetermination.

Explain the option to receive One-Time TANF (OTTANF) instead of TANF. Offer this option to households eligible for TANF but not currently receiving TANF. See A-2400, One Time Payments.

Inform the household of the one-time grandparent payment if the household is potentially eligible. See A-2400.

Inform individuals with a Choices noncooperation who reapply for TANF while in pay for performance to contact the local workforce solutions office within 10 days to allow sufficient time to demonstrate 30 days of cooperation before the 40th day after the interview date. See A-2151, Open Penalty at Reapplication in Pay for Performance.

SNAP

Staff must:

Explain the Supplemental Nutrition Assistance Program (SNAP) time limits to individuals subject to these time limits.

Give Form H1805, SNAP Food Benefits: Your Rights and Program Rules, to all households at application and redetermination. Respond to any questions the applicant has about the form.

Give Form H1019, Report of Change, to all streamlined reporting households. Explain that these households are only required to report changes in residence and when their ongoing gross income exceeds 130 percent of the Federal Poverty Income Limit (FPIL) for the household size. Explain that changes must be reported within 10 days after the household knows of the change. Explain that these households must respond to all notices and letters from the employment program as directed, even if they are employed. Indicate the appropriate reporting requirement on page 1.

TP 43, TP 44 and TP 48

Staff must:

- Mail Form H0025, HHSC Application for Voter Registration, with the initial eligibility notice to a newly certified family. **Note:** Also mail Form H0025 at subsequent redeterminations.
- Inform the family that when HHSC processes an application and determines the child is ineligible for Medicaid but eligible for the Children's Health Insurance Program (CHIP), the family is notified on Form TF0001, Notice of Case Action. Form TF0001 also informs the household that the CHIP enrollment packet will be sent to the household.
- Inform new caretakers about the requirement to participate in a health care orientation. Include Form TF0001. This one-time requirement applies only to caretakers who have not been included as a certified or budget group member of a Medical Programs Eligibility Determination Group (EDG) within the past two years.
- Inform caretakers of Medicaid children under age 19 of the requirement to comply with the regimen of care prescribed by the Texas Health Steps program. The requirement applies to children starting at age 2. Begin checking for compliance with the first redetermination after the caretaker is informed of the requirement.

Related Policy
Registering to Vote, A-1521

A—1520 Special Reminders

Revision 11-1; Effective January 1, 2011

A—1521 Registering to Vote

Revision 15-4; Effective October 1, 2015

All Programs

HHSC must offer individuals an opportunity to register to vote at application, redetermination and any time the individual has a change of address. The individual is provided with Form H0025, HHSC Application for Voter Registration, with each application/redetermination packet, if not already provided. Additionally, the individual will be provided with Form H0025 whenever the individual reports a change of address. System-generated application and redetermination packets contain Form H0025.

If the individual declines the opportunity to register to vote, the individual is given Form H1350, Opportunity to Register to Vote, to sign and decline to register to vote. Advisors should indicate in the Texas Integrated Eligibility Redesign System (TIERS), Voter Registration Information section of the Individual Demographics page, that the individual declined and document that Form H1350 was mailed to the individual. When the individual returns Form H1350, advisors are to send the form for imaging. The imaged, signed form must be retained for at least 22 months. The individual is not required to sign Form H1350 if the individual has signed the form within the last 22 months.

A—1521.1 Who Cannot Register to Vote

Revision 15-4; Effective October 1, 2015

All Programs

To register to vote, a person must be:

- a U.S. citizen; and
- at least age 17 years and 10 months.

Staff should not offer a voter registration application to an applicant or recipient if the individual states or the advisor has proof that the individual does not meet these two requirements.

A—1521.2 Staff Requirements for Voter Registration

Revision 15-4; Effective October 1, 2015

All Programs

Staff must tell the individual the following:

- HHSC will offer the same help and services when aiding the individual with voter registration activities as when aiding the individual with agency forms, whether HHSC provides the service in the office, outside of the office or at the individual's home.
- The decision to register or to decline to register to vote does not affect eligibility or benefit amount, and HHSC will keep all voter registration information confidential and only use it for voter registration purposes.
- The individual may decide whether or not to seek help from staff to fill out the voter registration application form, or the individual may fill out the application form in private.
- The individual may return the completed application form to:
  - the Secretary of State (SOS), by mail using the postage-paid, self-addressed application form;
  - the local voter registrar, by mail or in person; or
  - the advisor.
- The individual may ask additional voter registration questions or file a voter registration complaint by contacting the Elections Division of the Secretary of State, P.O. Box 12060, Austin, TX 78711, 1-800-252-8683.

Staff must not:

- influence an individual's political preference or party registration;
- display any political preference or party affiliation;
- make any statement to discourage the individual from registering to vote;
- make any statement to an individual or take any action for the purpose or effect to make the individual believe that a decision to register or not to register has any bearing on the availability of services or benefits; or
- pend the EDG or delay or deny benefits if the individual fails or refuses to complete the voter registration information on any form, or fails to return Form H0025, HHSC Application for Voter Registration, or Form H1350, Opportunity to Register to Vote.

Austin Imaging Center Staff

If the individual inadvertently sends Form H0025 to the Austin processing center with other documents, Austin staff will forward Form H0025 to the correct local voter registrar within five days of receipt.

A—1521.3 Voter Registration During Interviews

Revision 15-4; Effective October 1, 2015

All Programs

The following chart should be used by staff in addressing voter registration during the interview:

If …	then …

If …	then …
the individual responds, "I do not wish to register,"	determine the reason why the individual doesn't wish to register. Ask the individual to sign Form H1350, Opportunity to Register to Vote, attesting that the individual does not wish to register to vote. Sign and mark the appropriate box in the Agency Use Only: Voter Registration Status section of Form H1350 documenting the reason the individual declined to register. Send the form for imaging. When completing a telephone interview, mail Form H1350 to the individual. Indicate in TIERS, Voter Registration Information section of the Individual Demographics page, that the individual declined and document that Form H1350 was mailed to the individual. When the individual refuses to sign Form H1350, mark the Client Declined box in the Agency Use Only: Voter Registration Status section of Form H1350. Send the form for imaging.
the individual is not a U.S. citizen and at least age 17 years and 10 months,	TIERS will automatically mark that the individual does not meet citizenship and/or age requirements in the Valid Reason, Voter Registration Information section of the Individual Demographics screen.
the individual answered Yes to the question on the application, redetermination or change report form, "Do you wish to register to vote?" and meets citizenship and age requirements,	provide the individual with Form H0025, HHSC Application for Voter Registration, to complete to register to vote. Advise the individual that the completed form can be returned directly to SOS, the local voter registrar or the local office. The local office liaison forwards to the local voter registrar. TIERS automatically sends the individual Form H0025 if the worker answers Yes to the question, “Send Voter Registration Application?” in the Voter Registration Information section of the Individual Demographics screen. Enter the actions taken to provide the individual with the opportunity to register to vote by answering the questions in the Valid Reason, Voter Registration Information section of the Individual Demographics screen. When interviewing an authorized representative (AR) or representative payee, ask the AR or representative payee to give the form to the individual. Enter in the Valid Reason, Voter Registration Information section of the Individual Demographics screen, Client to Mail.
the individual completes and returns Form H0025 before leaving the office,	review the form for completeness. Return the form to the individual for any corrections, if necessary. When the individual has fully completed Form H0025, forward the form to the local office liaison. The local office liaison will review the form for completeness and send to the local voter registrar within five days. Enter in the Valid Reason, Voter Registration Information section of the Individual Demographics screen, the actions taken to provide the individual with the opportunity to register to vote.

A—1521.4 Voter Registration During Non-Interviews

Revision 15-4; Effective October 1, 2015

All Programs

The following chart should be used by staff in addressing voter registration during non-interviews:

If …	then …
the individual "does not wish to register" on the application/redetermination or change report form,	mail the individual a return envelope and Form H1350, Opportunity to Register to Vote, to sign attesting that the individual declined to register to vote. Enter in the Valid Reason, Voter Registration Information section of the Individual Demographics screen. If the individual returns Form H1350, sign and mark the Client Declined box in the Agency Use Only: Voter Registration Status section of Form H1350. Send the form for imaging.
the individual is not a U.S. citizen and at least age 17 years and 10 months,	TIERS automatically marks that the individual does not meet citizenship and/or age requirements in the Valid Reason, Voter Registration Information section of the Individual Demographics screen.

If …	then …
the individual answered Yes to the question on the application/redetermination form, "Do you wish to register to vote?",	• if the individual did not return Form H0025, HHSC Application for Voter Registration, enter in the Valid Reason, Voter Registration Information section of the Individual Demographics screen, the actions taken to provide the individual with the opportunity to register to vote. • when the individual returns Form H0025 to the local office, review the form for completeness. Return the form to the individual for any corrections, if necessary. Enter in the Valid Reason, Voter Registration Information section of the Individual Demographics screen, the actions taken to provide the individual with the opportunity to register to vote. Forward the fully completed Form H0025 to the local office liaison. The local office liaison reviews the form for completeness and sends to the local voter registrar within five days.
the individual answered Yes to the question, "Do you wish to register to vote?" on the change report form,	Enter Yes to the question, "Send Voter Registration Application?" in the Voter Registration Information section of the Individual Demographics screen. TIERS automatically sends the individual Form H0025. This documents the actions taken to provide the individual with the opportunity to register to vote.

A—1521.5 Local Office Liaison Duties

Revision 15-4; Effective October 1, 2015

All Programs

The local office liaison must:

- Maintain in stock, the office supply of Form H0025, HHSC Application for Voter Registration, and Form H1350, Opportunity to Register to Vote.
- Maintain the local voter registrar list to provide the name and address of the local voter registrar to staff and individuals. See www.sos.state.tx.us/elections/voter/county.shtml for information regarding the local voter registrar.
- Review Form H0025 for completeness.
- Send completed Form H0025 to the designated local voter registrar within five days of receipt.

A—1521.6 Documentation

Revision 15-4; Effective October 1, 2015

All Programs

All actions taken to provide the individual with an opportunity to register to vote must be documented at application, redetermination, and change of physical address in TIERS in the Voter Registration Information section of the Individual Demographics — Citizen page.

A—1522 Personal Responsibility Agreement

Revision 15-4; Effective October 1, 2015

TANF

Staff must inform TANF caretakers and second parents that they must:

- participate in the Choices programs unless exempt;
- cooperate with child support requirements;

- not voluntarily quit a job;
- have their child(ren) screened through the Texas Health Steps (THSteps) program;
- have their child(ren) immunized;
- have their child(ren) attend school;
- attend parent skills training, if referred; and
- not abuse drugs or alcohol.

Staff must inform TANF payees/disqualified adults that they must:

- cooperate with child support requirements;
- have their child(ren) screened through the THSteps program;
- have their child(ren) immunized;
- have their child(ren) attend school; and
- not abuse drugs or alcohol.

A—1523 Child Support Responsibilities

Revision 15-4; Effective October 1, 2015

TANF and TP 08

Staff must ensure that applicants read and understand the information on Form H1712, Explanation of Child/Medical Support, Family Violence and Good Cause, and that the applicant understands that signing an application for TANF or TP 08 constitutes the assignment of rights to child and medical support.

A—1524 Earned Income Deduction

Revision 15-4; Effective October 1, 2015

TANF

Staff must inform the applicant that if the individual goes to work and reports the job in a timely manner, the individual may be eligible for extra deductions.

A—1525 Voluntary Quit

Revision 15-4; Effective October 1, 2015

SNAP

Staff must explain the voluntary quit policies in A-1850, Voluntary Quit, to applicants and individuals, including:

- primary wage earner determination;
- how to establish good cause; and
- reapplication after voluntary quit.

A—1526 Family Violence

Revision 15-4; Effective October 1, 2015

TANF and TP 08

Staff must explain to applicants and recipients that if family violence or the potential for family violence exists, HHSC may grant an exemption from the requirement to cooperate with child support, and Choices staff may grant good cause for noncompliance with Choices participation for TANF.

Related Policy
Explanation of Good Cause, A-1130
Determining Good Cause, A-1860

A—1527 The Texas Works Message

Revision 15-4; Effective October 1, 2015

TANF

During the redetermination process, staff deliver the Texas Works message to TANF recipients explaining that:

- TANF is temporary and has time limits;
- there are alternatives and options for the recipient instead of TANF benefits;
- a TANF recipient should consider jobs and other resources such as child support rather than continuing TANF;
- if a TANF recipient chooses to continue receiving assistance, the recipient is requesting help finding a job; and
- if a TANF recipient chooses not to continue receiving assistance, the recipient may still qualify for medical assistance and SNAP to support employment while working toward self-sufficiency.

Judgment must be used when deciding which messages are appropriate for a particular recipient.

A—1528 Handbooks

Revision 13-2; Effective April 1. 2013

A—1528.1 Availability of Handbooks for Client Review

Revision 13-2; Effective April 1, 2013

All Programs

A *Texas Works Handbook* is available for review upon request. Individuals may view an electronic version of the handbook. All sections of the handbook must be easily accessible to the individual.

A—1529 Interactive Voice Response (IVR) System

Revision 13-2; Effective April 1, 2013

All Programs

Eligibility staff must review and understand information currently available to individuals through 2-1-1 and encourage individuals to use the self-service options. Encouraging individuals to use the self-service options will help reduce workload in local offices. Individuals can get answers to basic questions 24 hours a day, seven days a week through the automated phone system, the IVR.

Additional information can be accessed by visiting the Texas Health and Human Services Commission, "How to Get Help" website at hhs.texas.gov/services/safety/2-1-1-disaster-assistance.

The *2-1-1 Texas Finding Help In Texas* job aid describes how an individual accesses various types of information via the 2-1-1 IVR System.

A—1530 Medical and Dental Benefits

Revision 07-1; Effective January 1, 2007

A—1531 Texas Health Steps (THSteps)

Revision 15-4; Effective October 1, 2015

TP 43, TP 44, TP 45 and TP 48

The Early and Periodic Screening Diagnosis and Treatment (EPSDT) program is a federally mandated health care program of prevention, diagnosis, and treatment for Medicaid individuals under age 21. In Texas, EPSDT is known as THSteps. Through THSteps, individuals receive regularly scheduled medical and dental checkups. The THSteps program:

- facilitates early detection and treatment of medical and dental problems;
- provides health supervision for infants; and
- enables individuals to establish links with primary health care providers who can meet future needs for care.

THSteps' mission is to:

- expand individual awareness of existing health services offered by the program;
- stimulate individual use of preventive services; and
- make comprehensive services available through private and public providers so that infants, children and adolescents in the THSteps individual population can receive medical and dental care before health problems become chronic and irreversible damage occurs.

THSteps services include the following:

Medical Screens — The THSteps medical checkup is a thorough health screening that includes:

- a comprehensive medical history (including physical and mental health and development);
- a complete physical examination;
- screening of nutritional, developmental and mental-health status;
- laboratory tests (including lead screening);
- routine immunizations;
- health education;
- Tuberculosis screening;
- dental screening and referral to a dentist;
- vision screening;
- hearing screening; and
- referrals to other health care providers as needed.

THSteps offers checkups according to a recommended schedule. The frequency varies according to the stages of growth. In addition to an inpatient newborn screening, THSteps individuals can get 25 outpatient checkups. The recommended schedule for periodic medical checkups is:

- birth to 35 months — 11 health checkups to ensure:
  - proper growth and development; and
  - immunizations are administered according to the Advisory Committee on Childhood Immunization Practices (ACIP) recommended schedule;
- 3 through 5 years — three health checkups (once a year);
- 6 through 10 years — five health checkups (once a year); and
- 11 through 20 years — 10 health checkups (once a year).

Dental Services — THSteps provides comprehensive dental care, including emergency, preventive, therapeutic, and orthodontic services. THSteps individuals are eligible to receive routine dental checkups every six months starting at six months of age. Emergency or medically necessary dental services are available to THSteps individuals at any time from birth through age 20.

Vision Services — Each THSteps health checkup includes:

- a vision screen;
- diagnosis and treatment, including eyeglasses every two years for defects in vision; and
- one eye examination per state fiscal year (September through August).

Lost or destroyed eyeglasses are replaced with no limit on the number of replacements. The individual may receive additional services that are medically necessary because of a vision change.

Hearing Services — Each THSteps medical checkup includes a hearing screen. Additional testing for hearing problems, as well as diagnosis, treatment and hearing aids, is available through the Medicaid Program.

Case Management for Children and Pregnant Women (CPW) — In order to encourage the use of cost-effective health and health-related care, CPW provides services to children with a health condition/risk from birth through age 20 and to high-risk pregnant women of all ages. Together, the case manager and family assess the medical, social and educational needs of the eligible recipient.

THSteps Comprehensive Care Program (CCP) — This program provides expanded benefits to THSteps individuals. Under CCP, individuals under age 21 are eligible for any medically necessary and appropriate health care service covered by Medicaid. Limitations of the current Texas Medicaid Program do not apply to these individuals. Expanded benefits include durable medical equipment and supplies, prosthetics, orthotics, private-duty nursing and therapeutic services.

A—1531.1 Accessibility of THSteps Services

Revision 13-2; Effective April 1, 2013

Medical Programs (except TP 08, TA 31, TP 32, TP 33, TP 34, TP 35, TP 36, TP 42 and TP 56)

Texas Department of State Health Services (DSHS), its contractors and local Texas Works staff provide initial and periodic outreach and information to help individuals access services and assist them with appointment scheduling and transportation. Volunteers in Service to America (VISTA) also provide local outreach through the Texas VISTA Health Corps. Written information includes checkup reminders according to the THSteps periodicity schedule.

The Medical Transportation Program (MTP) provides non-ambulance transportation to a Medicaid-allowable medical or dental service for Medicaid-eligible individuals and necessary attendants when they have no other means of transportation. An HHSC contractor or an individual contractor of the individual's choice, such as a parent, friend, neighbor or volunteer may provide transportation. An individual contractor:

- must have a written agreement with the MTP before providing the service; and
- will be reimbursed for mileage to an authorized facility at the state rate.

MTP approves cost-effective meals and lodging and up-front funds if it is medically necessary for an individual under age 21 and the individual's attendant to be away from home overnight.

Households may contact MTP by calling toll-free 1-877-633-8747.

Complete Form H1093, THSteps Extra Effort Referral, if a household requests help accessing MTP services.

More information on MTP and a list of frequently asked questions is at hhs.texas.gov/services/questions-about-your-benefits/getting-a-ride-frequently-asked-questions.

A—1531.2 THSteps Service Providers

Revision 15-4; Effective October 1, 2015

Medical Programs (except TP 08, TA 31, TP 32, TP 33, TP 34, TP 35, TP 36, TP 42 and TP 56)

The Medicaid/THSteps service-delivery system includes both public and private providers. Physicians, dentists, advance practice nurses, physician assistants, home-health agencies, clinics, hospitals, Federally Qualified Health Centers (FQHCs) and others offer THSteps

services to eligible individuals. Providers must enroll as THSteps providers and be enrolled with the claims administrator, HHSC's health-insuring agent.

A—1531.3 Program Administration

Revision 16-1; Effective January 1, 2016

Medical Programs (except TP 08, TA 31, TP 32, TP 33, TP 34, TP 35, TP 36, TP 42 and TP 56)

To comply with the *Frew v. Traylor* lawsuit requirements, Texas Works advisors play a role in educating individuals about the THSteps program. Within the THSteps program, "outreach/informing" is a term applied to efforts, strategies, plans, events, organized activities, and courses of action taken to advertise, educate or increase the number of THSteps checkups.

A—1531.4 Explanation of Benefits

Revision 18-1; Effective January 1, 2018

Medical Programs (except TP 08, TA 31, TP 32, TP 33, TP 34, TP 35, TP 36, TP 42 and TP 56)

THSteps Outreach and Informing staff provide the following materials to HHSC to help Texas Works staff effectively inform individuals:

- A desk reference containing key THSteps information to inform individuals about the program. The desk reference has toll-free numbers, call center hours and website addresses for THSteps and the Medicaid Transportation Program. The desk reference contains information that is consistent with the current THSteps periodicity schedule.
- The THSteps brochure, "Don't Miss a Beat," presents key information about the THSteps program and is easy to understand.
- The Appointment Education Brochure, known as "Good Health Takes More Than an Apple a Day," provides helpful tips to make the visit to the doctor or dentist a positive experience.
- A current THSteps wallet card to give to every Medicaid-eligible household with a child under age 21. Families use the cards as a quick reference to the THSteps screening appropriate for their child, based on the child's age. The back of the card provides important information on immunizations.

Each household is given the brochures and a wallet card at every certification or redetermination, or via mail if the individual is interviewed by telephone or when no interview is conducted.

THSteps materials may be ordered online at: dshs.state.tx.us/thsteps/THStepsCatalog.shtm.

Supervisors must ensure that each advisor has the following THSteps materials and uses them as required:

- A desk reference.
- "Don't Miss a Beat" and "Good Health Takes More Than an Apple a Day" brochures.
- "Checkups Help Children Stay Healthy!" THSteps wallet cards.
- Form H1093, THSteps Extra Effort Referral. This form is used to help individuals who need:
  - to schedule a THSteps checkup or appointment;
  - more information on THSteps medical, dental and case management services; and
  - services other than those listed above.

Fax Form H1093 to THSteps Outreach and Informing staff at 512-533-3867.

A—1531.5 Compliance Requirements

Revision 15-4; Effective October 1, 2015

TP 44 and TP 48

Starting at age 2, children under age 18 must comply with the regimen of care prescribed by the THSteps Program. At the first redetermination, advisors should check for overdue dates. If one exists, the advisor should contact the caretaker and allow the caretaker to self-declare that the child:

- had the screening;
- is scheduled for the screening; or
- has not been screened, but has good cause.

If the advisor is unable to contact the caretaker by telephone, the advisor must send Form H1024, Subject: Self-Declaration Notice, to obtain the information.

If the household does not return Form H1024, the EDG is denied for failure to provide. If the household returns Form H1024 indicating noncompliance, the advisor should schedule the individual for a telephone interview and emphasize the importance of the checkups. Staff must use the appropriate script located in C-1117, Texas Health Steps (THSteps) Quick Reference Guide and Recipient Enrollment Script, or C-1118, Health Care Orientation Quick Reference Guide and Enrollment Script, when a recipient has a telephone interview due to a THSteps/Health Care Orientation noncompliance. If the individual does not keep the appointment, the EDG is denied for failure to provide. **Note:** The denial applies to all children's Medicaid EDGs for the household, except TP 45 for newborns.

At the next redetermination, if TIERS still shows the same overdue date for the child, the individual must provide verification that the child had the check up or have a telephone interview appointment before redetermination.

When adding a sibling to a case and the redetermination is due on the existing EDG, the change is processed in Change Action mode through Disposition, and the review is initiated and the redetermination is processed on both EDGs. TIERS will match the EDG end dates.

If a child has a THSteps overdue date, the caretaker must comply, show good cause, or have a telephone appointment, or the advisor must deny the Medicaid EDGs for all the children in the family, except TP 45 coverage for newborns.

Related Policy
Continuous Medicaid Coverage, A-832
General Reminders, A-1510
Processing Children's Medicaid Redeterminations, B-123

A—1532 Medicaid

Revision 16-4; Effective October 1, 2016

Medical Programs

Applicants must be informed that:

- they will receive a Your Texas Benefits Medicaid ID card if certified;
- they must show the Medicaid ID card to medical providers;
- each individual can receive three paid prescriptions a month;

  Exception: The following Medicaid recipients are eligible for unlimited paid prescriptions:
  - managed care individuals;
  - nursing facility residents; and
  - individuals under age 21, through the month of their 21st birthday.

  Note: Lost or destroyed prescriptions may be replaced by contacting the pharmacy that originally filled the prescriptions. The pharmacy can call the vendor drug toll-free pharmacy provider line to obtain procedures for overriding the system.
- if they lose their Medicaid ID card, they can request a new one by calling 1-855-827-3748 (providers can still verify Medicaid eligibility without the card); and
- Medicaid will not reimburse them for any bills they pay.

Note: If the household has members who are elderly or have disabilities who wish to apply for Medicaid, but who do not qualify for any Medical Programs for families and children, refer them to HHSC's MEPD programs. Staff must provide the household with the address and telephone number of the nearest office, or the self-service website www.hhsc.state.tx.us/help/index.shtml.

Medical Programs (except TA 31, TP 32, TP 33, TP 34, TP 35, TP 36 and TP 56)

Applicants living in a managed care area must be informed that they are required to select a managed care plan and primary care physician.

Emergency Medicaid

Staff must explain that Medicaid coverage is limited to the dates of the emergency medical condition.

TP 40

Encourage the pregnant woman to start receiving prenatal care.

A—1532.1 Spend Down EDGs

Revision 15-4; Effective October 1, 2015

TP 56 and TP 32

For applications with spend down, staff are required to verbally explain the following:

- Children or pregnant women in the certified group are not eligible for Medicaid until spend down is met (i.e., the household's excess income is depleted with medical expenses incurred by members of the budget group).
- TIERS mails Form H1120, Medical Bills Transmittal/Insurance Information, and Form H3087S, Spend Down Medicaid Identification, to the individual. Form H1120 provides the Medically Needy Clearinghouse with information needed to determine spend down for clients and provides the individual with information needed to submit medical bills to the Clearinghouse. Form H3087S summarizes the spend-down amount and potential eligible months and explains to providers how they can assist the individual by submitting bills.
- The household or a provider must submit bills to the Medically Needy Clearinghouse. The Clearinghouse must receive the bills within 30 days of the later of the following dates:
  - the day Form TF0001, Notice of Case Action, processes; or
  - the last day of the application month.

  The individual should be advised to contact the Clearinghouse if the 30-day time limit is near and there is a delay getting bills from a provider, third-party resources (TPR) information, etc. The Clearinghouse allows bills paid during the month(s) of potential eligibility by:

  - members of the household composition, and
  - state or local government agencies (County Indigent Health Care, Children with Special Health Care Needs, MIHIA, etc.).

  - The Clearinghouse also allows unpaid bills that are itemized regardless of when they were incurred. Itemized bills must include:
  - name of the provider,
  - date the service was provided,
  - date(s) and amount(s) paid toward the bill, and
  - balance due.

  If a bill was incurred 60 days or more before the applicant submits it, the applicant must provide a current itemized statement.

  Staff should assist the individual in determining whether bills are current, itemized, and complete, if requested.
- The individual must submit claims to TPRs, if any, before submitting the bills to the Clearinghouse. When submitting the bills, the individual must provide the Clearinghouse with verification that a TPR will not pay certain bills or portions of bills. An Explanation of Benefits (EOB) provides this information.
- The individual must answer the Clearinghouse's request for additional information no later than 30 days after the:
  - last day of the application month, or
  - date of the Clearinghouse's request.

Staff should advise the applicant of the types of assistance available to help the individual with the spend-down process.

On the same day the advisor approves the EDG, the advisor gives or TIERS mails to the individual:

- Form TF0001, Notice of Case Action;
- Form H3087S, Spend Down Medicaid Identification;
- Form H1120, Medical Bills Transmittal/Insurance Information; and
- a preaddressed Clearinghouse envelope for the applicant to use to submit bills to the Clearinghouse.

Do not give Form H1120 to anyone other than the applicant or the applicant's AR. Explain that it is best to submit all bills at the same time because the Clearinghouse must establish a hierarchy when processing bills to meet spend down. This hierarchy ensures that spend down is met by nonreimbursable bills before reimbursable bills because nonreimbursable bills:

- were incurred before a month of potential eligibility, or
- are not for Medicaid-covered services.

A—1533 Transitional and Post Medicaid

Revision 15-4; Effective October 1, 2015

TP 08

The individual should be informed that the household may be eligible for additional months of transitional Medicaid and child care if TP 08 is denied because of earned income (TP 07).

The household should be informed that they may be eligible for four additional months of post Medicaid if TP 08 is denied because of spousal support income.

The individual should also be informed that if the household is not eligible for transitional or post Medicaid, the household may be eligible for other medical program coverage.

A—1534 Requirement to Report Accidents

Revision 15-4; Effective October 1, 2015

Medical Programs

Staff should instruct the individual to report accidents. This is to determine whether the individual has any TPRs other than Medicaid that could cover medical expenses.

A—1540 Redeterminations

Revision 13-2; Effective April 1, 2013

A—1541 Periodic Redeterminations and Special Reviews

Revision 15-4; Effective October 1, 2015

TANF and TP 08

Staff should explain to the individual that:

- an advisor will periodically redetermine the individual's EDG, and
- HHSC will send an appointment for the redetermination.

TANF

Staff delivers the Texas Works Message to TANF recipients.

A—1542 Special Reviews

Revision 15-4; Effective October 1, 2015

All Programs

Staff explains to the individual:

- that a special review is set for the individual's EDG,
- the purpose of the special review, and
- how and when HHSC will notify the individual of the special review.

A—1543 Notice of Expiration

Revision 15-4; Effective October 1, 2015

SNAP

TIERS automatically sends an expiration notice to households before their certification ends.

Exceptions: The individual may be given Form H1830, Application/Review/Expiration/Appointment Notice, and Form H1010, Texas Works Application for Assistance — Your Texas Benefits, at certification if the advisor approves an EDG for:

- one or two months, or
- three months and the advisor completes the certification after cutoff in the first benefit month.

A—1550 Issuance and Use of Benefits

Revision 04-1; Effective January 1, 2004

A—1551 Advisor Responsibilities

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Staff should inform the individual about:

- how HHSC issues TANF and SNAP benefits,
- how the individual uses those benefits, and
- the individual's responsibilities.

Cover each item listed in C-1131, Advisor Guide for Explaining EBT.

A—1552 EBT Issuance Staff Responsibilities

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Staff are responsible for informing the individual about each item listed in C-1132, Issuance Staff Guide for EBT Issuance and Training. This includes the TANF cash withdrawal policy and procedures if the individual applies for TANF and has any questions about the advisor's

explanation.

A—1553 Use of TANF Benefits

Revision 15-4; Effective October 1, 2015

TANF

Staff should explain that TANF benefits can only be used to purchase goods and services essential or necessary for the welfare of the family. This includes food, clothing, housing, utilities, furniture, transportation, telephone, laundry, medical supplies not paid by Medicaid, and incidentals such as household equipment, supplies, and recreation for children. Staff must advise recipients that failure to use the benefits as required may result in HHSC establishing a protective payee (as explained in A-222, Who Is Not Included).

A—1554 Use of SNAP Benefits

Revision 15-4; Effective October 1, 2015

SNAP

Staff must explain the following rules regarding use of SNAP benefits:

- SNAP benefits may be used to purchase food items and garden seeds at retailers approved by the U.S. Department of Agriculture (USDA). They may not be used for hot, ready-to-eat foods or food marketed to be heated in the store (except as listed in B-400, Special Households).
- SNAP benefits may not be used to pay off charge accounts.
- Change is not given on EBT food account purchases.
- Sales tax may not be charged on any item purchased with SNAP benefits.

A—1555 Use of One-Time Temporary Assistance for Needy Families (OTTANF) Benefits

Revision 15-4; Effective October 1, 2015

OTTANF

Staff should ensure that OTTANF applicants understand that OTTANF benefits are intended as emergency cash assistance for families who do not currently receive TANF but who are otherwise eligible. In addition to meeting TANF requirements, the household must meet one of the four crisis criteria explained in A-2440, Determining Crisis Criteria (OTTANF).

HHSC issues a $1,000 payment with the intent that it will:

- resolve a short-term crisis,
- keep the household connected to the workforce, and
- serve as a diversion from ongoing TANF.

Staff shall explain the 12-month ineligibility period and obtain original signatures on Form H1072, One Time Temporary Assistance for Needy Families (OTTANF) Acknowledgement.

A—1560 Documentation Requirements

Revision 15-4; Effective October 1, 2015

All Programs

The following must be documented:

- the nature of expected changes and when the individual expects the change to occur;
- the status of overpayments, and explain recoupment action;
- the refusal or failure to sign Form H1350, Opportunity to Register to Vote, in TIERS Case Comments; and
- in the Valid Reason, Voter Registration Information section of the Individual Demographics screen, that the advisor gave or mailed Form H0025, HHSC Application for Voter Registration, to the individual, authorized representative or representative payee, providing the individual with an opportunity to register to vote.

Related Policy
Registering to Vote, A-1521

TANF

The following situations must be documented if the individual:

- has good cause for not cooperating with THSteps services;
- does or does not want THSteps services; and
- chooses to withdraw from the TANF program as a result of Texas Works activities.

Related Policy
Documentation, C-940
The Texas Works Documentation Guide

TWH, A-1600, School Attendance

Revision 17-1; Effective January 1, 2017

A—1610 Eligibility Requirement

Revision 15-4; Effective October 1, 2015

TANF

The following persons must attend school full time if they do not have a high school diploma or general equivalency diploma (GED):

- An eligible dependent child age 6 to 18 living with a caretaker and/or second parent
- A teen parent, even if disqualified, under age 19

A child who is age 6 on or before September 1 of the current school year must attend school.

Example 1: If a child turns age 6 on August 31, school attendance must be verified at the next complete review on or after September 1.

Example 2: If a child turns age 6 on September 2, verification of school attendance is not required at the next complete review on or after September 1, and no penalty should be imposed for not attending school.

If a child or teen parent who is home-schooled is attending school, the parent's statement that the child attends school at home is acceptable.

TANF

A child age 18, in school (high school, technical, or vocational) full time, and expected to graduate before or in the month of the student's 19th birthday is eligible for Temporary Assistance for Needy Families (TANF) through the month of graduation.

A child who will not graduate until after the month of the student's 19th birthday is not eligible after the month of the student's 18th birthday.

Age	In School?	Graduation Month	Eligible?

Age	In School?	Graduation Month	Eligible?
16 or 17	Yes	N/A	Yes
16 or 17	No	N/A	Yes
18	Yes	Before or in the same month as 19th birthday	Yes, until graduation
18	Yes	After 19th birthday	No, not after month of 18th birthday
18	No	N/A	No
Over 19	N/A	N/A	No

SNAP and Medical Programs except TP 08 and TA 31

School attendance requirements are not applicable for these programs. For the Supplemental Nutrition Assistance Program (SNAP), if a child under age 18 works and is in school, the child's earned income may be excluded. See A-1323.1, Children's Earned Income.

TP 08 and TA 31

School attendance requirements only apply when the only dependent child(ren) of a parent or caretaker relative applying for TP 08 or TA 31 is(are) age 18 at application and redetermination.

A child(ren) age 18 meets the school attendance requirements when they:

- attend school in any of the following educational settings:
  - high school;
  - technical school;
  - vocational school;
  - trade school; or
  - home school;
- attend school full time; and
- are reasonably expected to graduate before or in the month of the student's 19th birthday.

A child who will not graduate until after the month of the student's 19th birthday is not considered a dependent child after the month of the student's 18th birthday.

Example 1: If there are two dependent children, one child is age 6 and the other child is age 18, and their parent is applying for TP 08, school attendance requirements do not apply to the child who is age 18 since there is another dependent child, age 6, for the TP 08 parent or caretaker relative to claim.

Example 2: If there are two dependent children both age 18 and their parent is applying for TP 08, school attendance requirements apply to both children because both children are age 18 and there are no other dependent children for the TP 08 parent or caretaker relative to claim.

A—1620 Determining Attendance

Revision 15-4; Effective October 1, 2015

TANF

After the caretaker and second parent or teen parent sign Form H1073, Personal Responsibility Agreement, staff must verify whether the child or teen parent met the school attendance requirement.

School attendance must be verified:

- at each complete review;
- when curing a school attendance penalty; and
- at application, if school is in session.

Notes:

- School is considered to be in session during holiday breaks.

- If an individual applies when school is not in session and indicates a child is not meeting school attendance requirements and will not meet the requirement when school begins, a full-family sanction is imposed. See A-2131.1, Initial Application.

At complete or incomplete review, if the child is determined to have 10 or fewer excused or unexcused absences per semester, no further action is required. If the child has more than 10 absences, Form H1086, School Attendance Verification, is used to request verification of school attendance. The school determines whether the child meets school attendance requirements, regardless of the number of absences.

At application, if verification is required, the application is pended for 10 days to allow the household time to cooperate. If the household has proof of the child's attendance or excused absences for a minimum of five consecutive school days during the 10-day pending period, the child is considered to be cooperating and no penalty is imposed.

Note: Accept verification for a different 10-day period if received prior to certification.

During the summer months, the advisor must verify whether a child or teen parent met the school attendance requirement since the last complete review. If the child or teen parent:

- met the school attendance requirement, no further action is required. The child or teen parent meets school attendance requirements by:
  - being promoted,
  - attending summer school, or
  - graduating.
- did not meet the school attendance requirement, a full-family sanction is imposed.

TANF, SNAP, TP 08 and TA 31

The local school system determines the criteria for half- or full-time attendance. A child meets the criteria even if he is out of school because of vacation, temporary illness, or family emergency.

Children with disabilities may attend fewer hours than other students. They may also receive instructions from a visiting teacher at home and still meet the school attendance requirements.

A child enrolled in a vocational adjustment program is in school full time.

A—1621 Exemptions from School Attendance Requirements

Revision 17-1; Effective January 1, 2017

TANF

A child is exempt from the school attendance requirements if the child:

- is eligible to participate in a school district's special education program;
- is at least age 16 and attends a course to prepare for the high school equivalency exam;
- is enrolled in the Texas Academy of Mathematics and Science;
- is enrolled in the Texas Academy of Leadership in the Humanities;
- is specifically exempted under another law;
- has a physical or mental condition of a temporary and remediable nature that makes it unfeasible for the child to attend school. Staff must obtain a statement from the child's physician specifying the:
  - child's medical condition; and
  - anticipated period of the child's absences from school.

A—1630 Failure to Cooperate with School Attendance

Revision 15-4; Effective October 1, 2015

TANF

If a child or teen parent does not meet school attendance requirements, a school attendance penalty is imposed and a full-family sanction is applied.

If the individual does not cooperate with school attendance requirements at ...	then ...
application (before certification but after signing the Personal Responsibility Agreement),	refer to A-2144, Imposing a Penalty.
complete review or incomplete review,	refer to A-2144.
reapplication,	• if the individual has an open penalty, follow the procedures in A-2151, Open Penalty at Reapplication in Pay for Performance. • if the individual does not have an open penalty, follow the procedures in A-2131.2.1, Verifying Prior Cooperation Status at TANF Reapplication.

TP 08 and TA 31

Advisors must deny TP 08 or TA 31 if the only dependent child(ren) who makes the individual eligible for TP 08 or TA 31 is age 18 and:

- has graduated;
- is expected to graduate after the month of their 19 birthday;
- is not attending high school, technical school, vocational school, home school, or trade school full time; or
- school attendance is not verified by the due date.

Related Policy
Form TF0001 Required (Adequate Notice), A-2344.1

A—1631 Good Cause for Noncooperating with School Attendance

Revision 15-4; Effective October 1, 2015

TANF, TP 08 and TA 31

Good cause for not cooperating with the school attendance requirement must be explored at:

- application,
- each complete review, and
- the individual's request.

Good cause exists if:

- the teen parent has a child under age 12 weeks; or
- no one in the home is willing and able to care for the child, and free child care is not available through the Texas Workforce Commission (TWC) or the school district. The local workforce board should provide free child care paid by TWC.

The individual's statement about a household member's inability to provide care is acceptable. Good cause is allowed only if TWC and the local school district provide verification that they will not provide free child care.

A—1632 Curing the School Attendance Penalty

Revision 15-4; Effective October 1, 2015

TANF

After a penalty is imposed, the child or teen parent can cure the penalty:

- by attending school with no unexcused absences for the next 30 days;
- by claiming good cause; or

- during the summer months by:
  - being promoted,
  - attending summer school, or
  - graduating.

The individual is responsible for reporting when the child or teen parent has cured the penalty or has good cause.

Note: See A-2151, Open Penalty at Reapplication in Pay for Performance, when curing an open school attendance noncooperation for a reapplication under pay for performance.

A—1640 Verification Requirements

Revision 15-4; Effective October 1, 2015

TANF

School attendance must be verified:

- at each complete review. During the summer months, the advisor must determine whether the child or teen parent met the requirement since the last complete review;
- when curing a school attendance penalty; and
- at application, if school is in session. **Notes:**
  - School is considered to be in session during holiday breaks.
  - If an individual applies when school is not in session and indicates a child is not meeting school attendance requirements and will not meet the requirement when school begins, a full-family sanction is imposed. See A-2140, Full-Family Sanction.

TP 08 and TA 31

Advisors must verify full-time school attendance when the only dependent child(ren) of an individual requesting TP 08 or TA 31 is(are) age 18 at application and redetermination. When an individual on TP 08 has dependent children younger than age 18, no verification of school attendance is required for the younger children or for the 18-year-old.

During the summer months, staff must determine whether the dependent child met the school attendance requirements at the end of the previous school year and confirm that the child intends to meet the requirements when school begins.

A—1641 Verification Sources

Revision 15-4; Effective October 1, 2015

TANF, TP 08 and TA 31

School attendance may be verified with the following sources:

- School attendance registrar records;
- Current report card;
- Form H1086, School Attendance Verification; or
- Statement from the individual indicating the child is home schooled, if not questionable. **Note:** If the individual's statement is questionable, have the individual provide copies of their curriculum, study materials, or other proof of coursework.

Related Policy
Questionable Information, C-920
Providing Verification, C-930

A—1650 Documentation Requirements

Revision 15-4; Effective October 1, 2015

TANF, TP 08 and TA 31

The following information must be documented:

- verification source;
- date verified;
- exemptions, if any; and
- reason for good cause.

Related Policy
Documentation, C-940
The Texas Works Documentation Guide

TWH, A-1700, Management

Revision 13-4; Effective October 1, 2013

A—1710 General Policy

Revision 13-2; Effective April 1, 2013

All Programs except TP 40 and Children's Medicaid

A thorough discussion of how a household meets expenses lets you check the accuracy of information the household provides. You must explore management at each application and redetermination. Also check management when a change affects how the household meets its expenses.

Ask two questions to examine management:

- How long has the household managed this way?
- Are the household's reported net income and resources enough to pay their expenses?

Require additional explanation and verification when management is questionable or negative.

Questionable Management — A household has questionable management when its billed basic expenses exceed reported net income and resources.

Negative Management — A household has negative management when its paid basic expenses exceed reported net income and resources plus support the Health and Human Services Commission excludes such as vendor payments.

A—1720 How to Evaluate Management

Revision 13-2; Effective April 1, 2013

All Programs except TP 40 and Children's Medicaid

Explore past, present and future management. Review the previous Form H1010, Texas Works Application for Assistance — Your Texas Benefits, or Form H1010-R, Your Texas Works Benefits: Renewal Form, or case comments and verification before the interview. Decide if the information given in the past is consistent with the current situation.

Review the EDG and decide if the household's reported net income meets its basic expenses. Examples of basic expenses include

- food,
- transportation,
- shelter,

- utilities, and
- recurring expenses such as
  - credit card payments,
  - loans,
  - insurance,
  - clothing, and
  - disposable diapers.

Review Data Broker reports and other on-line verification sources to see if the household reported all their income, resources, and expenses. **Example:** Credit reports may show regular payments that cause monthly expenses to exceed reported income. (See C-827, Date Broker Combined Reports.)

If net income and resources do not cover paid expenses, ask the household if anyone has income from

- tips,
- commissions,
- overtime,
- bonuses, or
- part-time employment such as
  - paper routes,
  - street vending,
  - babysitting,
  - sewing,
  - laundry,
  - lawn and garden work,
  - carpentry, and
  - seasonal labor.

Explore whether the household pays expenses by

- borrowing from friends or relatives;
- receiving cash contributions or gifts;
- using checking or savings accounts; or
- having another source (HUD rental assistance, the Salvation Army, community-based organizations, insurance, or friends/relatives) pay expenses directly to the vendor.

If the applicant intends to repay a loan, determine how the applicant will pay it back.

If the loans, gifts, or vendor payments are temporary, set a special review to check management.

Exception: Do not set a special review for management for streamlined reporting households.

A—1730 Advisor Action

Revision 13-4; Effective October 1, 2013

All Programs except TP 40 and Children's Medicaid

Step	If ...	then ...
1	management is questionable at initial application, Temporary Assistance for Needy Families/Medical Programs (TANF/MP) complete redetermination, or Supplemental Nutrition Assistance Program (SNAP) redetermination,	• verify whether the household's basic billed expenses are paid or delinquent, and • go to Step 2.
-	a recent change causes questionable management,	TANF/MP — Set a special review. SNAP (SR) — Take no action. NPA-SNAP (Non-SR) — Shorten the certification period as specified in B-635.
2	verification shows basic billed expenses are paid,	go to Step 3.
-	verification shows basic billed expenses are past due,	see A-1731.

Step	If ...	then ...
-	the household does not return verification,	TANF/MP — Deny the household. SNAP — Deny the household.
3	management is negative for three months or more,	explore management as described in A-1720. Verify how the household made the payment (vendor payments, in-kind, cash contributions, or unreported income).
-	-	**If management is negative and the household ...** / **then ...**
-	-	provides proof that the household paid billed expenses with non-recurring assistance, / consider management questionable and follow policy in A-1731.
-	-	fails to provide available verification of the income or resources used to meet their expenses, / TANF/MP — Deny the household at application, complete, or incomplete redetermination. SNAP — Deny the household only at application or redetermination.
-	management is negative for less than three months,	see A-1731.

Related Policy
Length of Certification, A-2324
Streamlined Reporting Households, A-2350
Processing Special Reviews, B-125
What to Report, B-621

A—1731 Monitoring Questionable Management

Revision 03-3; Effective April 1, 2003

TANF and Medical Programs except TP 40, TP 43, TP 44, TP 46, TP 47 and TP 48

Set special reviews to monitor cases with questionable management.

SNAP

Do not set a special review due to questionable management for streamlined reporting (SR) households. Set a six-month certification period for SR households.

Set the appropriate certification length for non-streamlined reporting households. See A-2324, Length of Certification.

A—1740 Verification Requirements

Revision 13-4; Effective October 1, 2013

All Programs except TP 40 and Children's Medicaid

Verify whether the household's basic expenses are paid or delinquent when the household's billed expenses exceed reported net income/resources at application, redetermination, and at special reviews set for management. **Exception:** Do not set special reviews due to questionable management for streamlined reporting households.

A—1750 Documentation Requirements

Revision 13-2; Effective April 1, 2013

All Programs except TP 40 and Children's Medicaid

When past, current and future management is negative or questionable, document the individual's explanation of how management was met.

Completing the Management logical unit of work (LUW) in the Texas Integrated Eligibility Redesign System (TIERS) Data Collection may be sufficient documentation if all expenses have been addressed and management is not questionable or negative. This includes expenses listed in the Data Broker credit report, for example, credit card expenses.

Document the steps taken to resolve or clear management that has been negative for more than three months. Refer to the chart in A-1730, Advisor Action.

Related Policy
The Texas Works Documentation Guide

TWH, A-1800 Employment Services

Revision 17-3; Effective July 1, 2017

A—1810 General Policy

Revision 12-3; Effective July 1, 2012

TANF and SNAP

The Employment Services Program (ESP) consists of two programs. They are Choices for Temporary Assistance for Needy Families (TANF) individuals and Supplemental Nutrition Assistance Program (SNAP) Employment and Training (E&T) for SNAP individuals. Recipients must participate in these programs unless exempt. If a nonexempt member does not comply, he may be subject to a penalty that results in a full-family sanction for TANF and either a denial or disqualification for SNAP.

TANF

The Texas Workforce Commission (TWC) and Local Workforce Development Boards (LWDBs) determine the level of Choices services to provide in each county according to available Choices resources. After coordination with state office, TWC and the LWDB designate a county to provide one of two service levels:

- full service; or
- minimum service.

Full Service Requirements

Each nonexempt TANF caretaker or second parent who lives in a full service Choices county must participate in Choices employment services if contacted. Nonexempt and exempt members in full service Choices counties may voluntarily participate in employment services at any time. Exempt individuals are eligible for the same services as nonexempt individuals.

Minimum Service Requirements

Individuals in minimum service Choices counties are exempt from participation requirements because of the lack of available Choices resources in the area (even when they are coded mandatory registrants). Individuals in minimum service counties may choose whether or not to participate in Choices services offered to them.

SNAP

Each nonexempt household member age 16 through 59 must be registered for employment services at initial certification.

Exception:

For expedited service, register the applicant being interviewed unless he is:

- exempt from registration; or
- a nonparticipating authorized representative.

A—1811 Strikers and Employment and Training (E&T)

Revision 01-1; Effective January 1, 2001

SNAP

A striker must comply fully with the work registration requirement. He does not have to accept employment at a location subject to a strike or lock-out. If a strike is prohibited under either the Taft-Hartley or Railway Labor Acts, Health and Human Services Commission (HHSC) considers this a continuing offer of suitable employment to the striker. Failure by the striker to return to this employment, for any reason, is failure to comply with work registration requirements. This makes the entire household ineligible.

A—1820 Employment Services Programs (ESP) Procedures

Revision 12-3; Effective July 1, 2012

A—1821 Choices

Revision 12-3; Effective July 1, 2012

TANF

In all counties:

- determine the work registration status of all individuals; and
- obtain information about education level, work history, and vocational training for caretakers and second parents.

Note: See State Time Limits, A-2500, for state time limit tier levels for TANF individuals certified as caretakers and second parents.

A—1821.1 Choices Exemptions

TANF

A member is exempt from participation if he is one of the following:

Code A (Child under 19 years of age) — A child, age 18 or younger.

Code C (Caring for an ill or disabled child in the home) — Needed at home to care for an ill or disabled child in the household, even if that person is not a member of the certified group. The caretaker must provide a completed Form H1836-B, Medical Release/Physician's Statement, to claim this exemption. This includes caring for a family member receiving disability benefits such as Supplemental Security Income (SSI). SeeA-1821.1.2, Claiming Exemption Due to Caring for a Disabled Household Member, for specific information of Form H1836-B expectations.

Note: This exemption can be applied to more than one parent/caretaker if there are two or more disabled individuals in the household and it requires more than one person to provide care for the disabled members.

Code E (Disability expected to last greater than 180 days) — Unable to work due to a mental or physical disability expected to last more than 180 days. To claim an exemption based on disability, the individual must provide a completed Form H1836-A, Medical Release/Physician's Statement. Receipt of Social Security benefits based on disability or Veterans Affairs (VA) disability benefits is not an automatic disability exemption for Choices. See A-1821.1.1, Claiming Exemption Due to Disability of Self, for specific information of Form H1836-A expectations.

Code F (60 years of age or older) — Age 60 or older. Obtain verification of age if not already established.

Code G (Meets Caretaker Exemption criteria, child in EDG) and Code R (Meets Caretaker Exemption criteria, child not in EDG) — A single parent or single caretaker relative caring for a child under age one at initial application. See A-1821.5, Caretaker Exemption, for information on setting the caretaker exemption end date.

Notes:

- Neither parent in a two-parent household may receive a caretaker exemption. This includes households with a disqualified legal parent or non-certified parent (for example, legal parent receiving SSI).
- Another relative caretaker whose spouse is in the household may not receive the caretaker exemption.

Code H (Cares for a disabled adult in the home, expected to last greater than 180 days) — Needed at home to care for a disabled adult in the household even if that person is not a member of the certified group and the disability is expected to last more than 180 days. The caretaker must provide a completed Form H1836-B to claim this exemption. This includes caring for a member receiving disability benefits such as SSI. See A-1821.1.2, Claiming Exemption Due to Caring for a Disabled Household Member, for specific information of Form H1836-B expectations.

Note: This exemption can be applied to more than one parent/caretaker if there are two or more disabled individuals in the household and it requires more than one person to provide care for the disabled members.

Code J (Not certified for TANF) — Not certified for TANF for reasons other than being a non-recipient parent (Codes X, V or Y) or sanctioned for Choices (Code W).

Code N (Time Limited Employment Hardship) — Eligible for a state time limit hardship exemption based on lack of available employment opportunities. See A-2543.3, Employment Hardship Exemption (ESP Code N), for detailed information about this work registration code.

Code Q (Time Limited Personal Hardship) — Eligible for a state time limit hardship exemption based on personal disability or caring for a disabled household member. See A-2543.2, Severe Personal Hardship Exemption (ESP Code Q), for detailed information about this work registration code.

Code T (Pregnant and unable to work) — Pregnant and unable to work. To claim an exemption based on pregnancy, the individual must provide proof of pregnancy on Form H3037, Report of Pregnancy, or another document containing the same information and completed by a physician, nurse, advanced nurse practitioner or other medical professional, and a completed Form H1836-A, verifying the disability is due to pregnancy. See A-1821.1.1, Claiming Exemption Due to Disability of Self, for specific information of Form H1836-A expectations.

Code U (Single grandparent 50 or older caring for child under 3) — A single grandparent, age 50 or over, caring for a child under age three. Obtain verification of age and TANF relationship, if not already established.

Code V (SSI Recipient) — An SSI parent.

Code X (Exhausted STL) — A parent who has exhausted his/her state time limits.

Code Y (Disqualified for TPR non-compliance, Disqualified for SSN non-compliance, Has an IPV, Disqualified for failure to report temporary absence of a certified child, Is a fugitive, Has a felony drug conviction, Disqualified for QC non-compliance, Minor parent domicile non-compliance) — A parent disqualified because of:

- third-party resource requirements;
- Social Security number requirements;
- intentional program violation;
- failure to report a child's absence;
- being a fugitive;
- having a felony drug conviction;
- failure to cooperate with Quality Control; or
- noncompliance with the unmarried minor parent domicile requirement.

A—1821.1.1 Claiming Exemption Due to Disability of Self

Revision 09-1; Effective January 1, 2009

Form H1836-A, Medical Release/Physician's Statement, must be obtained to verify a personal disability due to illness, injury or pregnancy. In order for an individual to receive an exemption from Choices requirements due to illness or injury, the disability must be expected to last more than 180 days. A pregnancy-related disability does not have to last any specific length of time.

Note: Receipt of Social Security benefits based on disability or Veterans Affairs (VA) disability benefits is not an automatic disability exemption for Choices.

A new Form H1836-A must be obtained when the form in the file is more than six months old.

If the Form H1836-A on file at the time of review is less than six months old but will reach the six month period during a new certification period, advisors must:

- request a new Form H1836-A at the time of the review; or
- set a special review six months from the date Form H1836-A is signed to request a new Form H1836-A.

Example: The individual has a current Form H1836-A dated in July on file. The advisor interviews the individual for a periodic review in October. Form H1836-A is current at the time of the interview. The advisor may request a new Form H1836-A at the interview or set a special review for December to request a new Form H1836-A.

The following Choices exemption codes require a completed Form H1836-A:

- T – pregnant and unable to work, and
- E – unable to work due to a mental or personal disability and the disability is expected to last more than 180 days.

The medical provider completes Section II, Part A, by checking one box.

If the medical provider checks ...	then the individual is ...
1(a) or 1(b)	mandatory for Choices.
2(a) or 2(b)	mandatory for Choices. **Note:** The medical provider should complete Part B and Part C.
3(a) or 3(b)	exempt from Choices because the disability is permanent or expected to last more than 180 days. **Note:** The medical provider should complete Part C.
3(c) and the individual has a personal or mental disability	mandatory for Choices. **Note:** The medical provider should complete Part C.
3(c) and the individual is disabled due to pregnancy	exempt from Choices because there is no timeframe associated with a disability due to pregnancy. **Note:** The medical provider should complete Part C.

Note: If the medical provider fails to complete Part B or Part Cfor a Temporary Assistance for Needy Families individual but indicates that the individual is permanently disabled or temporarily disabled for more than 180 days, the individual meets the criteria for a Choices exemption.

A—1821.1.2 Claiming Exemption Due to Caring for a Disabled Household Member

Obtain verification that the caregiver is unable to work or participate in workforce activities due to illness or injury of an adult or child family member. In order for an individual to receive an exemption from Choices requirements due to a disabled adult family member, the disability must be expected to last more than six months (180 days). There is no timeframe associated with the length of the disability if the individual is caring for a disabled child.

Note: A caregiver caring for an adult or child family member who is receiving disability benefits such as Supplemental Security Income (SSI) does not qualify for an exemption unless the caregiver provides Form H1836-B, Medical Release/Physician's Statement, verifying the caregiver is needed in the home to provide care.

The following Choices exemption codes require a completed Form H1836-B:

- "C" – needed at home to care for an ill or disabled child in the household even if the person is not a member of the certified group, and
- "H" – needed at home to care for a disabled adult in the household even if the person is not a member of the certified group and the disability is expected to last more than 180 days.

A new Form H1836-B must be obtained when the form in the file is more than six months old.

If the Form H1836-B on file at the time of review is less than six months old but will reach the six month period during the new certification period, advisors must:

- request a new Form H1836-B at the time of the review; or
- set a special review six months from the date Form H1836-B is signed to request a new Form H1836-B.

Example: The individual has a current Form H1836-B dated in July on file. The advisor interviews the individual for a periodic review in October. Form H1836-B is current at the time of the interview. The advisor may request a new Form H1836-B at the interview or set a special review for December to request a new Form H1836-B.

The medical provider completes Section II, Part A, by checking one box.

If the medical provider checks ...	then the individual is ...
1 or 2(a or b)	mandatory for Choices.
3(a or b)	exempt from Choices. **Note:** The medical provider must complete Part B.
3(c) and the individual is needed at home to care for an adult family member	mandatory for Choices. **Note:** The medical provider must complete Part B.
3(c) and the individual is needed at home to care for a child	exempt from Choices. **Note:** The medical provider must complete Part B.

A—1821.2 Choices Participation

Revision 13-4; Effective October 1, 2013

TANF

A member is required to participate if he is one of the following:

Code B (Caretaker/Parent under age 19 in school full time) — A caretaker or second parent, age 18 or younger, attending elementary, secondary, vocational or technical school full time.

Code K (Appeal pending with Choices) — Appealing a Choices sanction. Use this code to indicate the individual is appealing the Choices sanction. See Appeals, A-1870, for more information.

Code L (Time limited Severe Economic Hardship, Lives in Economically Deprived County) — Eligible for a state time limit hardship exemption based on residing in a designated hardship county. See A-2543.1, County Hardship Exemption (ESP L), for detailed information about this work registration code.

Code M (Mandatory registrant) — Does not qualify for any of the exemptions and does not meet the Code P criteria. **Note:** Use this code for an individual who receives in-kind income for working.

Code P (Meets TANF full time employment requirement) — Employed or self-employed at least 30 hours per week, and receiving earnings of at least $700 per month. The required compliance is limited to only reporting hours of work. These individuals may be sanctioned if they do not report their hours to Choices staff.

Code W (Sanctioned for Choices nonparticipation) — Sanctioned for TANF based on non-compliance with Choices.

Local Workforce Development Boards (LWDBs) develop a Family Employment Plan with the involvement of all adults on the TANF EDG. In TANF-SP households, both adults must agree who will satisfy their work requirement. All adults on the TANF EDG are required to sign the plan.

Failure to sign the plan or meet the work requirements without good cause results in the LWDB sending a sanction request for the non-cooperating individual. For TANF-SP households, the LWDB will send the following penalty:

If the household's caretaker/parent and second parent are ...	then the LWDB sends a sanction request for ...
both mandatory participants,	the caretaker and second parent. **Note:** If one parent non-complies with Choices and the other parent already has an open Choices penalty (work registration code W or K), the LWDB does not send a penalty request for the parent with the open Choices penalty.
one is a mandatory participant and one is exempt but volunteers,	only the mandatory participant.
one is a mandatory participant and one is exempt but does not volunteer,	only the mandatory participant.

A—1821.3 Work Registration Code Hierarchy

Revision 12-3; Effective July 1, 2012

TANF

TIERS determines the appropriate work registration code based on data collection entries. Staff should review work registration status prior to disposition to ensure the correct work registration code is assigned to an individual. Use the following chart to determine the work registration code that should be assigned if the individual qualifies for more than one work registration code.

Code	Description
V	non-recipient parents who receive Supplemental Security Income
X	non-recipient parents who have exhausted their state time limits
Y	non-recipient parents who have certain disqualifications
J	ineligible for TANF and for Choices
A or F	child under age 19 or adult over age 60
L, N or Q	receiving hardship exemption from the state time limit
G or R	caring for a child under age 1
C	caring for a disabled child
U	grandparent caring for a child under age 3
H	caring for a disabled adult
E	personal disability
T	pregnant and unable to work

Code	Description
K	appeal pending with Choices
W	sanctioned for Choices nonparticipation
P	employed at least 30 hours per week and earning at least $700 per month
B	parent under age 19 and in school full time
M	mandatory participant

A—1821.4 Switching the Exemption — TANF-SP

Revision 02-8; Effective October 1, 2002

TANF

TANF-SP parents may switch participation designations (that is, exempt and nonexempt codes) once if the switch is before or during Choices assessment for the parent initially designated as nonexempt. The exemption code must be one that applies to either parent. Choices staff use Form H2583, Choices Information Transmittal, to inform Texas Works staff when TANF-SP parents request to switch Choices codes. The parent cannot switch after completion of the Choices assessment.

A—1821.5 Caretaker Exemption

Revision 12-3; Effective July 1, 2012

TANF

TANF single parents or single relative caretakers caring for a child under age one at initial application are exempt from Choices participation (Choices exemption Code G or R) until the child reaches age 1. **Note:** Caretakers under age 20 who have not completed high school or its equivalent do not qualify for these Choices exemptions, even if the caretaker exemption end date is in the future. These individuals may be exempt for another reason.

A—1821.5.1 Setting the Caretaker Exemption End Date

Revision 12-3; Effective July 1, 2012

TANF

TIERS sets a caretaker exemption end date based on the youngest child under age 1 in the home at the time of initial certification. See Individual- Summary, Time Limits screen in TIERS for the caretaker exemption end date.

A caretaker is not eligible for this exemption after the end date. The end date does not change when another child is born to the caretaker or moves into the home after TIERS sets the end date.

A—1821.5.2 Resetting the End Date

Revision 17-3; Effective July 1, 2017

TANF

If the child for which the caretaker's exemption end date is based on leaves the home, TIERS resets the end date based on the:

- next older child; or
- date the child leaves the home if no children under one remain in the household.

Contact the IEE/TIERS Technical Help Desk to address any issues with the caretaker exemption end date.

A—1822 E&T Procedures

Revision 14-3; Effective July 1, 2014

SNAP

In all counties, at initial certification and at each recertification:

- determine each individual's registration/participation exemption status;
- provide Form H1808, SNAP Work Rules, for each registrant in the household (including registrants exempt from participation); and
- inform the person interviewed about the:
  - registrant's rights and responsibilities,
  - registrant's requirement to provide proof of identity and work eligibility when requested by HHSC or E&T staff,
  - documents accepted as proof of identity and work eligibility (a list of acceptable proof is included on Form H1808), and
  - consequences of failure to comply.

Note: Remind streamlined reporting households they must respond to all notices and letters from the employment program.

A—1822.1 E&T Exemptions

Revision 17-1; Effective January 1, 2017

SNAP

Exempt a member from registration for E&T services if the individual meets one of the following criteria:

Code A (Child under age 16, age 16 or 17 and not head of household, or age 16 or 17 and attends school/training at least half time) — Age:

- 15 or younger;
- 16 or 17 and not the head of household; or
- 16 or 17 and attending school, including home schooling, or an employment training program on at least a half-time basis.

Code E (Physically/mentally unfit for employment) — Physically or mentally unfit for employment. Require proof of a disability that is not obvious before exempting the applicant. Obtain Form H1836-A, Medical Release/Physician's Statement. A physician's statement with the required information is also acceptable. See A-1822.1.1, Claiming Exemption Due to Disability of Self, for specific information of expectations.

Receipt of a temporary or permanent disability benefit from a private or government source, including VA non-service-connected disability benefits, is acceptable verification that a person is physically or mentally unfit for employment. For VA service-connected disability benefits that are less than 100%, do not exempt the individual.

As explained in B-476.1.2, Work Registration, individuals who apply for SSI and SNAP at a Social Security Administration (SSA) office receive a work registration exemption until the SSA determines the individual's eligibility for SSI.

Code F (Age 60 or older) — Age 60 or older.

Code G (Caring for a child under age 6) — Each parent or other household member responsible for the care of a child under age 6.

Note: This exemption can be applied to more than one household member who is responsible for the care of a child under age 6 if there are two or more children under age 6 in the household. The number of individuals who receive the exemption may not exceed the number of

children under age 6 in the SNAP household.

Code H (Cares for a person with a disability who is living in the home) — A parent or other household member caring for a person of any age who has a disability and lives with the household. The individual who has a disability does not have to be part of the SNAP budget group, but must reside at the same address. Require proof that the parent or household member is needed in the home to care for the person with a disability, including a member receiving disability benefits, such as SSI. Obtain Form H1836-B, Medical Release/Physician's Statement, or a physician's statement with the required information. See A-1822.1.2, Claiming Exemption Due to Caring for a Household Member With a Disability, for specific information.

Note: This exemption can be applied to more than one parent/caretaker if there are two or more individuals with a disability living in the household and it requires more than one person to provide care for the members who have a disability.

Code J (In drug/alcohol treatment program) — A regular participant or outpatient in a drug addiction or alcoholic treatment and rehabilitation program.

Code N (Receiving/applying for unemployment benefits) — Receiving unemployment insurance benefits or has applied but not been notified of eligibility.

Code P (Meets SNAP full-time employment requirement) — Employed or self-employed:

- at least 30 hours a week; or
- receiving earnings equal to 30 hours a week multiplied by the federal minimum wage. If the applicant's income is not enough to meet this exemption, the individual must verify that the individual works at least 30 hours a week.

Allow this exemption for an individual:

- who receives in-kind income for working at least 30 hours a week at a business, government entity or non-profit organization; or
- who home-schools a child living in the home. The individual must home-school the child at least 30 hours a week.

Any combination of the activities listed as an exemption for meeting the full-time employment requirement, or those activities in combination with employment hours, can be used as long as the combination totals at least 30 hours a week.

Notes:

- The individual may choose to average hours and/or income over the certification period or 12 months to meet this exemption.
- Migrant and seasonal farm workers are exempt if they are under contract or similar agreement with an employer or crew chief to begin work within 30 days.

Code Q (Registered with Choices) — Lives in a full-service Choices county and is nonexempt from Choices participation, or lives in any county and has an open Choices case.

Code S (Student age 18 or older in school/training program at least half time)

- a student age 18 or older who is enrolled at least half time in school or a training program, including an institution of higher education (see B-410, Students in Higher Education), or a person participating in a training program; or
- a refugee who is enrolled at least half time in English as a Second Language (ESL) courses or E&T programs administered by a refugee contractor or Match Grant program.

A—1822.1.1 Claiming Exemption Due to Disability of Self

Revision 06-4; Effective October 1, 2006

Form H1836-A, Medical Release/Physician's Statement, must be obtained to verify a disability for individuals who appear capable of employment but claim a disability. There is no requirement that the disability last more than 180 days.

A new Form H1836-A must be obtained when the form in the file is more than 12 months old.

The following E&T exemption code requires a completed Form H1836-A:

- E – physically or mentally unfit for employment if the disability is not obvious.

The medical provider completes Section II, Part A, by checking one box.

If the medical provider checks ...	then the individual is ...
1(a or b) or 2(a or b)	mandatory for E&T.

If the medical provider checks ...	then the individual is ...
3(a, b or c)	exempt from E&T.

A—1822.1.2 Claiming Exemption Due to Caring for a Household Member With a Disability

Revision 14-3; Effective July 1, 2014

Obtain Form H1836-B, Medical Release/Physician's Statement, to verify an individual who claims to be needed in the home to care for a household member with a disability. There is no requirement that the disability last more than 180 days.

Obtain a new Form H1836-B when the form in the file is more than 12 months old.

The following E&T exemption code requires a completed Form H1836-B:

- H – a parent or other household member caring for a person of any age who has a disability and lives with the household.

The medical provider completes Section II, Part A, by checking one box.

If the medical provider checks ...	then the individual is ...
1 or 2(a or b),	mandatory for E&T.
3(a, b or c),	exempt from E&T.

A—1823 Work Registration Status Changes

Revision 12-3; Effective July 1, 2012

A—1823.1 Reporting Changes in Work Registration Status

Revision 12-3; Effective July 1, 2012

TANF

Individuals must report changes that could affect employment services within 10 days of the change.

A—1823.1.1 Advisor Action on Status Changes

Revision 13-1; Effective January 1, 2013

TANF

Change the work registration code if:

- the individual reports a change in his exemption status, or
- information in the case record indicates a change in the individual's exemption status.

When the individual has a Code G or R and the youngest child reaches age one, TIERS:

- changes the individual's work registration status based on the hierarchy listed in A-1821.3 at cutoff of the caretaker exemption end date month,
- sends the individual a notice of the change in work registration status, and
- transmits the information to TWC.

Notify the individual on TF0001, Notice of Case Action, that their work registration status has changed.

SNAP

Change the work registration code within 10 days if the individual

- becomes exempt from E&T because he meets the criteria for exemption Code Q.
- loses E&T exemption status because of a
  - change the household is required to report,
  - change in TANF work registration code or open Choices case status, or
  - TANF penalty for Choices noncompliance.

If the individual loses E&T exemption status for any other reason, register the individual at the next recertification.

Notify the individual on TF0001 that their work registration status has changed.

A—1824 Information Transmittal from Choices or E&T Staff

Revision 12-3; Effective July 1, 2012

TANF and SNAP

When Choices or E&T staff discover information during an individual contact, they use Form H2583, Choices Information Transmittal, or Form H1817, Food Stamp E&T Information Transmittal, to forward the information to the advisor.

TANF

Each Form H2583 requires advisor action:

- If Choices staff receive information that affects an individual's work registration status, they discuss the individual's status with the advisor, or send Form H2583, asking the advisor to reconsider the individual's registration.

  The advisor evaluates the individual's work registration status and changes the work registration code in TIERS, if necessary.

- Information on earned or unearned income requires a budget to determine ongoing eligibility.

  Choices staff attempt to obtain verification from the employer. If the information on Form H2583 is complete and includes the name of the person contacted, use the information for eligibility determination without further verification from the individual.

- Medical or other information affecting Choices participation or designation as a TANF-Basic or TANF-State Program EDG. Review and correct the work registration status or EDG type as needed.

SNAP

Each Form H1817 requires advisor action.

- If E&T staff receive information that affects an individual's work registration status, they send Form H1817 to the advisor asking the advisor to reconsider the individual's registration.

  The advisor evaluates the individual's work registration status and changes the work registration code in TIERS, if necessary.

  If you decide the individual

  - is still subject to work registration, notify E&T staff within 10 days using Form H1817.
  - qualifies for an exemption, do not respond on Form H1817.
- Information on earned or unearned income requires a budget to determine ongoing eligibility.
- Medical or other information affects E&T participation. Review and correct work registration status as needed.

A—1830 ESP Actions

Revision 04-3; Effective April 1, 2004

A—1831 Action in Full Service Choices Counties or E&T Counties

Revision 14-3; Effective July 1, 2014

TANF

For households in full service Choices counties:

- provide an explanation of:
  - the Choices program;
  - the supportive services available (such as child care, help with transportation expenses related to job search or training, Texas Health Steps, and family planning);
  - the individual's rights and responsibilities;
  - how recipients (both exempt and nonexempt) may voluntarily participate and what this means regarding state time-limited benefits (see A-2500, State Time Limits);
  - the full-family sanction for noncooperation for nonexempt individuals;
  - transitional child care and Medicaid; and
  - the requirement to provide proof of identity and work eligibility when requested by HHSC or a Choices provider, and the types of documents accepted as proof (Form H2580, TANF Employment Services Notice, lists examples of proof).

    Explain these policies again at periodic review, unless the caretaker and/or second parent show an open Choices case in TIERS inquiry.
- provide a completed Form H2580 for each caretaker and/or second parent. At the application interview, also provide Form H2580 to the TANF EDG name.

SNAP

For households in E&T counties:

- provide the individual with Form H1808, SNAP Work Rules, for each registrant, along with the explanations in A-1822, E&T Procedures;
- explain who provides local E&T services and provide the address; and
- explain that E&T staff may provide transportation and/or child care assistance, if needed, to allow participation.

If the advisor conducts a single interview for a household filing jointly for TANF and SNAP, and the advisor certifies the SNAP application while the TANF application remains pending, TIERS will assign work registration Code Q, as if the individual were receiving TANF. After the advisor makes the TANF decision, TIERS will change the SNAP work registration code, if necessary. If an individual is registered for SNAP E&T, send the individual Form H1808.

A—1831.1 Referral Processes

Revision 12-3; Effective July 1, 2012

TANF

Advisors in full service Choices counties refer TANF applicants to a workforce orientation. This is a separate eligibility requirement from Choices program participation. See Workforce Orientation, A-2200, for more information.

HHSC sends a daily electronic file of all TANF recipients to Choices staff when:

- the TANF EDG is certified; or
- a TANF recipient's work registration code changes.

Non-exempt TANF recipients in full service Choices counties must participate in employment service activities when notified by Choices staff.

SNAP

HHSC sends a daily electronic file of all SNAP recipients to E&T staff when:

- the SNAP EDG is certified; or
- a SNAP recipient's work registration code changes.

E&T staff use this electronic file to register individuals with TWC when the individual:

- lives in an E&T county; and
- is a non-exempt registrant.

Registration is effective for 12 months. At the end of each 12-month period, TWC renews the registrant's status if the individual is:

- active;
- living in an E&T county; and
- a non-exempt registrant, not identified as an able-bodied adult without dependents (ABAWD).

A—1831.1.1 Choices Outreach

Revision 12-3; Effective July 1, 2012

TANF

TANF or TANF-SP recipients in full service Choices counties whose information is transmitted to the TWC through the daily electronic file may be outreached for Choices services.

Local Workforce Development Boards and TWC access various types of education, training and employment services from local providers, including other state agencies. Services vary depending on an individual's specific needs and the availability of programs in the local area.

A—1831.1.2 ABAWD Referral Process

Revision 16-2; Effective April 1, 2016

SNAP

An ABAWD is an individual age 18 up to age 50 who:

- is physically and mentally able to work at least an average of 20 hours per week;
- is not a member of a SNAP EDG where a household member on the SNAP EDG is under age 18; and
- is not pregnant.

The ABAWD designation:

- is applied the month after an individual turns age 18; and
- is no longer applied beginning with the month when an individual turns age 50.

HHSC sends a daily electronic file of all SNAP recipients, including ABAWDs, to E&T staff. After receiving the electronic file, E&T staff may contact local HHSC staff to obtain SNAP allotment amounts and the number of ABAWDs in the SNAP household.

E&T staff use information provided on the electronic file to outreach the ABAWD for E&T services. If the ABAWD completes the first two weeks of participation in an allowable activity, E&T staff return Form H1822, ABAWD E&T Work Requirement Verification, to the advisor verifying the ABAWD:

- now meets the SNAP ABAWD work requirement; or
- being recertified continues to meet the work requirement.

The advisor must process a change in "work requirement status" as required per A-1940, SNAP ABAWD Work Requirements, if work status changes.

After Form H1822 verifies participation, it is assumed to continue unless:

- E&T staff send Form H1816, SNAP E&T Noncompliance Report, notifying the advisor of noncompliance;
- the individual has at least a one-month break in SNAP benefits; or
- the individual reports he no longer participates.

Note: See A-1840, Noncompliance with ESP.

At recertification, HHSC staff must provide Form H1822 to the ABAWD to verify participation during the recertification process. The ABAWD must then take the form to the local workforce center for E&T staff to complete. The ABAWD or E&T staff returns the completed Form 1822 to HHSC.

A—1831.2 Individual Participation Requirements

Revision 12-3; Effective July 1, 2012

TANF and SNAP

To comply with participation requirements, the individual must:

- provide supplemental information when requested;
- appear for an interview upon request; and
- report for job interviews and accept an offer of suitable employment.

Note: Streamlined reporting households must respond as directed to all notices and letters from the employment program even if employed.

TANF

To comply with participation requirements, the individual must also:

- participate in activities listed in the employability plan, including keeping appointments, attending training or other education classes, and participating in work experience and job search activities; and
- not voluntarily leave a job unless he has good cause (as interpreted under the Texas unemployment insurance laws).

Exception: Individuals coded P are only required to report their hours.

Individuals may choose to voluntarily withdraw from TANF. Accept Form H1802, Voluntary Withdrawal from Temporary Assistance for Needy Families (TANF), as an individual'sintent to withdraw from TANF. When a local eligibility determination office receives a signed Form H1802, follow change procedures in B-600 to:

- process the TANF denial, and
- make changes to the Supplemental Nutrition Assistance Program (SNAP) EDG, if applicable.

When a request to voluntarily withdraw from TANF is received in the same month as a Choices noncooperation, the advisor must send Form TF0001, Notice of Case Action, informing the household of the Choices noncooperation. Open a Choices penalty as listed in A-2144, Imposing a Penalty. The household must reapply in pay for performance.

Note: If Form H1802 sent by the Local Workforce Development Board (LWDB) has not been processed and the individual does not want to withdraw from TANF, notify the LWDB using Form H2583, Choices Information Transmittal, that the individual remains certified for TANF.

Explore the appropriate medical program for each household member. Advisors must provide continuous Medicaid coverage for

- pregnant women and
- children under age one who are eligible through the month of their first birthday.

SNAP

To cooperate with participation requirements, the individual must also cooperate with assigned E&T activities.

A—1832 Action in Minimum Service Choices Counties or Non-E&T Counties

Revision 14-3; Effective July 1, 2014

TANF

In minimum service Choices counties, provide the individual a general explanation of:

- employment services available in the area, such as Workforce Innovation and Opportunity Act (WIOA), TWC, local workforce solutions offices, or the Texas Department of Assistive and Rehabilitative Services (DARS);
- Choices and Welfare-to-Work services (if available);
- available supportive services, such as subsidized child care through the local Workforce Development Board; and
- transitional child care and Medicaid.

SNAP

In non-E&T counties, provide the individual a general explanation of:

- the types of employment services available in the area, such as those provided through WIOA, TWC, local workforce solutions offices or DARS; and
- individual rights and responsibilities outlined in A-1832.1, Individual Responsibilities.

Provide Form H1808, SNAP Work Rules, for each registrant, including those with participation exemptions.

A—1832.1 Individual Responsibilities

Revision 12-3; Effective July 1, 2012

TANF

An individual living in a minimum service Choices county does not have to meet any employment services requirements. Advise the household that they

- are exempt from Choices program requirements;
- may choose whether to participate in Choices services offered to them; and
- will not be penalized for noncompliance if they participate and later stop participating.

See A-2530 for state time limit counting policies for individuals who live in minimum service Choices counties.

SNAP

An individual living in a non-E&T county

- is subject to usual registration requirements;
- must comply with E&T if the county becomes an E&T county and the registrant is contacted; and
- must accept or continue suitable employment, when offered, even if not referred by E&Tstaff.

A—1840 Noncooperation with ESP

Revision 04-5; Effective July 1, 2004

A—1841 Minimum Penalty Periods

Revision 07-4; Effective October 1, 2007

SNAP

Use the following minimum penalty periods.

If this is the individual's ...	then the minimum penalty period is ...
first noncooperation,	one month or when he cooperates, whichever is longer.
second noncooperation,	three months or when he cooperates, whichever is longer.
third or subsequent noncooperation,	six months or when he cooperates, whichever is longer.

Exception: See Reestablishing Eligibility During the Penalty Period(SNAP) A-1846.

A—1842 Failure/Refusal to Register

Revision 12-3; Effective July 1, 2012

SNAP

If the household member who fails to furnish all information needed to register is:

- the primary wage earner (PWE), deny the EDG.
- a member who is not the PWE, disqualify the individual.

See Minimum Penalty Periods, A-1841.

Exception: For expedited applications:

- postpone work registration if necessary, for members not present at the interview until after the household receives its first month's benefits (or first two months if you issue a combined allotment); and
- take adverse action for the second month (or third month if you issue a combined allotment) if all required registrants fail to provide the necessary information.

A—1843 Noncooperation with Choices

Revision 17-2; Effective April 1, 2017

TANF

Choices staff determine when a nonexempt individual fails without good cause to cooperate with Choices requirements. They use Form H2581, Choices Noncooperation Report, to notify advisors the date they made the noncooperation decision.

Failure to cooperate with Choices requirements results in:

- a full-family sanction for one month or until cooperation, whichever is longer; and
- denial of the TP 08 EDG for TANF recipients also certified for TP 08 benefits.

Related Policy
Completing the Penalty Action, A-1845.2
Imposing a Penalty, A-2144

A—1843.1 TANF-SP Procedures

Revision 12-3; Effective July 1, 2012

TANF

If a nonexempt parent in a full service Choices county fails to cooperate, apply a full-family sanction for one month or until cooperation, whichever is longer.

A—1844 Noncooperation with E&T

Revision 14-4; Effective October 1, 2014

SNAP

E&T staff determine when an individual fails to cooperate with employment services requirements without good cause. E&T staff send Form H1816, SNAP E&T Noncompliance Report, electronically through the automated interface to notify advisors of the individual's failure to cooperate.

If a PWE fails to cooperate with employment services requirements, Choices requirements or with work requirements in TWC's unemployment insurance program, the household is ineligible for the minimum penalty periods listed in A-1841, Minimum Penalty Periods.

If an individual who is not the PWE fails to cooperate, disqualify the individual for the applicable minimum penalty period listed in A-1841.

Note: If the noncooperating individual moves to a new household:

- deny the new household for the remainder of the penalty period if the individual is the new household's PWE, or
- disqualify the individual for the remainder of the penalty period if the individual is not the new household's PWE.

The following procedures apply to a household with an individual who is:

- exempt from registration due to TANF-Choices status or receipt of/application for unemployment insurance benefits (UIB), and
- penalized in that program for not cooperating with a program requirement.

When an individual fails to cooperate with ...	then ...
a Choices requirement in TANF,	apply the E&T noncooperation penalty unless the individual is exempt for another reason. See A-1822.1, E&T Exemptions.
a work requirement in TWC's UIB program,	apply the E&T noncooperation penalty unless the individual is exempt for another reason. See A-1822.1.

After the minimum penalty period expires, an individual may re-establish eligibility.

Related Policy
Re-establishing Eligibility During the Penalty Period, A-1846
Re-establishing Eligibility After the Penalty Period, A-1847

A—1844.1 Determining Primary Wage Earner (PWE) for Noncooperation Situations

Revision 13-3; Effective July 1, 2013

SNAP

Determine a household's PWE as follows:

If ...	then the ...

If ...	then the ...
(a) the household includes: • a parent of a child of any age living in the home; or • an adult with parental control of a child under age 18 living in the home,	household selects the PWE and all adult members must agree to the selection. The PWE selected must: • be an adult parent of a child of any age; or • have parental control of a child under age 18 living in the home. The household must select a PWE at certification, recertification, or when household composition changes.
(b) adult household members cannot agree on a PWE, or Item (a) does not apply,	PWE is the member (including a disqualified member) who: • earned the most income in the two months before the month of noncooperation; and • was employed at least 20 hours per week at the federal minimum wage or had earnings equal to this amount.
(c) a PWE cannot be designated using the criteria in Item (a) or (b) above,	PWE is the member listed as head of household on the noncooperation date.

Exception: For Items (b) and (c) in the chart above, a person (any age) may not be the PWE if he lives with his parent (or person fulfilling the role of his parent) who is:

- registered for work through the SNAP E&T program (even if he has a participation exemption); or
- exempt from registration due to employment, TANF-Choices status, or receipt/application for UIB.

The household can change the PWE during the certification period. **Exception:** The household cannot change the PWE if the current PWE has failed to cooperate with SNAP E&T requirements or has voluntarily quit a job, unless a new member has joined the household and is selected as the PWE.

A—1844.2 Tracking the Number of Sanctions

Revision 14-4; Effective October 1, 2014

SNAP

Document in the case record each time the individual is sanctioned for:

- employment services,
- voluntary quit,
- voluntarily reducing work hours,
- Choices, or
- unemployment insurance.

A sanction for any of these work requirements counts as a noncooperation penalty.

Example: The individual has one sanction for voluntary quit without good cause. The individual served a one-month penalty and obtained a comparable job. The individual was laid off and was registered with the E&T program. The individual noncooperated with one of the E&Trequirements. This is the second sanction.

A—1845 Action on Noncooperation

Revision 05-3; Effective July 1, 2005

A—1845.1 Sending Notice of Failure to Cooperate

Revision 12-4; Effective October 1, 2012

TANF and SNAP

When a certified household member does not cooperate with an employment services requirement, send Form TF0001, Notice of Case Action, within:

- five workdays after receiving notice of Choices noncooperation. Send Form H2581, Choices Noncooperation Report, to tell Choices staff the sanction effective date and send the individual adequate notice of adverse action.
- 10 calendar days after receiving notice of E&T noncooperation. Send the individual advance notice of adverse action. Do not send a response to E&T staff.

Exception: E&T noncooperation notices received in the last benefit month require adequate notice of adverse action.

If a penalty is applicable but the EDG is denied, advisors must still enter the penalty information into TIERS and send Form TF0001.

Note: See policy in A-1870, Appeals, for procedures when an individual appeals a penalty.

A—1845.1.1 Failing to Timely Send Notice of Adverse Action

Revision 12-3; Effective July 1, 2012

SNAP

If E&T staff fail to timely notify HHSC of a noncooperation or the advisor fails to send notice of adverse action, the advisor must send the notice of adverse action as soon as possible after discovering the error. Do not file a claim.

TANF

If HHSC does not take action on a noncooperation report within a reasonable time frame, send Form TF0001, Notice of Case Action, to initiate the noncooperation sanction as soon as possible.

Form TF0001 is sent within a reasonable time frame if the:

- Choices penalty is received within five calendar days after the end of the month in which the Choices noncooperation occurred; and
- advisor sends Form TF0001 within 10 calendar days after becoming aware of the noncooperation or within the same calendar month as the date of noncooperation listed on the Choices noncooperation notice.

If the advisor does not send Form TF0001 within a reasonable time frame, the first month of noncooperation is the month Form TF0001 was sent. Do not file a claim.

Note: A postponed first month results in a forfeit month, but does not count toward two consecutive months of noncooperation. See A-2141.1, Determining the First Month of Noncooperation.

A—1845.1.2 Failing to Impose a Penalty After Providing Notice of Adverse Action

Revision 05-3; Effective July 1, 2005

TANF and SNAP

If the advisor sends notice of adverse action for noncooperation, but fails to impose the penalty for the correct month:

- for SNAP, file a claim for any months received in error; and
- for TANF, determine the actual first and second month of noncooperation. If the individual:
  - cooperates in the second month, file a claim for the month that should have been forfeited. The household is not required to reapply for TANF.

- fails to cooperate in the second month, file a claim for the months that should have been forfeited. The household must reapply in pay for performance.

A—1845.1.3 Penalty is not Applicable

Revision 12-3; Effective July 1, 2012

TANF and SNAP

Do not send Form TF0001, Notice of Case Action, and take adverse action if:

- the individual was exempt at the time Choices or E&T staff made the noncooperation decision. Change the individual's work registration code as appropriate and do not take adverse action.
  - Send Form H2581 to notify Choices staff that the individual was exempt at the time of noncooperation, which you will not impose the sanction and the noncooperation does not count.
  - Do not respond to E&T sanctions.
- Choices or E&T noncooperation month is after the effective date of the denial. There is no penalty since the individual was not a recipient for that month.
  - For TANF EDGs, send Form H2581 to notify Choices staff that since the individual was not certified at the time of noncooperation, you will not impose a sanction and the noncooperation does not count.
  - For SNAP EDGs, do not send a response to E&T staff.

A—1845.2 Completing the Penalty Action

Revision 12-3; Effective July 1, 2012

TANF

Complete the penalty action as follows.

If the caretaker or second parent noncomplies:

- ensure there is a signed Form H1073, Personal Responsibility Agreement, for the EDG;
- do not establish a protective payee;
- change the work registration code to W.

For each caretaker and second parent who noncomplies with Choices, advisors must enter start dates (and end dates, if applicable) for a Choices penalty.

SNAP

Complete the penalty action as follows.

- If the noncomplying member is the PWE, change his work registration code to U (Primary wage earner failed to comply with ESP) and deny the EDG.
- If the noncomplying member is not the PWE, disqualify him and change the work registration code to Code T (Disqualified household member).

Note: See A-1841, Minimum Penalty Periods.

A—1846 Re-establishing Eligibility During the Penalty Period

Revision 14-4; Effective October 1, 2014

SNAP

An individual disqualified for an E&T noncompliance or a household denied because the PWE failed to comply with E&T may re-establish eligibility during the penalty period if the noncomplying individual becomes exempt from E&T registration.

A household denied because the PWE failed to comply with E&T may also re-establish eligibility if:

- the PWE leaves the home, or
- a new individual joins the household who would have been the PWE. If the household is otherwise eligible, certify the household and disqualify the previous PWE for the remainder of the penalty period.

When an individual disqualified for an E&T noncompliance on an active SNAP EDG re-establishes eligibility by becoming exempt, end the disqualification effective the first day of the month after the individual provides the information/verification required to qualify for the exemption. A household denied due to an individual's E&T noncompliance must file a new application to re-establish eligibility and is eligible from the file date if all required information/verification is provided by the final due date.

When a household is denied because the PWE did not comply with E&T requirements, the disqualified household may apply and be interviewed for SNAP during the last month of the E&T penalty period.

A—1847 Re-establishing Eligibility After the Penalty Period

Revision 14-3; Effective July 1, 2014

TANF

See A-2150, Pay for Performance, to determine the action to take when an individual has an open penalty at reapplication.

SNAP

An individual cannot become eligible until after the minimum penalty period expires or the individual meets the exceptions in A-1846, Re-establishing Eligibility During the Penalty Period. If the individual is still nonexempt, the individual must sign Form H1808, SNAP Work Rules, to agree to participate with E&T. Add the individual to the EDG after the individual signs Form H1808. Send E&T staff Form H1816, SNAP E&T Noncompliance Report, to advise staff that the individual agrees to participate.

- If the individual wants to report to E&T staff to obtain services after signing Form H1808, give the individual a copy of Form H1816 and send the original Form H1816 to TWC.
- HHSC offices co-located with E&T may establish different procedures to advise E&T staff that the individual signed Form H1808.

End the non-primary wage earner's disqualification effective the first day of the month after the individual complies, if the minimum penalty period expires.

Notes:

- The disqualified individual may comply in the last month of the penalty period and be added the first day of the next month.
- A denied household may file a new application and be certified in the last month of the penalty period, but is not eligible for SNAP for any month the household was previously disqualified.
- If a denied household reapplies after the penalty period has ended, certify from the file date and not the date Form H1808 is signed.
- A denied household that meets expedited criteria and has more than one disqualified individual who has served the minimum disqualification period at the time of the application may choose to:
  - delay the certification until all disqualified individuals have signed Form H1808, or
  - receive expedited benefits for the PWE and any individual who has signed Form H1808 at the time of the interview. Any additional disqualified individuals will be added to the household using change-processing procedures. Add additional individuals the month after the signed Form H1808 is provided.

A—1850 Voluntary Quit

Revision 05-3; Effective July 1, 2005

SNAP

If an applicant or participating household reports the loss of earned income or reduction in work hours to less than 30 hours a week, determine whether the household member voluntarily quit his job or reduced his work hours.

Note: See A-2123 for TANF Voluntary Quit policy.

A—1851 Applying Voluntary Quit

Revision 13-3; Effective July 1, 2013

SNAP

Voluntary quit procedures apply to:

- any local, state, or federal government employee who loses his job because he participates in a strike;
- a person who leaves a job unannounced or does not return to work without good cause, even if he technically was fired; or
- a person who voluntarily reduces his work hours to less than 30 hours a week.

Voluntary quit procedures do not apply to people who

- are exempt from E&T registration;
- end a self-employment enterprise;
- resign a job at the employer's demand; or
- are currently on strike.

A—1851.1 How to Determine if Voluntary Quit Applies

Revision 13-3; Effective July 1, 2013

SNAP

-	Yes	No
1. Has a household member (including a disqualified member) quit a job or reduced his hours of employment to less than 30 hours a week within 60 days before the application date or anytime after?	For quits, go to Step 2. For reduction of work hours, go to Step 3.	Not applicable. Stop.
2. Did the job involve at least 30 hours per week at federal minimum wage or equivalent earnings?	Go to Step 3.	Not applicable. Stop.
3. Did the person have good cause for quitting his job or reducing his work hours?	Not applicable. Stop.	Go to Step 4.
4. Was the person exempt from E&T on the quit date or date hours were reduced?	Not applicable. Stop.	Go to Step 5.
5. The voluntary quit penalty applies.		

A—1852 Determining PWE for Voluntary Quit Situations

Revision 13-3; Effective July 1, 2013

SNAP

Determine a household's primary wage earner as follows:

If ...	then the ...
(a) the household includes • a parent of a child of any age living in the household, or • an adult with parental control of a child under age 18 living in the household,	household may select the PWE. All adult members must agree to the selection. The PWE selected must: • be an adult parent of a child of any age, or • have parental control of a child under age 18 living in the household. A selection must be made at certification, recertification, or when household composition changes.
(b) adult household members cannot agree on a PWE, or Item (a) does not apply,	PWE is the member (including a disqualified member) who earned the most income in the two months before the month of quit if he was: • otherwise required to register on the quit date (interview date for applicants), and • employed at least 20 hours per week at the federal minimum wage or had earnings equal to this amount.
(c) a PWE cannot be designated using the criteria in Item (a) or (b) above,	PWE is the head of household on the quit date (for active EDGs only) if he was required to register on the quit date (or would have been if not disqualified).

Exception: For Items (b) and (c) in the chart above, a person (any age) may not be considered the primary wage earner if he lives with his parent (or person fulfilling the role of his parent) who is:

- registered for work through the SNAP E&T program; or
- exempt from registration.

The household can change the PWE during the certification period.

Exception: The household cannot change the PWE if the current PWE has failed to cooperate with SNAP E&T requirements or has voluntarily quit a job, unless a new member has joined the household and is selected as the PWE.

A—1853 Advisor Action on Voluntary Quit or Reduction in Work Hours

Revision 12-3; Effective July 1, 2012

SNAP

If you discover the quit ...	then ...	
before completing certification,	apply the sanction using the penalty periods found in A-1841, Minimum Penalty Periods.	
after certification and early enough to prevent issuance of the last month's benefits,	apply the sanction using the penalty periods found in A-1841. Start the sanction the first month after the adverse action notice period ends.	
too late in the certification period to prevent issuance of the last month'sbenefits,	**if the household ...**	**then ...**
-	reapplies before the end of the certification period,	apply the penalty. Notify the household on Form TF0001, Notice of Case Action, that the penalty period starts the first month of the new certification period.
-	does not reapply by the last day of the certification period,	on the last day of the certification period send Form TF0001 to notify the household of the sanction period beginning with the month after the old certification period expires.

If the primary wage earner (PWE) noncomplies, deny the EDG.

If the non-PWE noncomplies, disqualify the individual and change his work registration code to Code T (Disqualified household member).

If the PWE moves to another household and would have been the PWE, deny that household for the remainder of the penalty period. If he moves, but would not have been the PWE of the new household, disqualify the individual for the remainder of the penalty period.

If the individual quits or voluntarily reduces his work hours without good cause but does not report it or HHSC does not act timely, apply the penalty as soon as possible after the adverse action notice expires.

Related Policy
Tracking the Number of Sanctions, A-1844.2

A—1854 Re-establishing Eligibility During the Penalty Period

Revision 13-3; Effective July 1, 2013

SNAP

A person or household, disqualified or denied because of a voluntary quit or a reduction in work hours, may re-establish eligibility during the penalty period if the non-complying member becomes exempt from E&T registration.

A household denied because the PWE voluntarily quit a job, or voluntarily reduced work hours, may also re-establish eligibility during the penalty period if:

- the PWE leaves the home; or
- a new member joins the household who would have been the PWE. If the household is otherwise eligible, certify it and disqualify the old PWE for the remainder of the penalty period.

A—1855 Re-establishing Eligibility After the Penalty Period

Revision 14-3; Effective July 1, 2014

SNAP

To re-establish eligibility after the penalty period for a voluntary quit, the individual must:

- become exempt from E&T registration;
- agree to comply by signing Form H1808, SNAP Work Rules; or
- obtain a new job comparable to the one the individual quit. A job is considered comparable if it involves one of the following:
  - equal or increased salary or hours; or
  - fewer hours or lower net salary, with the individual's statement that the new job offers better chances to improve job skills or provide advancement opportunities.

To re-establish eligibility after the penalty period for voluntarily reducing work hours, the individual must:

- become exempt from E&T registration; or
- return to work for 30 or more hours a week.

End the non-primary wage earner's disqualification effective the first day of the month after the individual complies or becomes exempt, if the minimum penalty period has ended.

Notes:

- The disqualified individual may comply in the last month of the penalty period and be added the first day of the next month.
- A denied household may file a new application and be certified in the last month of the penalty period, but is not eligible for SNAP for any month the household was previously disqualified.

A—1860 Determining Good Cause

Revision 12-3; Effective July 1, 2012

TANF

If, during the adverse action notice period the individual claims good cause for failing to respond to outreach and provides a reasonable explanation:

- use Form H2581, Choices Noncooperation Report, to refer the individual to Choices staff for a determination.
- provide continued benefits following procedures in B-1051, Continued Benefits, if Choices staff provide notice of good cause before the notice period expires.

For other good cause claims, the individual must file an appeal to receive a determination.

The Choices automated interface sends TIERS a good cause code with start or end dates. The advisor does not set a good cause start/end date.

If the individual has an open Choices penalty, the Choices automated interface may send TIERS a good cause start date. Advisors must remove the Choices penalty if good cause is sent during the first noncooperation month. Good cause sent during the second noncooperation month is a notice of cooperation. Reinstate benefits after the forfeit month.

SNAP

Determine good cause for:

- voluntary quit noncompliance; and
- any E&T registrant whose UIB is lowered or denied because of noncompliance with the UIB program (see Noncooperation with E&T, A-1844).

SNAP E&T staff at TWC are responsible for determining good cause for noncompliance with the E&T program. If an individual wishes to claim good cause during the adverse action period for not complying with E&T requirements, provide Form H1816, SNAP E&T Noncompliance Report, to the individual and refer the individual to TWC for a good cause determination. SNAP E&T staff will review the individual's good cause claim and send a response to advisors through the automated interface.

A—1861 Reasons for Good Cause

Revision 00-5; Effective July 1, 2000

SNAP

Good cause exists when circumstances beyond the applicant's control prevent him from complying with the requirements. Explore reasons for good cause before establishing voluntary quit.

Good cause includes, but is not limited to, the following:

- Unavailability of care for children ages 6 through 11 (based on individual's statement).
- Discrimination by an employer based on age, race, sex, color, handicap, religious belief, national origin, or political beliefs.
- Work demands or conditions that make continued employment unreasonable (**example:** not being paid on time).
- Unavailability of transportation.
- A change of job.
- Illness of individual or another household member.
- Enrollment (at least half time) in a recognized school, training program, or institution of higher education that requires the primary wage earner to quit a job.
- Household emergency.
- Relocation to another county or political subdivision because of another household member's employment or school enrollment.
- Resignations by people under 60 years old that the employer recognizes as retirement.
- A job change that does not happen or results in employment of less than 20 hours a week or weekly earnings of less than the federal minimum wage multiplied by 20 hours.
- A habitual job change. (**Example:** migrant work or construction habitually require workers to move from one employer to another.)
- An unsuitable job. Employment is unsuitable if the:
  - wages are less than the highest of:
    - the applicable federal minimum wage, or
    - 80% of the federal minimum wage, if the federal minimum wage is not applicable.
  - average hourly wage based on piece-rate is less than minimum wage.
  - household member, as a condition of employment, must join, resign from, or not join a labor organization.
  - work is at a place subject to a strike or lock-out at the time of the offer.

Exceptions:

- the strike was enjoined under Section 208 of the Labor-Management Relations Act (29 U.S.C. 178-Taft Hartley Act), or
- an injunction was issued under Section 10 of the Railway Labor Act (45 U.S.C. 160).

- degree of risk to health and safety is unreasonable.
- household member is physically or mentally unfit for the job.
- commuting time from the household member's home to the job is more than two hours a day. Taking achild to and from a child care facility is not included.
- distance from home to the job is unreasonable because, after considering commuting time and costs, the individual earns less than minimum wage.
- distance to the job prohibits walking and transportation is unavailable.
- working hours or nature of the employment interferes with the member's religious beliefs.
- job is outside the individual's usual line of work. (This applies only during the first 30 days of registration and does not apply if the individual voluntarily quits a job.)

A—1870 Appeals

Revision 14-3; Effective July 1, 2014

TANF and SNAP

An individual is entitled to a hearing to contest the:

- advisor's decision to not allow an exemption, and
- denial or reduction of benefits because of noncompliance.

TANF

If, during the adverse action notice period, the individual appeals a noncompliance penalty:

- process the request;
- update the work registration code as Code K to indicate the individual is appealing the Choices sanction; and
- provide continued benefits, if applicable, following procedures in B-1050, Handling of Benefits During the Appeal Process, unless the individual waives the right to continued benefits.

The hearing officer notifies both the advisor and Choices staff about the hearing date and the Choices noncompliance appeal decision.

If the individual requests continued benefits and the hearing officer sustains the decision, change the work registration code from Code K to Code W to show the individual is sanctioned. Then:

- add the penalty with the original penalty start date;
- file a claim to recover benefits for the months the individual received continued benefits; and
- deny the EDG as explained in A-2140, Full-Family Sanction, if the household failed to cooperate with the Personal Responsibility Agreement for two consecutive months.

If the hearing decision was reversed, enter the appropriate work registration code in TIERS.

SNAP

If the individual appeals the noncompliance penalty during the adverse action advance notice period:

- process the request for:
  - voluntary quit/reduction in hours, or
  - noncompliance with E&T. This includes adverse actions:
    - on a noncompliance that does not involve E&T staff; and
    - when E&T staff fail to provide notice of good cause within the adverse action notice period, or deny good cause, and the household wants to appeal. The hearing officer notifies both the advisor and E&T staff of the hearing date.
- provide continued benefits following procedures in B-1051, Continued Benefits, unless the individual waives the right to continued benefits. **Note:** If an individual appeals a first offense, offer the individual an opportunity to sign Form H1808, SNAP Work Rules, before the end of the one-month minimum penalty period.

If the individual requests continued benefits and the hearing officer sustains the decision:

- impose the penalty for the remaining number of months, if appropriate;

- update the E&T penalty counter on an active EDG after the penalty expires, if appropriate; and
- file a claim to recover benefits for the months the individual received continued benefits.

A—1880 Verification Requirements

Revision 17-1; Effective, January 1, 2017

TANF

Verify all exemptions.

SNAP

Verify:

- exemptions that are questionable;
- that a member is physically or mentally unfit for employment (Code E) if the disability is not obvious;
- that a parent or other household member is caring for a disabled person of any age living in the household (Code H); and
- that a refugee is participating at least half-time in a training program administered by a refugee contractor or Match Grant Program (Code S).

Note: See A-1640, Verification Requirements.

Related Policy

E&T Exemptions, A-1822.1

A—1881 Verification Sources

Revision 16-4; Effective October 1, 2016

SNAP and TANF

Acceptable forms of verification must state self-employment hours worked. Acceptable forms of verification include:

- business records and receipts;
- checks;
- tax records;
- a statement from a knowledgeable source; and
- acceptable verification for self-employment income described in A-1370, Verification Requirements, except for the Form H1049 and client statement.

A—1890 Documentation Requirements

Revision 11-4; Effective October 1, 2011

TANF

Document:

- how you verified exemptions;
- failure to comply; and

- penalty information from the automated TWC interface or Form H2581, Choices Noncooperation Report, including the noncooperation date, applicable penalty period and reason when a Choices penalty is not entered in the automated system.

SNAP

Document:

- all exemptions;
- failure to comply;
- penalty information from the automated TWC interface or Form H1816, SNAP E&T Noncompliance Report, including the noncooperation date, applicable penalty period and reason when the SNAP E&T penalty is not entered in the automated system;
- voluntary quit/reduction of work hours;
- good cause for failure to comply and voluntary quit/reduction of work hours;
- the selection/non-selection of a PWE at application, recertification and when household composition changes; and
- which option the household chose when reapplying for and meeting expedited criteria once members disqualified for E&T have served their minimum penalty period.

Related Policy
The Texas Works Documentation Guide

TWH, A-1900, Federal Time Limits (FTLs)

Revision 17-4; Effective October 1, 2017

A—1910 General Policy

Revision 16-2; Effective April 1, 2016

TANF and SNAP

Federal legislation requires that certain individuals receive benefits for a limited number of months. Encourage individual independence!

TANF

A household with a caretaker or second parent is limited to receiving Temporary Assistance for Needy Families (TANF) for 60 months. Each caretaker and second parent has his own separate federal time limit clock. When the caretaker or second parent reaches the 60th month of the federal time limit (regardless of who reaches it first), the Texas Health and Human Services Commission (HHSC) denies the entire household at the end of the 60th month. Benefits received as an eligible child do not count toward the time limit if the child is later certified as a caretaker or second parent. A child who was certified on a TANF EDG that reaches the federal time limit may continue to receive TANF if certified with another caretaker or payee who did not reach federal time limits while certified with that child. **Note:** Do not count TANF-SP benefits toward a caretaker's or second parent's 60-month federal time limit.

SNAP

Unless exempt, an able-bodied adult without dependents (ABAWD) is any individual, age 18 up to age 50, who is not meeting the work requirement, as defined in A-1831.1.2, ABAWD Referral Process. These individuals are initially limited to three months of Supplemental Nutrition Assistance Program (SNAP) eligibility in a 36-month period. After the initial 36-month period ends, another 36-month period begins the first month the individual fails to meet the work requirement.

Related Policy
General Policy (Resources), A-1210
SNAP — Budgeting for Members Disqualified for Citizenship, SNAP ABAWD Work Requirement, or Noncompliance with SSN Requirements, A-1362.3
ABAWD Referral Processes, A-1831.1.2

A—1920 Determining the Number of FTL Months Used

Revision 11-3; Effective July 1, 2011

TANF

Effective with October 1999 benefits, each month a caretaker or second parent receives a TANF benefit counts toward the FTL, even if the month does not count toward the state time limit. This includes TANF benefits received in another state. Additionally, any month these members received benefits in Texas from November 1996 through September 1999 that counted toward the **state** time limit, also counts toward the FTL. **Note:** Individuals in control group cases were subject to FTLs beginning with October 1999 benefits.

Do not count a month toward the FTL if

- a caretaker or second parent is disqualified.
- the household's grant is:
  - cancelled and not reissued,
  - cancelled and reissued without including the caretaker or second parent's needs,
  - totally claimed as an overpayment.

A—1921 Tracking FTL Months

Revision 17-3; Effective July 1, 2017

TANF

Effective Oct. 1, 1999, an FTL month counts when a TANF benefit is issued to an adult caretaker or second parent.

To count a month an individual received benefits in another state, enter information in TIERS Data Collection – Out-of-State Benefits. FTL months only count if the individual received cash assistance. TIERS programming correctly determines FTL months for each individual. FTL information transferred from SAVERR during TIERS conversion. Advisors must contact the IEE/TIERS Technical Help Desk if FTL months need to be corrected in TIERS.

FTL months and years counted towards an individual's FTL can be found in TIERS on the TANF Time Limit page.

TIERS inquiry displays FTL data on the Individual – TANF Time Limits & PRA screen in the hover menu. It includes the:

- maximum months;
- FTL months used; and
- remaining months available.

A—1930 Extended TANF and Hardship Exemptions

Revision 06-4; Effective October 1, 2006

A—1931 General Policy

Revision 03-5; Effective July 1, 2003

TANF and TANF-SP

Federal law allows exemption from the 60-month lifetime limit due to hardship. Extended TANF is the TANF and TANF-SP cash assistance program beyond the 60-month lifetime limit. A caretaker or second parent can apply for extended TANF and a hardship exemption at any time during or after their 60th month of assistance.

A—1932 Eligibility Requirements

Revision 13-2; Effective April 1, 2013

TANF and TANF-SP

A caretaker or second parent may submit an application for extended TANF during their 60th month of lifetime TANF benefits, or after. They must:

- have fewer than 12 months of open Choices or child support penalties during a benefit month since Nov. 1, 1996;
- have a qualifying hardship exemption (see A-1933, Hardship Exemptions); and
- meet regular TANF eligibility criteria.

Note: Choices or child support penalty months may not be counted twice, if both penalties are open during the same month.

Review the extended TANF hardship exemptions with the applicant to identify the hardship. If the family qualifies under more than one hardship, the advisor and applicant should decide which hardship exemption is best for the household. After determining that the family meets extended TANF criteria, follow regular TANF eligibility requirements and program policies to determine eligibility.

As a condition of eligibility, require the extended TANF applicant to sign a new Form H1073, Personal Responsibility Agreement, and attend a Workforce Orientation refresher course, even if there is no break in benefits. Extended TANF caretakers and second parents are subject to the same Choices work requirements and exemptions as a regular TANF recipient.

The household is permanently ineligible from receiving TANF benefits when an individual non-complies with Choices or child support requirements after certification for extended TANF.

A—1933 Hardship Exemptions

Revision 13-2; Effective April 1, 2013

TANF and TANF-SP

The extended TANF applicant must have one of the following hardships:

1. **Personal Disability** – A personal mental or physical disability expected to last more than 180 days.
2. **Caring for a Family Member with a Disability** – Responsible for the care of a family member with a disability for more than 180 days.
3. **Family Violence** – Victim of family violence.
4. **Residence in a Minimum Service Choices County**– Resided in a minimum l service Choices county
    - during the 60th month of the initial 60-month period, or
    - at any time during the 11 countable months immediately preceding the 60th month.
5. **Lack of Employment** – The caretaker or second parent complied with Choices requirements with no more than one Choices penalty since November 1, 1996, but is unable to obtain sufficient employment during the last 12 consecutive months before the end of the 60-month time limit. The individual cannot qualify for this hardship if the lack of sufficient employment during the last 12-month period resulted from voluntarily quitting a job.

Note: Caretakers and second parents who qualify for extended TANF for reasons 4 (Residence in a Minimum Service Choices County) and 5 (Lack of Employment) are limited to a total of 24 cumulative months of benefits. Good cause and Choices exemption months count toward the 24-month limit.

A—1933.1 Advisor Action at Application

Revision 13-2; Effective April 1, 2013

A—1933.1.1 Personal Disability

Revision 14-3; Effective July 1, 2014

TANF and TANF-SP

The caretaker or second parent may qualify for the personal disability exemption if the individual:

- provides a completed Form H1836-A, Medical Release/Physician's Statement, dated no more than six months before the application month. Form H1836-A must establish that the disability is expected to last more than 180 days.
- is certified to receive HHSC Long-term Services and Supports.
- is certified for Supplemental Security Income (SSI).

If the caretaker or second parent is not certified for SSI, inform the caretaker or second parent claiming the disability that the individual must apply for SSI before the next complete review. Follow policy in A-1311.1, Requirement to Pursue SSI/RSDI.

Exception: An SSI application is not required if the applicant has an SSI application pending or previously applied for SSI and was denied within the last 12 months. If the SSI denial was more than 12 months before the extended TANF application month, a new SSI application is required. Inform the individual that this exemption must be re-evaluated at the next periodic review.

A—1933.1.2 Caring for a Family Member With a Disability

Revision 14-3; Effective July 1, 2014

TANF and TANF-SP

The caretaker or second parent may qualify for the caring for a family member with a disability exemption if the caretaker or second parent:

- provides a completed Form H1836-B, Medical Release/Physician's Statement, that is no more than six months old. Form H1836-B must establish that the family member's disability is expected to last more than 180 days and that the applicant is needed in the home to care for the family member with a disability.
- is listed as the primary caregiver in the care plan for the family member with a disability, for family members receiving HHSC Long-term Services and Supports.
- provides a completed Form H1836-B that is no more than six months old and indicates the applicant is needed in the home to care for the family member certified for SSI.

Refer to Step 2 of A-2543.2.2, Disabling Illness or Injury of Close Family Member, to determine the degree of relationship that applies. The degree of relationship that applies to state time limits applies to FTLs.

If the family member with a disability is not already approved for SSI, inform the person caring for the family member with a disability that the family member with a disability must apply for SSI before the next complete review. Follow policy in A-1311.1, Requirement to Pursue SSI/RSDI.

Exception: An SSI application is not required if the family member with a disability has an application pending or previously applied for SSI and was denied within the last 12 months. If the SSI denial was more than 12 months before the application month, a new SSI application is required. Inform the individual that this exemption must be re-evaluated at the next periodic review.

A—1933.1.3 Family Violence

Revision 13-4; Effective October 1, 2013

TANF and TANF-SP

If the applicant indicates on Form H1713, Service Plan for Family Violence Option and Report of Good Cause, that the individual is a victim of family violence, make an assessment referral to the family violence program specialist following policy in A-1131.1, Good Cause for Family Violence Option. A list of Family Violence Shelters is located at www.hhsc.state.tx.us/Help/family-violence/centers.shtml. The

family violence specialist makes a recommendation about the claim. If the family violence specialist establishes that the applicant is avictim of family violence, the applicant is eligible for the exemption.

A—1933.1.4 Residence in a Minimum or Mid-Level Service County

Revision 13-2; Effective April 1, 2013

TANF and TANF-SP

Verify that the applicant resided in a county that offered only minimum or mid-level Choices services during at least one of the last 12 countable months of the individual's 60-month period by reviewing the applicant's residence history. Contact the Local Workforce Development Board (LWDB) to verify the county's service level status during those 12 countable months.

Example: The applicant reached her 60th month of TANF assistance in January. She is applying for extended TANF in July and currently resides in a full-service county but claims that no Choices services were available in her county when she was receiving regular TANF benefits. Verify the applicant's county of residence over the last 12 countable months of her 60-month period. Determine the county's Choices service level status during those months by contacting the local board.

The applicant meets this exemption criteria if the individual resided in a minimum service Choices county in any month during the entire last 12 countable months of her 60-month time limit.

A—1933.1.5 Lack of Employment

Revision 13-2; Effective April 1, 2013

TANF and TANF-SP

The applicant must have

- no more than one Choices penalty during the individual's 60-month time limit; and
- been unable to obtain sufficient employment during the last 12 consecutive months before the end of his 60-month time limit. Count back 12 calendar months from the 60th month. The 60th month is month one of the 12 months.

Note: The individual cannot qualify for this hardship if the lack of sufficient employment during the last 12-month period resulted from voluntarily quitting a job.

A—1933.2 Advisor Action at Complete Review

Revision 13-2; Effective April 1, 2013

TANF and TANF-SP

At each complete review after initial certification for extended TANF benefits, advisors must verify that the individual continues to meet

- the hardship criteria for extended TANF benefits due to a disability, caring for a member with a disability, or family violence; and
- all other TANF eligibility requirements.

Advisors are not required to re-verify hardship due to residence in a minimum/mid-level service county or lack of employment exemptions at complete review.

A—1933.2.1 Personal Disability or Caring for a Family Member With a Disability

Revision 14-3; Effective July 1, 2014

TANF and TANF-SP

The advisor must:

- obtain a new Form H1836-A, Medical Release/Physician's Statement, or Form H1836-B, Medical Release/Physician's Statement, if the form in the EDG record is more than six months old to verify that the applicant:
  - or family member still has a disability expected to last more than 180 days, or
  - is needed in the home to provide care for a household member with a disability;
- verify that the caretaker or second parent with a disability is receiving HHSC Long-term Services and Supports or, in the case of a family member with a disability, that the recipient continues to be designated as the primary caregiver in the family member's care plan;
- verify that an application for SSI has been submitted since the previous TANF application, if applicable, or require a new application for SSI if it has now been 12 months since being denied for SSI; or
- verify that the caretaker/second parent or family member is certified for SSI.

Note: If the caretaker/second parent with a disability already receives SSI, then eligibility for the personal disability exemption is met. If the family member with a disability receives SSI, a current Form H1836-B is still required to verify that the caretaker/second parent is needed in the home to provide care.

At complete review, if the member with a disability ...	and ...	then ...
applied for SSI benefits,	the application is pending,	accept a pending notice as verification of the application or perform State Online Query/Wire Third-Party Query (SOLQ/WTPY) inquiry to check the status of the SSI application. **Note:** If the pending notice is more than 12 months old and the individual indicates this is the only notice received, check the status by performing SOLQ/WTPY inquiry.
applied for SSI benefits,	the individual is eligible for SSI benefits,	follow procedures in A-2344.1, Form TF0001 Required (Adequate Notice); send Form TF0001, Notice of Case Action, to remove the SSI household member from the EDG; and adjust the SNAP EDG, if applicable. **Note:** If an adult in a TANF-SP household is certified for SSI, transfer the remaining members to TANF, if eligible.
applied for SSI benefits,	the individual is ineligible for SSI benefits and provides Form H1836-A indicating the individual meets disability criteria,	accept Form H1836-A as verification.
has not applied for SSI benefits,		deny the EDG. If the individual reapplies after denial, the individual must provide verification of SSI application before certification.

A—1933.2.2 Family Violence

Revision 13-2; Effective April 1, 2013

TANF and TANF-SP

At complete review, if the recipient continues to indicate a victim of family violence status, provide the extended TANF recipient with Form H1713, Service Plan for Family Violence Option and Report of Good Cause. Make an assessment referral to the family violence program specialist following policy in A-1131.1, Good Cause for Family Violence Option. A list of Family Violence Shelters is located at

www.hhsc.state.tx.us/Help/family-violence/centers.shtml. If the family violence specialist establishes that family violence continues to exist, the household continues to be eligible for this exemption.

A—1940 SNAP ABAWD Work Requirements

Revision 16-2; Effective April 1, 2016

SNAP

The work requirement policy

- applies the month after an individual turns age 18, and
- does not apply in the month an individual turns age 50.

To meet the SNAP ABAWD work requirement, an individual must be working or participating in a specified work program (see A-1941.2, Meeting the Work Requirement Through a Work Program) an average of at least 20 hours per week in a month. An individual may use a combination of work and participation in a work program to meet this requirement.

A non-exempt individual's 36-month period begins with the first countable month the individual works less than an average of 20 hours per week and receives SNAP benefits in Texas or any other state. This is also the first of the three months of time-limited benefits. **Exception:** A month in which benefits are prorated is not a countable month.

The initial three months of time-limited benefits do **not** have to be consecutive.

A—1941 Definition of Work

Revision 03-5; Effective July 1, 2003

SNAP

Work may be regular employment, self-employment, or employment with a business, government entity, or non-profit organization that is volunteer labor or is paid in-kind.

Notes:

- Consider employment paid by vendor payment as regular employment.
- Consider work performed under the National and Community Services Act or Domestic Volunteer Service Act, such as VISTA or Americorps USA, as work for the purpose of meeting the work requirement.

A—1941.1 Meeting the Work Requirement Through Self-Employment

Revision 16-2; Effective April 1, 2016

SNAP

To meet the work requirement via self-employment, an individual must anticipate working an average of at least an average of 20 hours per week over the certification period. If the gross self-employment earnings do not equal at least an average of 20 hours per week multiplied by the federal minimum wage, the individual must verify that they are working at least an average of 20 hours a week using the same verification procedures used for Employment and Training (E&T)exemptions.

A—1941.2 Meeting the Work Requirement Through a Work Program

Revision 16-2; Effective April 1, 2016

SNAP

An individual may participate in one of the following work programs an average of at least 20 hours per week to meet the work requirement:

- Workforce Innovation and Opportunity Act (WIOA)
- Trade Adjustment Assistance Act Program
- SNAP E&T Program. **Note:** E&T Workfare also meets this work requirement even if it is less than an average of 20 hours per week.

Related Policy
Verification Requirements, A-1970

A—1942 Exemptions

Revision 17-4; Effective October 1, 2017

SNAP

An individual is exempt from the SNAP ABAWD work requirement if they:

- are pregnant;
- are a member of a SNAP EDG where a household member on the SNAP EDG is under age 18;
- are exempt from E&T registration;
- live in a waiver area (see C-330, SNAP ABAWD Work Requirement Waiver Counties);
- live in a SNAP non-E&T county. (C-341, SNAP Non-Employment and Training Counties); and
- meet the criteria as being physically or mentally unfit to work.

Individuals are physically or mentally unfit to work if they:

- have an obvious disability;
- receive temporary or permanent disability payments from a private or government source, including Veterans Affairs (VA) disability payments, regardless of disability rating; or
- provide a Form H1836-A, Medical Release/Physician's Statement, stating the individual is unable to work at least an average of 20 hours per week.

Note: Each household member must be exempt from the SNAP ABAWD work requirement for the household to meet the streamlined reporting criteria.

Related Policy
Streamlined Reporting Households, A-2350

A—1950 Counting Months Toward Time-Limited Eligibility

Revision 16-2; Effective April 1, 2016

SNAP

Count a benefit month as one of the three initial time-limited months if the individual:

- receives SNAP benefits in Texas or any other state that month,
- is not exempt from the work requirement that month, and
- fails to work an average of 20 hours per week that month.

Note: The advisor must verify any benefits the individual received in another state as an ABAWD if the individual indicates receiving benefits outside of Texas and the information is readily available.

Do not count SNAP benefit months toward the ABAWD time limit when:

- HHSC or the out-of-state agency:

    - disqualifies the individual from SNAP for any reason;
    - prorates benefits; or
    - files an overpayment claim for the entire month's benefit;
- the benefits are issued as restored benefits;
- the individual received an exemption from ABAWD work requirements and time limits in error; or
- the individual correctly received an exemption from ABAWD work requirements and time limits, but the household situation changed and the ABAWD status was not updated.

Examples:

- John Adams (an ABAWD) applied for SNAP benefits on March 1, 2011; the application was denied March 31, 2011, for missed appointment. Adams reapplies on April 4, 2011, and is approved SNAP benefits from April 4, 2011, ongoing, with May 2011 counting as the first month toward his three-month ABAWD time limit. On May 12, 2011, it was discovered that the denial on March 31, 2011, was in error and Adams is issued the full allotment for March 2011, and the portion that was prorated for April 2011 in restored SNAP benefits. Neither March nor April can be counted toward the ABAWD time limit.
- Susan Jones applied for SNAP benefits on Nov. 16, 2010. Jones received an E&T exemption because she had recently lost her job and had applied for unemployment benefits. As a result, she also was exempted from the ABAWD time limit requirements. Jones was approved for SNAP benefits Nov. 16, 2010, through April 30, 2011. At Jones's redetermination interview on April 11, 2011, it is discovered that unemployment benefits were denied and HHSC had exempted her from E&T in error. None of the months from the previous certification period can be counted toward the ABAWD time limit. Count only the months in the new certification period beginning May 2011.
- Becky and Bob Smith and their three children were approved SNAP benefits from Oct. 1, 2010, through March 31, 2011. The three children moved in with their grandmother on Nov. 2, 2010. The Smith household was certified as a streamlined reporting household and was not obligated to report that the children had left the home. The Smiths do not timely reapply and the SNAP certification period expires. On April 15, 2011, the Smiths reapply for SNAP benefits and are scheduled an interview the same day. At the interview the advisor discovers the children have been out of the home since November 2010. None of the months from the previous certification period can be counted toward the ABAWD time limit. ABAWD months are only counted in the new certification starting with April 2011. April will not count as an ABAWD month because benefits are prorated.

Redetermine eligibility effective the benefit month after the third countable time-limited benefit month. The advisor may set a:

- special review before cutoff in the third countable month, or
- three-month certification if the 36-month period starts at certification.

A—1951 After the Three Months of Time-Limited SNAP Eligibility

Revision 14-4; Effective October 1, 2014

SNAP

When the initial three months of time-limited eligibility expire, the advisor must:

- disqualify the individual; or
- deny the EDG if:
    - it is a single-person household, or
    - the disqualification makes the household ineligible.

Provide advance notice of adverse action, if required.

Note: Use the individual notice language specific to this disqualification in the comment section of Form TF0001, Notice of Case Action.

A—1960 Regaining Eligibility

Revision 16-2; Effective April 1, 2016

SNAP

An individual who lost eligibility due to the work requirement time limit in A-1951, After the Three Months of Time-Limited SNAP Eligibility, may regain eligibility if the individual:

- becomes exempt from the requirement, or
- begins working an average of 20 hours per week. Determine ongoing eligibility after verifying the individual started working or participating in a specified work program an average of 20 hours per week in a month.

A—1961 Second Time-Limited Three-Month SNAP Eligibility Period

Revision 13-2; Effective April 1, 2013

SNAP

An individual who already received the three months of time-limited benefits can qualify for one additional three-month period of eligibility in the 36-month period if the individual is not meeting the work requirement, but has worked for a specified period of time **after** receiving all three months of time-limited benefits. The individual must have:

- met the 20-hour per week work requirement after the first three-month eligibility period by working for at least 80 hours in a 30-day period, or
- participated in a recognized work program for at least 80 hours in a 30-day period after the first three-month eligibility period. A combination of work and participation in a specified work program also meets this requirement.

Note: The individual does not have to receive SNAP benefits during the month the individual worked or participated in a work program the minimum amount of hours to regain eligibility.

If HHSC prorates benefits, do not count the prorated month when determining the first month of the additional three-month period.

The individual can receive the additional eligibility period once in the 36-month period. Limit the additional eligibility period to three consecutive months, even if the individual returns to work or if HHSC denies SNAP for another reason during the three-month period. The additional consecutive three-month period may extend past the end of the original 36-month period if it began during the original 36-month period. Note: A new 36-month period can be established after the additional eligibility period.

For example: Brad Johnson's original 36-month period is September 2010 to August 2013. Brad used his initial three months in September 2010, October 2010 and April 2011. He reapplied for benefits on July 3, 2013, and met the criteria for an additional three-month period. Brad's second three-month period is August 2013, September 2013 and October 2013. Since July 2013 benefits are prorated, July is not a countable month. A new 36-month period can begin November 2013.

If all certified members' additional three-month eligibility periods ...	then ...
expire in the same month,	set the certification period to end the last month of the three-month eligibility period.
do not expire in the same month,	set special reviews to deny each member effective the end of the third month of the additional eligibility period.

Related Policy
Meeting the Work Requirement Through a Work Program, A-1941.2

A—1970 Verification Requirements

Revision 14-4; Effective October 1, 2014

TANF

Advisors must verify:

- any out-of-state TANF benefits received on or after October 1999 (see A-720, New Texas Residents, for a link to out-of-state TANF agencies);
- any hardship exemption for TANF according to policy in A-1933, Hardship Exemptions; and

- at each complete review after certification for extended TANF due to disability, caring for a household member with a disability, or family violence. See A-1933.1, Advisor Action at Application.

Note: See A-1933.2.1, Personal Disability or Caring for a Family Member With a Disability, for verification requirements for extended TANF EDGs.

SNAP

When verifying earned income, advisors must also verify whether the employee works an average of 20 hours a week in a month.

When determining if an individual qualifies to regain eligibility for SNAP after the individual has used three countable months of benefits in a 36-month period, advisors must verify that the individual worked, or complied with a work program, for at least 80 hours in a 30-day period for the individual to be eligible for the second set of three-month time-limited SNAP benefits.

Verify volunteer employment hours by contacting the employer. Verify the existence of a business or nonprofit organization, if questionable, by viewing federal income tax documents or nonprofit certification documents from the Internal Revenue Service or the Texas State Comptroller of Public Accounts.

Verify participation in the:

- Workforce Innovation and Opportunity Act (WIOA) through the local WIOA program administrative office,
- Trade Adjustment Assistance Program through the LWDB, and
- SNAP E&T program through the local E&T office.

Use Form H1822, ABAWD E&T Work Requirement Verification, to verify participation in the above programs.

Verify an individual's exemption from the 18–50 work requirement for:

- pregnancy, and
- being physically or mentally unfit to work 20 hours a week.

Verify any countable months of benefits received in another state by any household member who meets the ABAWD requirement (see A-720, New Texas Residents, for a link to out-of-state SNAP agencies).

A—1980 Documentation Requirements

Revision 16-2; Effective April 1, 2016

TANF

Advisors must document:

- the household was informed of FTLs at application, periodic review or when adding a new caretaker/second parent to the household;
- any out-of-state TANF benefits received on or after October 1999.

SNAP

Advisors must document:

- the reason for an exemption for each individual age 18 up to age 50;
- any time the individual's 36-month time-limited period begins;
  - the first and last month of the individual's 36-month period; and
  - month(s) HHSC or any other state issues or requests a SNAP benefit that counts toward the individual's three months of time-limited benefits; and
- when the initial three months of time-limited eligibility expires.

Related Policy
The Texas Works Documentation Guide

TWH, A-2000 Identifying Applicants Interviewed by Phone and Prevention of Duplicate Participation

Revision 17-3; Effective July 1, 2017

A—2010 General Policy

Revision 14-2; Effective April 1, 2014

All Programs

Staff must use available technology to verify identity and prevent duplicate participation.

Related Policy
Identity, A-600
Duplicate Participation, B-421.1
Duplicate Participation Procedures, B-454.1
Claims, B-700
Referrals for Intentional Program Violation (IPV), B-900
Establishing Identity for Contact Outside the Interview Process, B-1213

A—2020 Authenticating a Caller

Revision 15-4; Effective October 1, 2015

TANF, SNAP, TP 08 and TA 31

With more interviews completed by telephone, it is crucial that staff confirm the identity of the person being interviewed. Staff must ask identifying questions to confirm the identity of the person when interviewing by telephone. In addition to clearing all discrepancies, these questions serve as a tool to authenticate the caller.

At the start of the interview, staff should explain that the authentication questions help ensure the caller's identity and protect their confidentiality and information.

Note: This policy only applies to those programs that require an interview, or when the individual requests an interview.

A—2020.1 Authentication Questions and Verification Sources

Revision 17-3; Effective July 1, 2017

TANF, SNAP, TP 08 and TA 31

Staff must ask client-related questions from the list below to verify the caller's identity. Staff should ask questions to which the individual, authorized representative (AR), or personal representative (PR) generally will know the answers, but which are not easily known by others. This applies to ARs/PRs outside the household as well as household members. Available verification sources should be used to choose the questions and verify the responses of the person being interviewed. These sources include but are not limited to:

- Texas Integrated Eligibility Redesign System (TIERS);
- Data Broker; and
- Birth Verification System (BVS).

Staff should have the verification information for the client-related questions available during the interview to immediately confirm the responses. Not all the questions are applicable to every household, and staff should use prudent judgment to determine whether enough questions apply to the household's situation and whether the person being interviewed provides accurate responses.

From the lists below, staff should ask as many head of household-related questions as needed to allow the person being interviewed an opportunity to respond accurately to a total of two questions.

Initially, questions with available verifications should be chosen from a source other than the application, such as:

1. What is your Texas driver license or Texas state identification number?
2. What was a previous address for any place you lived?
3. Who are your neighbors?
4. What is/was the date of your wedding anniversary?
5. When was your divorce final?

If the person being interviewed cannot provide two accurate responses to any of the above questions, staff should ask as many of these additional questions as needed to receive a total of two accurate responses:

1. What is the Social Security number for a child (any child) on your case?
2. What is the date of birth for a child (any child) on your case?
3. What type of vehicle do you or another household member own?
4. Who are the members of your household?
5. What types of income do you or a member of your household receive?
6. From whom do you receive child support?
7. What is your alien registration number?
8. What is your (or your wife's) maiden name?
9. What is the name of a bank/financial institution where you have an account?
10. Who was a previous/last employer for you or another household member?
11. What is the name of your mortgage company or landlord?
12. To whom do you pay child support?

If necessary, staff may request a credit report on the head of household:

- for applicants new to Texas;
- when none of the above questions apply to the household's situation; or
- when you cannot gather verification of the responses from the sources listed above.

Information from the head of household's credit report may be used to develop questions to authenticate the caller. Examples of credit report questions to authenticate the caller include:

1. What is the name of a gas station or department store with which you have a credit card?
2. What is the name of a major credit card you have (Visa, MasterCard, American Express, Discover, etc.)?
3. What is the name of the bank/financial institution with which you have/had a student loan?
4. What is the name of the bank/financial institution with which you have/had a car loan?

Staff must document responses to the questions according to requirements in A-2050, Documentation Requirements.

Related Policy
Prudent Person Principle, A-137
Establishing Identity for Contact Outside the Interview Process, B-1213
Telephone Contact, B-1213.1
Actions on Inaccurate Responses to the Questions, A-2020.3
Documentation Requirements, A-2050

A—2020.2 Actions When Unable to Authenticate the Caller

Revision 15-4; Effective October 1, 2015

TANF, SNAP, TP 08 and TA 31

If none of the questions apply to a particular case situation or responses cannot be verified, staff should follow regional authentication policy and submit a policy clearance request to a local field policy specialist.

A—2020.3 Actions on Inaccurate Responses to the Questions

Revision 15-4; Effective October 1, 2015

TANF, SNAP, TP 08 and TA 31

If enough questions are applicable to the case but the individual cannot provide accurate responses to any two questions to authenticate the individual's identity, the individual should be advised that:

- the interview will be completed in order to gather required information; and
- the individual must come to the local office and provide verification of the individual's identity in person.

In the TIERS **Appointment – Details** page, **Caller Authentication** tab, staff should answer "No" to the question "Did caller accurately respond to the authentication questions?" and document in the page-level comments section the questions asked and the inaccurate responses provided.

TIERS will:

- pend for the individual to come into the office with identification and any missing information; and
- send the individual Form H1020, Request for Information or Action, requesting that the individual provide proof of identity at a local office.

Expedited Supplemental Nutrition Assistance Program (SNAP) applicants must follow current policy and provide proof of identity before receiving expedited benefits.

An active Eligibility Determination Group (EDG) must not be denied when adding a program if the individual fails to come to the local office to verify identity.

Related Policy
Pending Information, A-135
Expedited Service, A-140
Pending Verification on Applications, B-115
Processing Redeterminations, B-122

A—2020.4 Claiming Hardship for Coming to the Office

Revision 15-4; Effective October 1, 2015

TANF, SNAP, TP 08 and TA 31

If the person being interviewed states the individual is unable to come to the local office, the person should be allowed to claim hardship for any of the following reasons:

- Residence is more than 30 miles from the certification office (even if an itinerant office is less than 30 miles from the individual's home);
- Work or training schedule;
- Transportation difficulties;
- Prolonged severe weather;
- Illness;
- Care of a household member (the household member does not have to be part of the certified household); or
- Victims of family violence.

The individual must provide proof of identity by mail, email or fax.

A—2020.5 Actions When Verification Is Provided at the Local Office

Revision 15-4; Effective October 1, 2015

TANF, SNAP, TP 08 and TA 31

If the individual comes to the local office and provides appropriate verification, staff should refer to the **Appointment – Details** page, **Caller Authentication** tab, answer "Yes" to the question "Did caller accurately respond to the authentication questions?", and document in the page-level comments section the verification provided.

A—2020.6 Denial for Failure to Authenticate Identity

Revision 15-4; Effective October 1, 2015

TANF, SNAP, TP 08 and TA 31

If the individual does not come to the local office with acceptable verification of identity by the Form H1020, Request for Information or Action, due date, TIERS will create a task to deny only the EDG for which the authentication questions were asked, using the denial reason "failure to provide required information within specified time frame."

Related Policy
Pending Information, A-135
Pending Verification on Applications, B-115
Processing Redeterminations, B-122

A—2030 Prevention of Duplicate Participation

Revision 15-4; Effective October 1, 2015

All Programs

Texas Health and Human Services Commission (HHSC) staff must verify that household members do not currently receive benefits by already participating in Temporary Assistance for Needy Families (TANF), Medicaid and/or SNAP, at application and when adding a new household member.

Related Policy
Duplicate Participation, B-421.1
Changes Affecting Benefits, B-640

A—2030.1 Inquiry and Sources

Revision 15-4; Effective October 1, 2015

All Programs

HHSC staff must use existing technology, such as TIERS, Data Broker, State Online Query (SOLQ), etc., to verify the household members do not receive duplicate benefits.

At application, staff must:

- perform a TIERS file clearance to identify any household members receiving benefits in TANF, Medicaid or SNAP;
- use available online sources to verify the validity of information provided by the individual and missing or questionable information;
- contact the household and allow the individual the opportunity to explain any discrepancy; and/or
- send the household Form H1020, Request for Information or Action, requesting information or proof to resolve the discrepancies, if necessary.

Related Policy
Registering an Application, A-122.3
Automated Support Systems, C-800

A—2030.2 Duplicate Participation Match Procedures

Revision 15-4; Effective October 1, 2015

All Programs

If a household member is currently active for the same program on another EDG, HHSC staff must:

- notify the corresponding HHSC office by email or telephone;
- determine the correct EDG/case that will remain open;
- deny TANF, Medicaid and SNAP, if needed to prevent duplicate participation; and
- refer the household to the Office of Inspector General (OIG) for a TANF and/or SNAP overpayment.

Staff should refer to B-771, Filing an Overpayment Referral Using Automated System for the Office of Inspector General (ASOIG), and B-772, Filing an Overpayment Referral Using TIERS, for instructions on submitting a fraud and/or non-fraud referral to OIG. Staff may use either the TIERS interface with ASOIG or initiate the fraud referral directly in ASOIG.

Related Policy
Duplicate Participation, B-421.1
Participation Twice in Same Month, B-454
Duplicate Participation Procedures, B-454.1
Claims, B-700
Referrals for Intentional Program Violation (IPV), B-900

A—2040 Verification Requirements

Revision 15-4; Effective October 1, 2015

All Programs

TIERS file clearance and any other available sources may be used to verify the identity of the person being interviewed and that the household does not receive duplicate benefits.

Related Policy
Verification Sources, A-621
Questionable Information, C-920
Providing Verification, C-930

A—2040.1 Authentication of Caller Identity Verification Sources

Revision 15-4; Effective October 1, 2015

TANF, SNAP, TP 08 and TA 31 verification sources include:

- Adoption papers or records
- Birth certificate
- Certificate of Naturalization
- Certificate of U.S. citizenship
- Wage or check stub or check
- Collateral statement
- Department of Public Safety (DPS) identification card (current or expired)
- Driver license
- Finding of citizenship by another federal/state agency
- Hospital or birth records
- Identification card issued by federal/state/local government
- Immigration documents
- Military dependent's identification card with photo or other identifying info
- School identification card
- Tribal enrollment card

- U.S. Coast Guard Merchant Mariner card with photo or other identifying info
- U.S. passport
- U.S. military card/draft record with photo or other identifying info
- Voter registration card
- Work identification

A—2050 Documentation Requirements

Revision 15-4; Effective October 1, 2015

TANF, SNAP, TP 08 and TA 31

Staff must document in the **Appointment – Details** page, **Caller Authentication** tab, whether the caller was or was not verified. Staff must also document with a brief statement indicating which questions were correctly answered (e.g., "Caller verified Texas driver license and name of mortgage company"). If the caller fails to correctly answer the questions, staff notes which questions were asked and the inaccurate responses provided. Staff also documents whether the individual came into the office and provided verification of identity or claimed hardship.

Staff must document in TIERS Case Comments if an OIG referral was made via ASOIG; otherwise, the TIERS functionality is used.

Related Policy
Documentation, C-940
The Texas Works Documentation Guide

TWH, A-2100, Personal Responsibility Agreement

Revision 18-1; Effective January 1, 2018

A—2110 General Policy

Revision 12-3; Effective July 1, 2012

TANF

Require Temporary Assistance for Needy Families (TANF) recipients who are caretakers or second parents to sign Form H1073, Personal Responsibility Agreement (PRA). This includes minor parents who are certified as an adult. The agreement requires the caretaker and second parent to:

- participate in the Choices program (unless exempt);
- cooperate with child support requirements;
- not voluntarily quit a job;
- have their child(ren) screened through the Texas Health Steps (THSteps) program;
- have their child(ren) immunized;
- have their child(ren) attend school;
- attend parenting skills training if referred; and
- not abuse drugs or alcohol.

Require TANF payees and disqualified adults to sign Form H1073. The PRA requires the payee/disqualified adult to:

- cooperate with child support requirements;
- have child(ren) screened through the THSteps program;
- have child(ren) immunized;
- have child(ren) attend school; and
- not abuse drugs or alcohol.

If a caretaker, second parent, payee, or disqualified adult fails to sign Form H1073, deny the application. Failure to cooperate with the PRA results in a full-family sanction for the TANF household.

A payee certified as a caretaker on a separate TANF EDG may sign one PRA that is applicable to both EDGs.

A—2120 Individual Responsibilities

Revision 12-3; Effective July 1, 2012

TANF

Apply the following policies of the PRA, as appropriate, to caretakers, second parents, certified children, payees, and disqualified adults.

A—2121 Choices

Revision 12-3; Effective July 1, 2012

A—2121.1 When the Individual Signs Form H1073

Revision 12-3; Effective July 1, 2012

TANF

Inform the caretaker and second parents about the Choices requirements and full-family sanctions for noncooperation with Choices if they are required to register. Use TANF policies and procedures in A-1800,Employment Services, for a caretaker and second parent who sign Form H1073, Personal Responsibility Agreement.

Related Policy
Noncooperation with Choices, A-1843
TANF-SP Procedures, A-1843.1
Action on Noncooperation, A-1845
Completing the Penalty Action, A-1845.2
Re-establishing Eligibility During the Penalty Period, A-1847
Determining Good Cause, A-1860

A—2121.2 Ending a Choices Penalty

Revision 12-3; Effective July 1, 2012

TANF

Complete or Incomplete Review — The penalty end date is the month of cooperation.

Related Policy
Ending an Open Penalty, A-2145

A—2122 Child Support

Revision 05-3; Effective July 1, 2005

A—2122.1 When the Individual Signs Form H1073

Revision 12-3; Effective July 1, 2012

TANF

Inform the caretaker, second parent, payee and disqualified adult of the child support requirements and the full-family sanction. Use current TANF policies and procedures found in A-1100, Child Support, for individuals who are required to sign Form H1073, Personal Responsibility Agreement.

Related Policy
TANF, A-1124
Counting Child Support, A-1326.2.1
Imposing a Penalty, A-2144
Ending an Open Penalty, A-2145

A—2122.2 Explanation of Child/Medical Support, Family Violence and Good Cause

Revision 12-3; Effective July 1, 2012

TANF

In addition to signing Form H1010, which constitutes the assignment of rights to child/medical support, the individual must also sign Form H1073, Personal Responsibility Agreement. Use Form H1712, Explanation of Child/Medical Support, Family Violence and Good Cause, to help the individual understand the child support requirements.

A—2122.3 Good Cause for Child Support Noncooperation

Revision 12-3; Effective July 1, 2012

TANF

Determine if the individual has good cause for not cooperating with child support requirements using TANF policy in A-1130, Explanation of Good Cause. If the individual has good cause, do not sanction the household.

A—2122.4 Starting a Child Support Penalty

Revision 12-3; Effective July 1, 2012

TANF

Use the following chart to determine when to start a penalty.

If the individual fails to cooperate with the child support requirements at ...	then ...

If the individual fails to cooperate with the child support requirements at ...	then ...	
application, complete review, or incomplete review,	refer to A-2144, Imposing a Penalty.	
reapplication,	**if the individual has ...**	**then ...**
-	no open penalty,	follow procedures in A-2131.2.1, Verifying Prior Cooperation Status at TANF Reappplication.
-	an open penalty,	follow procedures in A-2152,Second Noncooperation During Pay For Performance.

Note: A child support noncooperation is not applicable if the noncooperation occurred:

- before Sept. 1, 2003, and the full-family sanction was never imposed; or
- on or after Sept. 1, 2003, but before signing Form H1073. Advisors must not open new PRA penalties for noncooperations that occurred before they signed the PRA.

A—2122.5 Ending a Child Support Penalty

Revision 12-3; Effective July 1, 2012

TANF

If the individual cures his penalty or proves good cause, end the penalty following procedures in A-2145, Ending an Open Penalty. **Note:** If the individual reports cooperation with the Office of Attorney General (OAG) but the advisor has not received Form H1701, contact the child support officer for the date of cooperation.

A—2123 Voluntary Quit

Revision 12-3; Effective July 1, 2012

A—2123.1 When the Individual Signs Form H1073

Revision 12-3; Effective July 1, 2012

TANF

Inform the caretaker and/or second parent (including a minor parent who is a caretaker or second parent) that they must not voluntarily quit a job of 30 or more hours a week. Voluntary quit applies to a caretaker/second parent who:

- signed the responsibility agreement;
- is non-exempt from Choices requirements whether the individual lives in a full service Choices county or a minimum service Choices county; and
- quit a job that was 30 hours or more a week without good cause.

A person has voluntarily quit a job if the individual:

- lost a job because of participation in a strike; or

- left a job unannounced or does not return to work without good cause, even if the person was technically fired.

A person is not considered to have voluntarily quit a job if the individual:

- reduced hours of employment, but continues to work for the same employer;
- ends a self-employment enterprise;
- resigns a job at the employer's demand;
- is currently on strike; or
- has good cause.

Note: See A-1850 for Supplemental Nutrition Assistance Program (SNAP) Voluntary Quit policy.

A—2123.2 Failure to Cooperate with Voluntary Quit

Revision 12-3; Effective July 1, 2012

TANF

Determine whether the individual failed to cooperate at application, complete or incomplete review after signing Form H1073. If the individual voluntarily quit a job before signing Form H1073, voluntary quit does not apply.

See Advisor Action on Noncooperation in A-2123.5.

A—2123.3 Curing Voluntary Quit

Revision 05-3; Effective July 1, 2005

TANF

The individual may cure the voluntary quit penalty if the individual:

- obtains a job working 30 hours or more a week; or
- becomes exempt from Choices.

A—2123.4 Good Cause for Voluntary Quit Noncooperation

Revision 12-3; Effective July 1, 2012

TANF

Good cause exists when circumstances beyond the recipient's control prevent the person from cooperating with the requirements. Explore all reasons for good cause before establishing voluntary quit. Reasons for good cause are the same as the SNAP Reasons for Good Cause in A-1861 with the following exception.

Exception: Acceptance of a job that later does not materialize or results in employment of less than 30 hours a week or weekly earnings of less than federal minimum wage multiplied by 30 hours is not considered good cause.

A—2123.5 Advisor Action on Noncooperation

Revision 05-3; Effective July 1, 2005

TANF

Apply a full-family sanction until the individual cooperates.

A—2123.5.1 Starting a Voluntary Quit Penalty

Revision 12-3; Effective July 1, 2012

TANF

Use the following chart to determine when to start a penalty.

If the advisor determines an individual voluntarily quit a job at...	then ...	
initial application,	start the full-family sanction the month of noncooperation if the individual signed Form H1073 before voluntarily quitting a job.	
complete or incomplete review,	refer to A-2144, Imposing a Penalty.	
reapplication,	**if the individual has ...**	**then ...**
-	no open voluntarily quit penalty,	follow procedures in A-2131.2.1, Verifying Prior Cooperation Status at TANF Reappplication.
-	an open penalty,	follow procedures in A-2152, Second Noncooperation During Pay For Performance.

A—2124 Texas Health Steps (THSteps) Program

Revision 12-3; Effective July 1, 2012

A—2124.1 When the Individual Signs Form H1073

Revision 12-3; Effective July 1, 2012

TANF

Inform a caretaker, second parent, payee, or disqualified adult who receives TANF for a child age two through 18 that the child must have

- a THSteps medical checkup according to the THSteps schedule, or
- good cause for not having the THSteps medical checkup.

Provide the caretaker, second parent, payee, or disqualified adult with the THSteps schedule (THSteps Wallet Card) for medical checkups and additional information provided to the Health and Human Services Commission (HHSC) by the Texas Department of State Health Services (DSHS). See A-1531 for information about the THSteps program.

A—2124.1.1 Setting the THSteps Overdue Month

Revision 12-3; Effective July 1, 2012

TANF

TIERS calculates and sets an overdue month for applications and complete reviews. TIERS uses the THSteps medical schedule and the child's birthdate plus 12 months to determine the overdue month. The child's birth month is month zero. The overdue month begins the first calendar day of the 12th month. This is the same formula DSHS uses to determine the child's overdue month for a medical checkup.

Example: The household has a child who turns 6 on April 3. According to the THSteps schedule, the child is due for a checkup when the child turns age 6. Consider April as month zero, and add 12 months to determine the overdue month. In this example, if the child does not have a medical checkup by the end of March, the child is overdue beginning April 1.

A—2124.2 At the First Complete Review After the Caretaker and/or Second Parent Signs Form H1073

Revision 12-3; Effective July 1, 2012

TANF

Determine if the individual failed to comply at each complete review after the individual signs Form H1073. If the overdue month is

- before or in the complete review interview month, the child is overdue. See A-2124.3.
- after the interview month and you complete the EDG in the
  - interview month, the child is not overdue.
  - overdue month, the child is overdue and must be penalized if the child has not had a THSteps medical checkup. At the interview, refer the household to the THSteps worker for assistance.

A—2124.2.1 Determining if the Child had a THSteps Medical Checkup

Revision 12-3; Effective July 1, 2012

TANF

Determine if a child had a THSteps medical checkup using one of the following methods:

- Checking information in TIERS Data Collection.
- Verifying and accepting a doctor's written statement if it:
  - is provided with the application or at the interview; and
  - provides enough information to determine a THSteps checkup has been completed.
- Verifying with the THSteps worker using Form H1087, Verification of Texas Health Steps (THSteps) Checkup.

Note: Do not pend for a doctor's statement. Follow the chart in A-2124.3, Advisor Action if the Overdue Month is Before or In the Complete Review Interview Month, if the individual states the child has had a checkup but does not have verification at the time of the interview.

A—2124.3 Advisor Action if the Overdue Month Is Before or In the Complete Review Interview Month

Revision 18-1; Effective January 1, 2018

TANF

Determine if the child had a medical checkup and use the following chart to determine the action to take.

If at the complete review the checkup is ...	then ...
not overdue,	do not apply a penalty.
overdue, but proof of a medical checkup that occurred before the discovery date is provided,	update the THSteps screening date in TIERS Data Collection.
overdue and the parent or guardian states the child had a checkup before the discovery date, but does not have proof,	fax Form H1087, Verification of Texas Health Steps (THSteps) Checkup, to THSteps staff at 512-533-3867. Do not refer the individual to the Medicaid provider. Local THSteps staff will contact the Medicaid provider. Pend the EDG to receive proof from THSteps staff. If proof is received within 10 days, update the THSteps screening date in TIERS Data Collection. TIERS recalculates a new overdue month. **Note:** If proof is not received within 10 days, contact Toni Sanders at 512-433-7478. If THSteps staff inform the advisor that they need more than 10 days, allow an additional 10 days. If the advisor determines the additional 10 days may cause a delinquency, accept the individual's statement that the child had a checkup and document in case comments. If THSteps staff provide proof of a checkup, take no further action. If THSteps staff state that a checkup did not occur, send Form TF0001, Notice of Case Action, advising the individual of the sanction for noncooperation. **Note:** The THSteps checkup date must be before the discovery date. If the individual has good cause for not complying, select the good cause reason. Refer to A-2124.5, Good Cause for THSteps Noncooperation.
overdue and the individual states the TANF child has not had a checkup and that the individual needs assistance making an appointment,	• refer the individual to THSteps staff using Form H1093, THSteps Extra Effort Referral. • apply a penalty for each child out of compliance without good cause. Refer to A-2124.6, Starting a THSteps Penalty. • if the individual has good cause for not complying, select the good cause reason. Refer to A-2124.5, Good Cause for THSteps Noncooperation.

A—2124.4 THSteps Overdue Month At Application

Revision 12-3; Effective July 1, 2012

TANF

For applications received in the last benefit month or in the two months following the last benefit month, determine if the child was not cooperating with the THSteps requirement in the last benefit month.

If the overdue month is:

- before or in the last benefit month and a noncooperation has not been imposed, impose a full-family sanction.
- after the last benefit month, do not impose a full-family sanction.

Related Policy
Verifying Prior Cooperation Status at TANF Reapplication, A-2131.2.1

A—2124.5 Good Cause for THSteps Noncooperation

Revision 12-3; Effective July 1, 2012

TANF

When an individual fails to cooperate with the THSteps requirement, explore good cause before applying a penalty. The individual may claim good cause for the following reasons:

- **Medical** — A screening puts the child'shealth at risk. The individual may provide medical records, a certificate, affidavit or statement from a licensed physician that the screening would be injurious to the health of the child. If verification from a THSteps worker indicates the child has had a screening within 12 months before the overdue date, allow a medical good cause. The THSteps worker will work with the provider to get the child back on schedule.
- **Religion** — The family has a religious belief that does not allow the child to have a screening. The applicant may provide a verbal statement on behalf of the child stating that the screening conflicts with the practices of arecognized church or religious organization to which the family adheres.
- **No medical provider or transportation** — There is no medical provider or transportation available within the geographic area. Regional THSteps staff provide this information to regional staff on a quarterly basis.

The individual must provide proof for good cause. If the advisor determines the individual has good cause for not cooperating with the THSteps requirements, select the good cause reason in TIERS Data Collection.

Use the following chart to determine when to start good cause.

If the advisor determines that good cause exists at ...	and the individual has ...	then ...
a complete review,	no open penalty,	start good cause the month the individual provides proof.
a complete review,	an open penalty,	start good cause the month after the individual provides proof. End the penalty the month the individual provides proof.
reapplication,	no open penalty,	start good cause the month of reapplication.
reapplication,	an open penalty,	start good cause the month of reapplication. End the penalty the month before the reapplication month. **Exception:** End the penalty the month of reapplication if the individual reapplies in a month in which benefits were received.

Redetermine good cause at the next complete review. The good cause end date is the month the advisor determines the individual no longer has good cause.

A—2124.6 Starting a THSteps Penalty

Revision 12-3; Effective July 1, 2012

TANF

Failure to comply with the THSteps schedule results in a full-family sanction.

Use the following chart to determine when to impose a full-family sanction.

If the individual fails to cooperate with the THSteps requirements at...	then ...
complete review,	refer to A-2144, Imposing aPenalty.
reapplication,	if the individual: • has an open penalty, follow procedures in A-2152, Second Noncooperation During Pay For Performance. • does not have an open penalty, See A-2131.2.1.

A—2124.7 Ending a THSteps Penalty

Revision 12-3; Effective July 1, 2012

TANF

At complete or incomplete Reviews, end the penalty following procedures in A-2145, Ending an Open Penalty, if the individual cooperates with the THSteps requirements or provides proof of good cause.

A—2125 Immunizations

Revision 12-3; Effective July 1, 2012

A—2125.1 When the Individual Signs Form H1073

Revision 12-3; Effective July 1, 2012

TANF

Inform caretakers, second parents, payees and disqualified adults who receive benefits for a child certified for TANF they must provide:

- proof that the child's immunizations are current; or
- good cause for not immunizing the child.

See Form H1012, Immunization Record, for the immunization schedule.

Related Policy
Verifying Prior Cooperation Status at TANF Reapplication, A-2131.2.1

A—2125.2 Determining if Immunizations are Current

Revision 05-3; Effective July 1, 2005

TANF

To determine whether a child is current with immunizations, use:

- Form H1012, Immunization Record;
- verification that THSteps checkups are current for a child age 2 or older unless other information indicates the child is not up-to-date with his immunizations; or
- verification that a child is enrolled and attending school unless other information indicates the child is not up-to-date with his immunizations.

If the records are not current but the individual provides proof that the child is on an alternate schedule, refer to A-2125.4 to allow good cause.

Do not count an immunization administered at birth as a required visit. An immunization is considered administered at birth if it is given between birth and seven days.

A—2125.3 Failure to Cooperate with Immunizations

Revision 12-3; Effective July 1, 2012

TANF

After the caretaker, second parent, payee or disqualified adult signs Form H1073, determine if the household cooperated with immunization requirements at each complete review.

Related Policy
Advisor Action on Noncooperation, A-2125.5
Verifying Prior Cooperation Status at TANF Reapplication, A-2131.2.1

A—2125.4 Good Cause for Immunizations Noncooperation

Revision 12-3; Effective July 1, 2012

TANF

Individuals have good cause for not cooperating with the immunization requirement if the caretaker, second parent, payee or disqualified adult can prove that:

- immunizations are not in the child's best medical interest; or
- the individual declined immunizations for the child for reasons of conscience, including a religious belief.

Good cause exists in the following situations:

- **Medical** — Administering immunizations puts the child's health at risk. The individual may provide medical records, a certificate, affidavit, or a statement from a licensed physician that the required immunization poses asignificant risk to the health of the child.
- **Conscientious Objector** — The immunization is being declined for reasons of conscience, including a religious belief. The person claiming the exemption must complete an affidavit on a form provided by DSHS stating the reason for the exemption. The child's parent, managing conservator, or guardian must sign the affidavit and have it notarized.
- **Alternate Schedule** — The child is behind on the current series of immunizations and the child is on an alternate schedule established by a doctor or health practitioner. The individual may provide a doctor's statement that the child is on an alternate schedule. Document the schedule and check the status at the next complete review.

Allow the individual 10 days to provide proof. Begin good cause the month the individual provides proof.

A—2125.5 Advisor Action on Noncooperation

Revision 12-3; Effective July 1, 2012

TANF

Apply a full-family sanction if a child does not meet the immunization requirement, and the household fails to provide proof of good cause.

Follow adverse action procedures in A-2343.1.

A—2125.5.1 Starting an Immunization Penalty

Revision 12-3; Effective January 1, 2012

TANF

Use the following chart to determine when to apply a full-family sanction when an individual noncooperates with immunizations.

If the individual fails to cooperate with the immunization requirements at ...	then ...
complete review,	refer to A-2144, Imposing aPenalty.
reapplication,	if the individual • has an open penalty, follow procedures in A-2152, Second Noncooperation During Pay For Performance. • does not have an open penalty, follow procedures in A-2131.2.1, Verifying Prior Cooperation Status at TANF Reapplication.

A—2125.5.2 Ending an Immunization Penalty

Revision 12-3; Effective July 1, 2012

TANF

At complete or incomplete Reviews, end the penalty the month the individual provides proof of cooperation with the immunization requirement or provides good cause following procedures in A-2145, Ending an Open Penalty.

A—2126 School Attendance

Revision 12-3; Effective July 1, 2012

A—2126.1 When the Individual Signs Form H1073

Revision 12-3; Effective July 1, 2012

TANF

Inform a caretaker, second parent, payee, disqualified adult or disqualified teen parent about the school attendance eligibility requirements in A-1610.

Related Policy
School Attendance, A-1600
Initial Application, A-2131.1
Verifying Prior Cooperation Status at TANF Reapplication, A-2131.2.1
Imposing a Penalty, A-2144
Ending an Open Penalty, A-2145
Open Penalty at Reapplication, A-2151

A—2127 Parenting Skills Training

Revision 12-3; Effective July 1, 2012

A—2127.1 When the Individual Signs Form H1073

Revision 14-3; Effective July 1, 2014

TANF

Inform TANF household members they must attend parenting skills training if they meet either of the following parenting skills mandatory referral criteria:

- There is a caretaker, or a caretaker and a second parent, when the EDG includes a certified child under age 5; or
- A minor parent is certified as a child.

Note: A household member who does not meet the mandatory referral criteria may volunteer for parenting skills training. Discuss the training with an individual who expresses a need or interest.

A—2127.2 Actions and Time Frames

Revision 06-2; Effective April 1, 2006

TANF

When explaining the PRA requirements at application, inform household members they must attend parenting skills training if referred.

At application or when a household member's status changes so that the member now meets the referral criteria, refer household members to parenting skills training if they:

- meet the mandatory referral criteria; or
- volunteer.

At the first review after referral, the complete review after approving good cause or imposing a penalty, an incomplete review after the individual notifies you of training completion and at reapplication after referral, follow procedures in A-2127.4, A-2127.5 and A-2127.6.

A—2127.3 Referral

Revision 17-3; Effective July 1, 2017

TANF

Do not refer a person to parenting skills training if the TIERS “Individual Summary TANF Time Limits” page and the personal responsibility agreement indicate they have completed training. The “Parenting Skills” field will show Yes.

An individual must complete parenting skills training once. Acceptable verification of training completion includes training that occurred before the individual referral, such as in a high school curriculum. The following is what needs to be provided when referring a person to parenting skills training.

- Form H1088, Verification of Parenting Skills Training, for each person referred.
- Information from 211Texas.org on classes in the area that are available where they may complete the parenting skills class and obtain verification. To find a class:
  - Go to 211Texas.org.
  - Enter the family's zip code to search.
  - On the next page, select the word search function.

    - Enter "parenting skills classes" within the Advance Search text box.
- If the parenting skills classes in the area do not contain all of the following four components, provide the individual with information on the classes that contain the component(s) the individual and advisor determine would most benefit the individual:
    - nutrition education;
    - budgeting;
    - survival skills; and
    - instruction on the necessity of physical and emotional safety for children.
- instruction that a parenting skills training certificate, letter, Women, Infants and Children identification card (only one card is needed to satisfy verification requirements for two-parent families), or other documentation that verifies completion of training is acceptable proof.
- the name(s) of the referred member(s) on Form TF0001, Notice of Case Action; and
- the following additional information on Form TF0001 for individuals who meet the mandatory referral criteria:
    - attendance of a parenting skills training must occur before the family's next TANF periodic review; and
    - the individual must provide verification of training completion at the next periodic review or the family's TANF EDG will be sanctioned, unless good cause exists. The penalty must remain on the EDG until the person(s) provides proof of training completion, has good cause, or is no longer mandatory.

A—2127.4 Failure to Cooperate with Parenting Skills Requirements

Revision 12-3; Effective July 1, 2012

TANF

At the complete review after the individual is referred to parenting skills training, determine if the individual completed the training.

If an individual who continues to meet the mandatory referral criteria does not have verification of class completion, determine if the individual has good cause for not completing the training during the months between reviews.

If an individual no longer meets the mandatory referral criteria when you are verifying training completion, do not determine good cause or impose a full family sanction.

A—2127.5 Good Cause for Parenting Skills Noncooperation

Revision 12-3; Effective July 1, 2012

TANF

Use the following chart to determine if good cause exists for the individual.

Good cause exists if ...	Verifications include, but are not limited to ...
no classes were available in the area.	• no classes listed in the Parenting Skills Resource Directory for the area; • a statement from the provider(s) that all classes were full.
the individual currently attends parenting skills training.	a statement or attendance record from the provider.
the person is or was ill and not able to attend an available class.	a doctor's statement or other medical evidence that the person is or was ill and unable to attend during the time when classes were available.
circumstances beyond the individual's control prevented the person from attending and/or completing the class. **Note:** Lack of usual transportation or dependent care is not acceptable for a good cause claim.	a report of a disaster or documentation of a family catastrophe that existed during the time when classes in the area were available.

A—2127.6 Advisor Action on Parenting Skills Noncooperation

Revision 05-3; Effective July 1, 2005

TANF

Apply a full-family sanction for failure to cooperate with the parenting skills requirement.

Follow adverse action procedures in A-2343.1.

A—2127.6.1 Starting a Parenting Skills Penalty

Revision 12-3; Effective July 1, 2012

TANF

Use the chart below to determine when to start a parenting skills penalty.

If the individual fails to comply with the parenting skills requirements at ...	then ...	
complete review,	refer to A-2144, Imposing a Penalty.	
reapplication,	**if the individual ...**	**then ...**
	has an open penalty,	follow procedures in A-2152, Second Noncooperation During Pay For Performance.
	does not have an open penalty,	follow procedures in A-2131.2.1, Verifying Prior Cooperation Status at TANF Reapplication.

A—2127.6.2 Ending a Parenting Skills Penalty or Good Cause

Revision 12-3; Effective July 1, 2012

TANF

Use the policies and procedures in the chart below:

- at a complete review after good cause was approved or a penalty imposed; or
- at an incomplete review if the individual notifies the advisor of training completion.

If the ...	and there is an open parenting skills ...	Then enter ...
individual provides verification of parenting skills training completion,	• good cause; or • penalty	• the month the individual verified training completion as the good cause or penalty end date.

If the ...	and there is an open parenting skills ...	Then enter ...
individual provides verification of good cause for the months between reviews,	penalty	• the month the individual verified good cause as the penalty end date; and • begin the good cause. When ending a penalty, enter the month after the individual verifies good cause as good cause start date.
individual does not provide verification of continuing good cause,	good cause	• the month the advisor makes the determination that good cause no longer exists as the good cause end date, and • open a penalty effective the month of disposition. **Note:** Procedures in A-2343.1, How to Take Adverse Action if Advance Notice Is Required.
individual no longer meets the mandatory referral criteria,	• good cause, or • penalty	the month the advisor determines the individual no longer meets the mandatory referral criteria as the good cause or penalty end date.

At each subsequent complete review until all individuals who meet the mandatory referral criteria have completed parenting skills training, continue to:

- refer members to parenting skills training, including members who were added to the EDG since the last complete review;
- verify completion of training;
- verify good cause for not completing the training; and
- impose parenting skills penalties.

A—2128 Alcohol or Drugs

Revision 12-3; Effective July 1, 2012

A—2128.1 When the Individual Signs Form H1073

Revision 12-4; Effective October 1, 2012

TANF

Inform a caretaker, second parent, payee or disqualified adult that they will forfeit a month of cash assistance if they are convicted (including a deferred adjudication) of a felony or misdemeanor criminal offense that involves using, selling or possessing marijuana or a controlled substance in violation of Health and Safety Code; Chapter 481, or abuse of alcohol after signing Form H1073 , Personal Responsibility Agreement. The penalty does not apply to an offense that occurred before the individual signed Form H1073. **Note:** A legal parent is permanently disqualified for a felony drug conviction (not deferred adjudication) for an offense that was committed on or after April 1, 2002, as specified in A-222, Who is Not Included.

Form H1010, Texas Works Application for Assistance — Your Texas Benefits, requires an applicant or recipient to answer a question regarding a conviction. Accept the individual's statement.

When the criminal history report in the Data Broker system indicates the individual was convicted of an alcohol or drug offense after signing Form H1073, discuss the situation with the individual. If the individual claims not to be the individual indicated on the criminal history report, but the identifying information (name, date of birth, physical description) leads the advisor to believe the information is

correct, or the individual disagrees with other information provided in the report (such as the type of conviction or whether it was a felony or misdemeanor), the advisor must:

- document the individual's response in the case record;
- proceed with the appropriate case action without acting on the criminal history report;
- contact the Office of Inspector General (OIG) by emailing the OIG General Investigations Policy and Quality Control Unit at oig_gi@hhsc.state.tx.us; and
- document the reason for contacting OIG in case record. Once OIG obtains information to clear the discrepancy, the assigned OIG investigator provides the response/finding by creating a task within the Task List Manager (TLM) system. The assigned advisor documents the results of the OIG's findings in case comments and, if applicable, makes an overpayment referral. (See B-770, Filing an Overpayment Referral.)

A—2128.2 Failure to Cooperate with the Alcohol or Drug Requirement

Revision 12-3; Effective July 1, 2012

TANF

At the complete review after Form H1073 is signed, if the individual answers yes to the question on Form H1010 regarding drugs and alcohol, determine if both the offense and conviction occurred after the individual signed Form H1073. If the offense and conviction occurred after Form H1073 was signed, apply a sanction.

Example 1: An individual signs Form H1073 in January 1999. The individual commits an offense in April 1999 and is convicted in November 1999. At the complete review after November 1999, the individual states on Form H1010 that he was convicted of possessing marijuana or a controlled substance. The advisor must impose a full-family sanction for one month.

Example 2: An individual signs Form H1073 in March. At the next complete review, the individual states he was convicted of a crime involving marijuana. The offense was committed before he signed Form H1073 and the individual was convicted after signing the form. The advisor cannot sanction the household because the offense occurred before the individual signed Form H1073.

A—2128.3 Advisor Action on Noncooperation

Revision 05-3; Effective July 1, 2005

TANF

If the individual states the offense and conviction occurred after signing Form H1073, apply a full-family sanction for one month. Accept the individual's statement as verification.

There is no good cause or cure for noncooperation with the alcohol or drug requirement.

Follow adverse action procedures in A-2343.1.

A—2128.3.1 Starting an Alcohol or Drug Penalty

Revision 12-3; Effective July 1, 2012

TANF

If the individual does not cooperate with the alcohol or drug requirement at a complete review or incomplete review, refer to A-2144, Imposing a Penalty.

Related Policy
Verifying Prior Cooperation Status at TANF Reapplication, A-2131.2.1

A—2128.3.2 Ending an Alcohol or Drug Penalty

Revision 05-3; Effective July 1, 2005

TANF

End the penalty the month after the forfeit month following procedures in A-2145, Ending An Open Penalty.

A—2129 Good Cause

Revision 12-3; Effective July 1, 2012

TANF

All requirements of the PRA have good cause except for the alcohol and drug requirement. If an individual has good cause for any requirement except alcohol and drug, do not penalize the individual for noncooperation.

Penalty and good cause start and end dates cannot overlap for the Choices, THSteps, immunization and parenting skills requirements. The good cause must end before a penalty can start and vice versa.

For more detailed information about good cause start and end dates, refer to each individual responsibility in A-2120, Individual Responsibilities.

A—2130 Form H1073, Personal Responsibility Agreement

Revision 12-3; Effective July 1, 2012

TANF

Form H1073, Personal Responsibility Agreement, lists the recipient's and HHSC's responsibilities. A caretaker, second parent, payee, or disqualified adult must sign Form H1073 before being certified. This includes a minor parent applying as an adult. If a caretaker, second parent, payee, or disqualified adult is not present to sign the agreement during the interview, pend the EDG to obtain the required signature.

Explain Form H1073 responsibilities and penalties for noncooperation at each periodic review.

Once the caretaker or second parent signs Form H1073, they do not have to sign the form again unless they are:

- denied and reapply; or
- added to the EDG.

Note: A disqualified member (as listed in A-222 #4) who cooperates must sign Form H1073 before being added to the TANF EDG. See A-2132.2. A member ineligible for Medicaid because of a Choices or child support noncooperation is not required to sign Form H1073 to reinstate benefits if the cooperation is completed before the end of the second month of noncooperation.

A—2131 Processing the PRA at Application

Revision 12-3; Effective July 1, 2012

A—2131.1 Initial Application

Revision 12-3; Effective July 1, 2012

TANF

At initial application, the individual must:

- sign the PRA; and
- be informed of its requirements and full-family sanction for noncooperation.

Impose a PRA noncooperation if the individual fails to comply with child support, voluntary quit or school attendance requirements after signing Form H1073 but before certification. If the individual cures the noncooperation before the eligibility determination, do not impose the full-family sanction and do not record the penalty.

The month the advisor discovers the noncooperation is also the first month of noncooperation. The applicant must cooperate by the end of the second noncooperation month to avoid reapplying in pay for performance. The forfeit month is the first month the household is otherwise eligible to receive a benefit, including a prorated benefit.

If the individual cooperates by the end of the second noncooperation month, certify the household with a future effective month equal to the month after the forfeit month.

After initial certification, impose a penalty for any PRA noncooperation discovered at complete review or when processing another case action.

If the required member(s) fails or refuses to sign the PRA, deny the application.

Continue to process the application for Medical Programs for Families and Children.

A—2131.2 Applicants Who Previously Received TANF

Revision 12-3; Effective July 1, 2012

TANF

Do not require a member who previously signed Form H1073 to sign it again unless the EDG is denied and the individual reapplies. In this situation, the member must sign Form H1073 again or the application must be denied.

A—2131.2.1 Verifying Prior Cooperation Status at TANF Reapplication

Revision 12-3; Effective July 1, 2012

TANF

When a household reapplies for TANF in the last month the household receives TANF assistance or the two months following, advisors must verify the household was in cooperation with all PRA requirements in the last month the household received TANF cash assistance. If the household was not in cooperation with all PRA requirements in their last month of TANF eligibility, impose a full-family sanction for a minimum of one month or until cooperation, whichever is longer. The month the advisor discovers the noncooperation is also the first month of noncooperation. The applicant must cooperate by the end of the second noncooperation month to avoid reapplying in pay for performance. The forfeit month is the first month the household is otherwise eligible to receive a benefit (including a prorated benefit). If the individual cooperates by the end of the second noncooperation month, certify the household with a future effective month equal to the month after the forfeit month. If the household reapplies for TANF later than two months following the month the household last received TANF benefits, treat the household like an initial application. See A-2131.1.

Related Policy
THSteps Overdue Month at Application, A-2124.4

A—2131.3 Imposing a Sanction on a New TANF Household When a Noncooperating Member Moves In

Revision 05-5; Effective October 1, 2005

TANF

When a noncooperating household member certified as an adult moves from an existing household into a new household that is currently not receiving TANF, but subsequently applies, determine which PRA requirement(s) the member did not cooperate with and use the following chart to determine what action to take.

If the adult ...	then ...	Follow policy in ...
did not cooperate with Choices, child support or voluntary quit,	the new household is considered to be applying in pay for performance.	A-2151, Open Penalty at Reapplication in Pay for Performance.
did not cooperate with parenting skills and moves into a household that includes achild under age 5,	the new household is considered to be applying in pay for performance.	A-2151, Open Penalty at Reapplication in Pay for Performance.
did not cooperate with parenting skills and moves into a household that does not include a child under age 5,	treat the household as an initial application.	A-2131.1, Initial Application.
moves from an existing household with a child who is not meeting THSteps, immunization, school attendance, or parenting skills requirements,	the household is considered to be applying in pay for performance.	A-2151, Open Penalty at Reapplication in Pay for Performance.
did not cooperate with any other PRA requirement,	treat the household as an initial application.	A-2131.1, Initial Application.

Note: If a noncooperating minor parent certified as a caretaker, second parent or disqualified individual is not in compliance with school attendance and moves from an existing household into a new household, follow policy in A-2151, Open Penalty at Reapplication in Pay for Performance.

When a household member certified as a child moves from an existing household into a new household that currently is not receiving TANF, but subsequently applies and the child has an open PRA noncooperation for immunizations, THSteps or school attendance, do not impose a full-family sanction on the new household. Follow policy in A-2131.1, Initial Application.

If the noncooperating household member moves back into the original household, follow policy A-2132.5.

A—2132 Processing Changes

Revision 12-3; Effective July 1, 2012

A—2132.1 Addition of a Caretaker or Second Parent at Incomplete Review

Revision 12-3; Effective July 1, 2012

TANF

Require the new member to sign Form H1073 within 10 days of the report date when adding a caretaker, second parent, payee or disqualified adult at incomplete review. If the new member refuses or fails to sign Form H1073, deny the EDG. Apply the full-family sanction policy if the member noncooperates with the PRA requirements after signing the PRA.

A—2132.2 Disqualification of a Caretaker or Second Parent

Revision 12-3; Effective July 1, 2012

TANF

If, after the PRA is signed, the caretaker is disqualified or both parents are disqualified in a two-parent household, inform the household of the payee/disqualified adult PRA requirements.

When the household consists of both the caretaker and second parent who have signed Form H1073 and only one parent is disqualified, the PRA requirements still apply to the household. When the disqualified member cooperates, the individual must sign Form H1073 before being added to the TANF EDG.

Note: This policy does not apply to members who are ineligible for Medicaid because of a noncooperation with PRA Choices or child support.

A—2132.3 Removing a Penalized Member During the First Noncooperation Month

Revision 12-3; Effective July 1, 2012

TANF

If the household reports the move ...	then...
before the PRA noncooperation is imposed,	do not apply a full-family sanction to the household. Record the penalty for the noncooperating individual.*
after the PRA noncooperation is imposed and the advisor verifies the member moved out of the household before the second month,	apply a full-family sanction to the household for one forfeit month only.

***Note:** The noncooperation is recorded with the individual's information only. TIERS will not set a Non Cooperation One (NC1) month until the individual reapplies.

A—2132.4 Removing a Penalized Member During the Second Noncooperation Month

Revision 12-3; Effective July 1, 2012

TANF

Deny the TANF EDG if the penalized member failed to cooperate and moved out during the second noncooperation month or afterwards. The household must reapply for TANF.

If the household reapplies for TANF and a member of the applying household

- has an open PRA penalty, the household must demonstrate PRA cooperation for one month through pay for performance.
- does not have an open penalty, the household does not have to demonstrate cooperation.

A—2132.5 Adding a Penalized Member to a Household

Revision 12-3; Effective July 1, 2012

TANF

A household currently receiving TANF cannot receive a benefit for the new penalized member for the identified forfeit month(s). Pend the EDG to add the penalized member for 30 or 40* days after the change is reported to allow demonstrated cooperation.

If the penalized member ...	then ...
demonstrates cooperation by the 30th or 40th day,	add the new member to the TANF EDG following current change policy, but no earlier than the month after the forfeit month(s).
fails to demonstrate cooperation by the 30th or 40th day,	Deny the EDG.**

*Follow policy in A-2151, Open Penalty at Reapplication in Pay for Performance, to determine if the EDG should be pended for 30 or 40 days.

**TIERS will transfer sanction information on the individual to the new case/EDG from the old case/EDG so there will be no change to NC1, Non Cooperation 2 (NC2), Forfeit 1 or Forfeit 2.

Provide a separate Form H1020, Request for Information or Action, Request for Information or Action, if other eligibility verification is required. If all eligibility information is provided except PRA cooperation, add the new member to the SNAP or Medicaid EDG as appropriate.

Example: On May 3, the Smith household requests that Sarah, who is a new member of the household and currently penalized, be added to their EDG. The advisor sends form H1020 to the household informing them that Sarah has an open penalty and cannot be added until she cooperates with the PRA. If the household fails to provide verification of cooperation by June 2, the advisor sends Form TF0001, Notice of Case Action, to deny the TANF cash assistance. Take action on any associated Medicaid or SNAP EDGs following existing policy.

A—2132.6 Certified Children Who Age Out Before/After the Caretaker or Payee Fails to Cooperate with PRA Requirements

Revision 12-3; Effective July 1, 2012

TANF

Once a certified child ages out of the certified group, the caretaker or payee is not required to cooperate with the PRA requirements for that particular child even if timely action has not been taken to remove the child from the EDG.

When a caretaker or payee receives a noncooperation for a certified child ...	then ...
and the certified child ages out before the noncooperation discovery month,	do not sanction the household.
and the certified child ages out during or after the noncooperation discovery month,	ensure the child is removed from the EDG and apply one forfeit month to the household.

Notes:

- Process an overpayment referral if the child was not removed timely from the EDG.
- A child ages out in the month the child turns 18 or the month the child graduates if graduating before or during the month of the individual's 19th birthday.

A—2140 Full-Family Sanction

Revision 12-3; Effective July 1, 2012

TANF

Impose a full-family sanction when an adult TANF recipient, minor parent certified as an adult or second parent, or payee/disqualified adult fails to cooperate with any applicable requirement of the PRA after the agreement has been signed. The full-family sanction is imposed for a minimum of one month or until cooperation, whichever is longer.

If the household does not cooperate with a PRA requirement for two consecutive months, the household loses TANF cash assistance and the family must demonstrate cooperation with the PRA for 30 days before receiving cash assistance again. This is referred to as pay for performance.

If the household does not cooperate with two or more PRA requirements during the initial NC1 or NC2 month, the household loses TANF cash assistance and the family must reapply in pay for performance.

A—2141 When to Start a Full-Family Sanction

Revision 12-3; Effective July 1, 2012

TANF

After the TANF recipient or payee/disqualified adult signs the PRA, the entire household loses eligibility for cash assistance if a:

- TANF recipient fails to cooperate with **any** PRA requirement, or
- payee/disqualified adult fails to cooperate with any of the modified PRA requirements.

This loss of cash assistance is referred to as a full-family sanction. During the full-family sanction the household is ineligible for cash assistance for one month or until they cooperate, whichever is longer. Once the full-family sanction is imposed, that month's benefit is forfeited and the family cannot regain that month's benefit, even if they later cooperate.

If the nonexempt TANF recipient fails to cooperate with Choices or child support, or the payee/disqualified adult or Choices-exempt TANF recipient fails to cooperate with child support, the noncooperating individual also loses Medicaid coverage (excluding Transitional Medicaid) for one month or until cooperation, whichever is longer, unless the individual is under age 19 or pregnant. The other family members remain eligible for Medicaid.

A noncooperation is not applicable if the noncooperation occurred:

- before Sept. 1, 2003, and the full-family sanction was never imposed, or
- on or after Sept. 1, 2003, but before signing Form H1073. Advisors must not open anew PRA penalty for noncooperations that occurred before the individual signed the PRA.

Notes:

- After the TANF EDG is denied for any reason, the noncooperating adult may reapply for Medicaid and qualify after the identified forfeit months. **Exception:** An adult who noncooperated with child support must comply before becoming eligible for Medicaid.
- If the family has new or increased earnings, child support income or loss of the 90% earned income disregard (EID) that causes ineligibility and a PRA noncooperation that affect the same month, the earned income, child support or EID change has hierarchy. **Exception:** Legal parents who fail to cooperate with Child/Medical Support or TPR requirements are not eligible for Transitional Child Support Medicaid.

Related Policy
Transitional Medicaid Coverage, A-840

A—2141.1 Determining the First Month of Noncooperation

Revision 14-1; Effective January 1, 2014

TANF

The first month of noncooperation, or the NC1 month, is the month:

- of the "noncooperation date" on Form H2581, Choices Noncooperation Report;
- HHSC receives notice of child support noncooperation on Form H1708-A, Report of Noncooperation (Automated). **Note:** There is no noncooperation date on Form H1708-A. Use the date the data is posted to the online system; or
- the advisor discovers noncooperation with other PRA requirements at either a complete or incomplete action.

A—2141.2 Determining the Second Month of Noncooperation

Revision 12-3; Effective July 1, 2012

TANF

The second month of potential noncooperation/cooperation, or the NC2 month, is the calendar month following the first month of noncooperation. The family must cooperate with the PRA by the last calendar day of the second month to avoid a second forfeit month and pay for performance requirements.

Consider the individual a TANF recipient during the second month of noncooperation even if this is a forfeit month. The individual has not lost eligibility during the second month of noncooperation and may regain eligibility during the second month if cooperation is established by the last calendar day of the month.

Note: When a member fails to cooperate with the drug and alcohol PRA requirement, the individual is considered to be back in cooperation status the month after the month of noncooperation unless convicted of a subsequent offense.

A—2141.3 Determining the Forfeit Month(s)

Revision 12-3; Effective January 1, 2012

TANF

For PRA penalties imposed on active EDGs, the first month the advisor can actually apply the full-family sanction and forfeit a month of TANF cash assistance after sending Form TF0001, Notice of Case Action, and allowing adverse action is the effective month.

For PRA penalties imposed at application, the first forfeit month for:

- TANF is the first month the household would otherwise receive a TANF grant.
- Medicaid for an adult who fails to cooperate with Choices or child support is the first month the advisor can impose the penalty on or after the PRA noncooperation discovery date. Provide Medicaid coverage for the adult for any eligible months before the PRA noncooperation discovery date.

Note: Forfeit months cannot be prior to the first noncooperation (NC1) month.

A TANF household that fails to cooperate with the PRA for two consecutive months must forfeit cash assistance for two consecutive months. The following individuals also forfeit Medicaid coverage for two consecutive months, unless the individual is pregnant or under the age of 19:

- Choices mandatory TANF caretaker or second parent who noncooperates with Choices or child support;
- Choices exempt TANF caretaker or second parent who noncooperates with child support; or
- payee/disqualified adult who noncooperates with child support.

Note: When the full-family sanction month has been determined and a Choices or child support noncooperation is received after cutoff in the first month of noncooperation, disqualify the noncooperating member the next effective month.

A—2142 Applying a Full-Family Sanction to Multiple TANF EDGs

Revision 12-3; Effective July 1, 2012

TANF

If the TANF recipient or payee/disqualified adult has more than one TANF EDG and fails to cooperate with:

- parenting skills, voluntary quit or Choices, the sanction applies only to the EDG with the certified adult;
- THSteps, immunizations or school attendance, the sanction applies to the EDG with the applicable child;
- child support or drugs and alcohol, the sanction applies to all TANF EDGs.

A—2143 Reinstating Cash Assistance After Cooperation

Revision 14-1; Effective January 1, 2014

TANF

If the family cooperates with all required PRA components by the last calendar day of the second consecutive month, the advisor must reinstate TANF cash assistance for the first month after the full-family sanction month. If the advisor receives verification of cooperation from the individual, Texas Workforce Commission (TWC), Office of Attorney General (OAG) or other sources after the second month and before cutoff of the following month, the individual must have cooperated in the second month to have cash assistance reinstated. **Note:** If HHSC later receives proof that the individual did cooperate in the second month, the individual may reapply without going through the pay for performance process.

Example: The advisor receives Form H1708-A, Report of Noncooperation (Automated), in November after cutoff and processes the EDG before December cutoff. The family's first month of noncooperation is November, and the full-family sanction is effective January. The family has forfeited January TANF cash assistance permanently. The noncooperating adult has also lost Medicaid for January.

The family's second consecutive month of noncooperation/cooperation is December. On Jan. 4, the OAG provides Form H1701, Child Support, TANF Foster Care and TANF/Medicaid Case Information Exchange, verifying the individual cooperated with child support requirements on Dec. 29, 2003. The advisor must reinstate TANF cash assistance (and Medicaid for the disqualified adult) effective February (the month after the forfeited month).

A—2144 Imposing a Penalty

Revision 14-2; Effective April 1, 2014

To impose a penalty, ensure required individuals have signed Form H1073, Personal Responsibility Agreement. Impose a full-family sanction using the following chart.

If processing ...	impose a full-family sanction ...
an initial application,	effective the first month the applicant would otherwise receive a grant if the individual does not cooperate with child support, voluntary quit or school attendance requirements before certification but after signing the PRA. Do not impose a full-family sanction for any other noncooperation at application.
an incomplete review,	the effective month based on the date Form TF0001, Notice of Case Action, is sent if the individual does not cooperate with Choices, child support or voluntary quit requirements.
a complete review on an active EDG,	the effective month based on the disposition date for any penalty.
a reapplication after denial,	as explained in each individual responsibility section (A-2120, Individual Responsibilities).

If processing ...	impose a full-family sanction ...
an application received in the last benefit month or within two months after the last benefit month,	effective the first month the applicant would otherwise receive a grant if the applicant was not cooperating with the PRA in the last benefit month (A-2131.2.1, Verifying Prior Cooperation Status at TANF Reapplication).

Issue Form TF0001, informing the individual of the PRA noncompliance. Include who did not comply with the PRA and which requirement the member failed to cooperate with.

Note: Impose a full-family sanction if the requested verification indicates the PRA requirement was met after the verification request date or if the verification is provided after the verification due date.

A—2144.1 Failing to Impose a Full-Family Sanction

Revision 12-4; Effective October 1, 2012

TANF

If HHSC does not take action on a noncooperation report within a reasonable time frame, send Form TF0001, Notice of Case Action, to initiate the noncooperation penalty as soon as possible.

Form TF0001 is sent within a reasonable time frame if:

- for Choices penalties, a Choices penalty notice is received from TWC within five calendar days after the end of the month in which the Choices noncooperation occurred; and
- for all penalties, the advisor sends Form TF0001 in the same calendar month as the date of noncooperation, or within 10 calendar days after becoming aware of the noncooperation if that is later.

If the advisor does not send Form TF0001 within a reasonable time frame, the first month of noncooperation becomes the month Form TF0001 was sent. This ensures the individual has a reasonable opportunity to demonstrate cooperation in the second month.

Note: A postponed first month results in a forfeit month, but does not count toward two consecutive months of noncooperation.

If the advisor sends Form TF0001 for a PRA penalty within a reasonable time frame but fails to timely impose the full-family sanction for the correct forfeit month, determine the actual first and second month of noncooperation. If the individual:

- cooperates in the second month, file a claim for the month that should have been forfeited. The household does not need to reapply for TANF.
- fails to cooperate in the second month, file a claim for the two months that should have been forfeited. The household must reapply in pay for performance status.

If a penalty is applicable but the EDG is denied, advisors still must enter the penalty information into TIERS and send Form TF0001.

A—2145 Ending an Open Penalty

Revision 12-3; Effective July 1, 2012

TANF

The end date for a PRA penalty is the month the individual cooperates or has good cause for certain PRA requirements.

Close a PRA penalty if the household cooperates by the end of the second month of noncooperation and provides verification by cutoff of the next month.

If verification is provided after cutoff of the following month, the household must reapply as explained in A-2143.

Note: Do not close a child support penalty incurred while receiving TANF when an individual applies for adult Medicaid and has cooperated with the OAG.

The end date cannot be later than the effective month (the month the advisor can affect benefits).

Enter the verification type and date when ending a penalty. If the advisor enters an end month with no verification, TIERS pends the page.

Note: If after imposing a penalty you determine the individual was incorrectly penalized, remove the penalty and restore benefits, if appropriate.

A—2146 Action When an Individual Fails to Cooperate with the PRA at Complete or Incomplete Review

Revision 17-2; Effective April 1, 2017

TANF

If the caretaker, second parent, payee or disqualified adult noncooperates with ...	then ...
Choices (Caretakers and second parents only)	• The first month of noncooperation is the month of the "noncompliance date" on Form H2581, Choices Noncooperation Report. • Refer the noncooperating adult to the workforce solutions office. Do not require a signed Form H2580, TANF Employment Services Notice. • Send Form H2581 response to TWC with the current appropriate response. • Send Form TF0001, Notice of Case Action, within five workdays after receiving Form H2581. • Terminate the TP 08 of the noncooperating adult, unless the individual is pregnant or under age 19. **Note:** TIERS will set the Work Registration Reason as "Sanctioned for Choices nonparticipation" for the noncooperating adult(s).
Child support	• The first month of noncooperation is the month HHSC receives Form H1708-A , Report of Noncooperation (Automated). • Send Form TF0001 within five workdays after receiving Form H1708-A. • Terminate the TP 08 of the noncooperating adult unless the individual is pregnant or under age 19.
THSteps, immunizations, school attendance, parenting skills or voluntary quit	• The first month of noncooperation is the month the advisor discovers the noncooperation. • Send Form TF0001.
Drugs and alcohol	• The first month of noncooperation is the month the advisor discovers the drug and alcohol conviction. • Send Form TF0001.

Note: See A-2147, Action When the Individual Cooperates with the PRA Requirements Before the End of the Second Noncooperation Month, for situations where the individual cooperates with the PRA requirements before the end of the second potential noncooperation month. If the individual provides other information needed to complete the review and cooperates with the PRA requirement, complete the review and impose a full-family sanction. End date the penalty effective the month the individual cooperates.

Related Policy
Imposing a Penalty, A-2144
PRA Requirements Before the End of the Second Noncooperation Month, A-2147
Recipients of TANF and TP 08, A-825.1

A—2147 Action When the Individual Cooperates with the PRA Requirements Before the End of the Second Noncooperation Month

Revision 12-3; Effective July 1, 2012

TANF

If the caretaker, second parent, payee or disqualified adult cooperates with the PRA requirement before the end of the second noncooperation month, then end date the penalty effective the month the individual cooperates. Send Form TF0001, Notice of Case Action, informing the household the sanction has ended and the ongoing benefit amount.

Notes:

- For Choices and child support, end the Medicaid disqualification the month the individual cooperates. Reinstate Medicaid benefits effective the month after the forfeit month.
- If after imposing a penalty, it is determined the individual was incorrectly penalized, remove the penalty and restore benefits, if appropriate.
- If the household cooperates with the PRA requirements but does not provide information requested to complete the periodic review, deny the household for failure to provide.

A—2148 Reserved for Future Use

Revision 12-3; Effective July 1, 2012

A—2149 Individual Notices

Revision 14-2; Effective April 1, 2014

TANF

Issue Form TF0001, Notice of Case Action, to impose a full-family sanction. Issue a second Form TF0001 for any PRA noncooperation that occurs in the first or second month of noncooperation after the original noncooperation has been identified to inform the household of the new noncooperation. Advise the household of the penalty and how the member can cooperate.

Use adequate notice when imposing a penalty for one or more PRA noncooperations. See A-2344.1, Form TF0001 Required (Adequate Notice).

A—2150 Pay for Performance

Revision 12-3; Effective July 1, 2012

TANF

If the household does not cooperate with one or more PRA requirements for two consecutive months, the household loses TANF cash assistance and the family must demonstrate cooperation with all PRA requirements for 30 days before they are eligible to receive TANF

cash assistance. This is referred to as pay for performance. Advisors must verify that the family has not cooperated by the end of the second consecutive month before applying the pay for performance policy. The 30 days of demonstrated cooperation starts when the family cooperated with the PRA requirement. **Note:** If cooperation was established before the application date, the 30 days of cooperation begins on the file date.

A household may reapply for TANF assistance under pay for performance after the second noncooperation month. Deny a TANF application, filed before the last day of the second noncooperation month as filed in error. **Exception:** Do not deny the TANF application if the appointment is scheduled after the second noncooperation month. At the interview, have the individual review Form H1010 and re-sign it. The file date is the first day of the interview month. Document the reason the file date changed.

Note: When a TANF applicant with an open PRA penalty applies for One-Time Temporary Assistance for Needy Families (OTTANF), the individual must demonstrate cooperation with all open noncooperations before being considered TANF-eligible. See A-2400 for OTTANF policy.

A—2151 Open Penalty at Reapplication in Pay for Performance

Revision 12-3; Effective July 1, 2012

TANF

If the TANF applicant or second parent is in pay for performance status because of failure to cooperate with ...	then ...

Choices	The individual must cooperate with Choices requirements for 30 days if the individual is not eligible for a Choices exemption. Refer the individual to the local workforce solutions office with Form H2588, Workforce Orientation Referral, indicating the individual is subject to pay for performance. Remind the individual to contact the local workforce solutions office within 10 days to allow enough time to demonstrate 30 days of cooperation. Pend the application until the 40th day after the interview date, and:
	• end the penalty the month of cooperation if notice of cooperation is received by the 40th day after the interview date and certify the application effective the:
	  ◦ month after the second forfeit month; or
	  ◦ 30th day from the file date if after the second forfeit month; or
	• deny the application if the workforce solutions office:
	  ◦ has not sent a notice of cooperation by the 40th day after the interview date; or
	  ◦ sends Form H2588 indicating the individual cannot demonstrate 30 days of cooperation before the 40th day after the interview date.
	  The individual must complete another application and restart the eligibility process.
	  Note: Choices staff will sign off on the Form H2588 after the individual attends the workforce orientation. Staff should not end a Choices penalty until an electronic notice of demonstrated cooperation is received through the automated interface.

Child support	The individual must cooperate with child support requirements. Refer the individual to the OAG and pend the application until the 30th day after the file date. If the individual:
	• complies by the 30th day after the file date, end the penalty the month of cooperation and continue pending the application until the 30th day after the cooperation date and certify the application effective the:
	  ◦ month after the second forfeit month; or
	  ◦ 30th day from the file date if after the second forfeit month; or
	• has not complied with the OAG by the 30th day after the file date, deny the application.

If the TANF applicant or second parent is in pay for performance status because of failure to cooperate with ...	then ...

Voluntary quit	The individual must cure the voluntary quit. Verify the individual has obtained employment of 30 hours or more per week, or is eligible for a Choices exemption. If the individual is employed on the interview date or is eligible for a Choices exemption, pend the application until the 30th day after the file date for proof of cooperation, and if the individual:
	• complies by the 30th day after the file date, end the penalty the month verification is provided, continue pending the application until the 30th day after the cooperation date and certify the application effective the:
	  ◦ month after the second forfeit month; or
	  ◦ 30th day from the file date if after the second forfeit month; or
	• is not employed for 30 hours per week or eligible for a Choices exemption, deny the application.

THSteps	The individual must cooperate with THSteps requirements. Refer the individual to the local THSteps worker using Form H1087, or THSteps regional hotline. Pend the application until the 30th day after the file date for proof of cooperation, and if:
	• the individual complies by the 30th day after the file date, end the penalty the month the individual provides verification of medical screening and continue pending the application until the 30th day after the cooperation date and certify the application effective the:
	  ◦ month after the second forfeit month; or
	  ◦ 30th day from the file date if after the second forfeit month; or
	• verification is not provided by the 30th day after the file date, deny the application.

Immunizations	The individual must cooperate with immunization requirements. Pend the application until the 30th day after the file date for proof of cooperation. If:
	• the individual cooperates by the 30th day after the file date, end the penalty the month verification is provided and continue pending the application until the 30th day after the cooperation date and certify the application effective the:
	  ◦ month after the second forfeit month; or
	  ◦ 30th day from the file date if after the second forfeit month; or
	• verification is not provided by the 30th day after the file date, deny the application.

School attendance	The individual must cooperate with school attendance requirements. Pend the application until the 40th day after the interview date, and
	• end the penalty the month school attendance is verified and certify the application effective the:
	  ◦ month after the second forfeit month; or
	  ◦ 30th day from the file date if after the second forfeit month; or
	• deny the application if verification is not provided by the 40th day after the interview date.

Parenting skills	The individual must cooperate with parenting skills requirements. Pend the application until the 30th day after the file date, and if
	• the individual cooperates by the 30th day after the file date, end the penalty the month completion is verified and continue pending the application until the 30th day after the cooperation date and certify the application effective the:
	  ◦ month after the second forfeit month; or
	  ◦ 30th day from the file date if after the second forfeit month; or
	• verification is not provided by the 30th day after the file date, deny the application.

If the TANF applicant or second parent is in pay for performance status because of failure to cooperate with ...	then ...
Drugs and alcohol	When a member fails to cooperate with the drug and alcohol PRA requirement, he is considered to be back in cooperation status the month following the month of noncooperation, unless the advisor discovers a second separate noncooperation in the month following the first noncooperation month. See A-2128.

Notes:

- When pending the EDG for verification of cooperation with PRA requirements, other than Choices or school attendance, document the following in the comments section of Form H1020: Your application cannot be certified earlier than the 30th day from the date of cooperation with (enter the PRA requirement)./Su solicitud sólo se puede certificar 30 días después de la fecha de cumplimiento con los requisitos relacionados con (enter the PRA requirement).
    - Child Support – la manutención de niños
    - Voluntary Quit – la renuncia voluntaria al trabajo
    - THSteps (enter name of child) – Pasos Sanos de Texas (enter name of child)
    - Immunizations (enter name of child) – las inmunizaciones (enter name of child)
    - Parenting Skills – la capacitación para ser buenos padres
    - Drugs/Alcohol – las drogas y el alcohol
- If the individual reapplies in pay for performance, but does not have any open penalties, the 30 days of cooperation begins on the file date.
- Explore Medicaid eligibility for the children and eligible adults.
- If an individual has an open Choices, Voluntary Quit or Parenting Skills penalty and is now a payee, the individual does not have to demonstrate cooperation.

A—2152 A Second Noncooperation During Pay for Performance

Revision 12-3; Effective July 1, 2012

TANF

The household must reapply in pay for performance to qualify for TANF cash assistance. An individual with an open penalty at application must cooperate with the PRA requirement that caused the penalty and demonstrate PRA cooperation for 30 days.

When a household reapplies for TANF during pay for performance and the advisor discovers a household member fails to cooperate with a second or subsequent PRA requirement:

- Before or during the reapplication interview, allow the individual to demonstrate cooperation for the initial and second or subsequent noncooperation. Pend the application for the required 30- or 40-day time period to allow demonstrated cooperation for the initial and second or subsequent penalty. If the household:
    - cooperates with both the initial and subsequent penalties, close the initial penalty and certify the application. Document that the household cooperated with the second or subsequent penalty.
    - cooperates with the initial penalty, but not second or subsequent penalty, close the initial penalty, open the second or subsequent penalty and deny the application as a result of the second or subsequent noncooperation.
    - fails to cooperate with the initial penalty, leave the penalty open and deny the application. Do not open a second or subsequent penalty.
- After the interview, deny the TANF reapplication. The initial penalty remains open. Open the second or subsequent penalty.

Note: Explore Medicaid eligibility for the children and eligible adults.

A—2160 Verification Requirements

Revision 08-3; Effective July 1, 2008

TANF

Verify a good cause claim as explained in A-2129, Good Cause.

Immunizations

Verify:

- that the child's immunizations are current;
- that a child is enrolled and attending school, unless there is other information that the child is not up-to-date with his immunizations; and
- prior cooperation status at reapplication, according to A-2125.5.1, Starting an Immunization Penalty.

A—2161 Verification Sources

Revision 12-3; Effective July 1, 2012

TANF

THSteps

- Checking the THSteps Overdue MED DT in TIERS Data Collection
- Verification from the individual such as a doctor's statement
- Verification from THSteps staff
- Form H1087, Verification of Texas Health Steps (THSteps) Checkup

Immunizations

- Form H1012, Immunization Record
- Statement from a medical provider such as a doctor or nurse
- Verification that a child is enrolled and attending school, unless there is other information that the child is not up-to-date with immunizations

Parenting Skills

- Form H1088, Verification of Parenting Skills Training
- Training certification, letter or Women, Infants and Children (WIC) identification card that verifies completion of parenting skills training

Related Policy
Questionable Information, C-920
Providing Verification, C-930

A—2170 Documentation Requirements

Revision 12-3; Effective July 1, 2012

TANF

Document the:

- personal responsibility requirements (PRA) were verbally explained to the individual according to A-2110, General Policy; and
- reason for good cause, if applicable.

Parenting Skills

Include documentation of the name and:

- address of the organization or person who provided the training; and
- telephone number of the contact person.

Drugs and Alcohol

Document the:

- individual's response when it disagrees with the information in a credit report, including the information the individual states is incorrect; and
- reason for referral to OIG.

Immunization

Document the:

- immunization status of each child; and
- review of immunization record and visits.

Full-Family Sanction

Document the household's:

- PRA noncooperation;
- first month of the noncooperation;
- full-family sanction month; and
- reason for delay if the application is pended due to PRA pay for performance.

Pay for Performance

Document the reason for denial when denying an EDG for failure to demonstrate cooperation when a household reapplies in pay for performance.

Related Policy
Documentation, C-940
The Texas Works Documentation Guide

TWH, A-2200, Workforce Orientation

Revision 13-4; Effective October 1, 2013

A—2210 Requirements

Revision 05-5; Effective October 1, 2005

TANF and TANF-SP

A caretaker and second parent (not disqualified) residing in a full service Choices county must attend a workforce orientation if he is applying for

- TANF/TANF-SP, or
- extended TANF.

Inform the applicant that he must attend the orientation before you can certify the household.

List the requirement to provide proof of workforce orientation attendance on Form H1020, Request for Information or Action.

See A-2214, Failure or Refusal to Comply with the Workforce Orientation Requirement. When denying a TANF/TANF-SP application for failure to attend workforce orientation, continue to process the application for Medical Programs for Families and Children and for the Supplemental Nutrition Assistance Program (SNAP), if applicable.

Some applicants may not be able to attend a regularly scheduled workforce orientation due to extraordinary circumstances. These applicants must complete an alternative workforce orientation via telephone or home visit by local workforce staff depending on available resources. **Exception:** Allow good cause for a caretaker/second parent who is unable to complete a regular or alternate workforce orientation because of being hospitalized or bedridden with a severe illness.

A—2211 Alternative Workforce Orientation

Revision 12-3; Effective July 1, 2012

TANF and TANF-SP

At the interview, inform applicants who cannot attend a regularly scheduled workforce orientation due to extraordinary circumstances that he must complete an alternative orientation. Inform the client that he must contact the workforce solutions office to request an alternative orientation. Extraordinary circumstances may include:

- no available transportation or a disruption in transportation arrangements;
- residing more than 30 miles from the nearest Local Workforce Development Board (LWDB) orientation site;
- caring for a child under four months of age;
- a conflicting work or school schedule;
- illness or injury of the applicant or spouse;
- illness or injury of another household member that requires the applicant's care; or
- being a victim of family violence and attending the orientation session would place the applicant/family in danger.

Generally, the alternative workforce orientation will consist of either a telephone call or a visit by local workforce staff. The type of alternative orientation will depend on resources available to the LWDB.

A—2212 Workforce Orientation Referral

Revision 03-5; Effective July 1, 2003

A—2212.1 Form H2588, Workforce Orientation Referral

Revision 12-3; Effective July 1, 2012

TANF and TANF-SP

Use Form H2588, Workforce Orientation Referral, to refer an applicant in a full service Choices county to a regular or alternative workforce orientation. Provide the applicant with a completed Form H2588 for each caretaker and second parent.

Note: If you determine the applicant requires an alternative workforce orientation, complete Form H2588, Part B – Workforce Orientation (Alternative).

Inform individuals of the requirements to

- attend a workforce orientation, regular or alternative, and
- have Form H2588 signed and stamped by Choices staff.

Choices staff are required to return the verification to the local eligibility determination office by fax, phone, courier, interagency mail, or regular mail.

If the Local Workforce Development Board (LWDB) determines they are not able to accommodate the applicant with an alternative orientation, the LWDB returns Form H2588 indicating they were not able to provide the orientation and that the applicant is considered to have met the requirement.

Note: The applicant may choose to return the stamped Form H2588 to HHSC instead of waiting for Choices staff to provide the verification to HHSC.

A—2212.2 Workforce Orientation Flyers

Revision 13-4; Effective October 1, 2013

TANF and TANF-SP

Choices staff provide offices with workforce orientation flyers. The flyers for the regular orientation informs applicants of the days, times, and locations of regular workforce orientation sessions. The LWDBs have flexibility in the development of the alternative workforce orientation flyer. If the flyer does not contain information regarding an alternative orientation, provide the applicant with the regular orientation flyer so they have the workforce solutions office's telephone number. Advisors must inform the individual that it is the individual who must contact the workforce solutions office to request an alternative workforce orientation. Provide a workforce orientation flyer, regular or alternative, with each Form H2588, Workforce Orientation Referral.

Advisors are not required to provide a TANF Workforce Orientation flyer with Form H2588 to TANF applicants who are interviewed by phone from a remote location, although this remains an acceptable option. At a minimum, advisors must provide the household with the workforce solutions office information based on the individual's residential address.

Staff can find the most accessible workforce solutions office for the household at www.twc.state.tx.us and clicking on "Find Locations."

Staff must list the requirement to provide proof of workforce orientation attendance on Form H1020, Request for Information or Action, Request for Information or Action, along with the contact information, address and phone number for the workforce solutions office. The applicant is responsible for making contact with the workforce solutions office and completing the workforce orientation.

The number of available orientations depends on the number of applicants local eligibility determination offices refer to Choices staff. Texas Works and Choices staff coordinates to determine the average number of referrals. Regular workforce orientations occur at least twice a week. Rural areas of full service Choices counties may hold orientations on an individual basis.

Note: If a workforce orientation, regular or alternative, is unavailable to an applicant in a full service Choices county within the 10-day pending period, do not require the applicant to attend the workforce orientation prior to certification.

A—2213 Workforce Orientation Session

Revision 03-5; Effective July 1, 2003

TANF and TANF-SP

The workforce orientation, regular and alternative, introduces applicants to the local labor market and the resources available to assist the applicant with finding a job. Workforce orientation emphasizes the impact of time-limited benefits, importance of work, and personal responsibility.

Workforce orientation staff informs applicants of related support services, such as childcare and limited transportation benefits.

A—2213.1 Related Support Services

Revision 03-5; Effective July 1, 2003

TANF and TANF-SP

Choices staff in a full service Choices county offer applicants the opportunity to take advantage of immediate job search or education/training resources. If the applicant attends the regular or alternative orientation and obtains a job before TANF certification, Choices staff offers an applicant childcare for up to 12 months and limited transportation benefits.

Once certified, the individual may receive childcare and limited transportation benefits if he gets a job within the first three months after TANF certification and if the household is not eligible for transitional benefits. If the individual gets a job after receiving TANF benefits for more than three months, the household is potentially eligible for transitional benefits.

A—2213.2 Employment Planning Session (EPS)

Revision 03-5; Effective July 1, 2003

TANF and TANF-SP

At the end of the workforce orientation, regular or alternative, Choices staff in full service Choices counties give or mail an EPS appointment to all applicants.

Some applicants are not required to attend the EPS. Choices staff let the applicant know if he must attend the EPS. Mark the"Potential Choices Status" box on Form H2588, Workforce Orientation Referral, to help local Choices staff determine who is potentially exempt or non-exempt from the Choices program and the EPS.

Local Choices staff advise applicants who are potentially

- non-exempt from Choices about sanctions for not attending the EPS.
- exempt from Choices that they do not have to attend the EPS but may volunteer to attend.

In most instances, Choices staff hold the EPS after the advisor certifies the TANF case; however, Choices staff may hold the EPS before TANF certification.

If the individual ...	then Choices staff ...
attends the EPS after certification,	set the appointment date as the date the individual attends the EPS.
fails to keep the EPS appointment after certification,	send a sanction request for a non-exempt TANF recipient. This counts as a Choices noncompliance.
attends the EPS before certification,	set the appointment date as the certification date.
fails to keep the EPS appointment before certification,	do not initiate a sanction. Instead, send another EPS appointment notice after case certification.

A recipient exempt from participating in Choices is not required to attend the EPS. By attending, the individual is voluntarily participating in the Choices program and is subject to time limits.

Related Policy
State Time Limits, A-2500

A—2214 Failure or Refusal to Comply with the Workforce Orientation Requirement

Revision 13-1; Effective January 1, 2013

TANF and TANF-SP

Deny an application or EDG if a required adult member in a full service Choices county fails to attend the regular workforce orientation or complete an alternative orientation.

A—2215 Addition of a New Household Member or Disqualified Member

Revision 13-1; Effective January 1, 2013

TANF and TANF-SP

When adding a new member or a household member previously disqualified for another reason, require that member to attend a workforce orientation.

A—2220 Verification Requirements

Revision 08-3; Effective July 1, 2008

TANF and TANF-SP

Verify workforce orientation attendance with:

- information provided by Choices staff; or
- a procedure established through a local region and Workforce Development Board Memorandum of Understanding.

Related Policy
Questionable Information, C-920
Providing Verification, C-930

A—2230 Documentation Requirements

Revision 12-3; Effective July 1, 2012

TANF and TANF-SP

Document the good cause reason when a caretaker/second parent is unable to complete a regular or alternate workforce orientation. See A-2210, Requirements.

Document verification obtained by phone or through an agreed procedure between the local region and Local Workforce Development Board (LWDB) staff.

Example: The LWDB provides rural offices with a workforce orientation video. Document the workforce orientation requirement was met with the viewing of the workforce orientation video.

Related Policy
Documentation, C-940
The Texas Works Documentation Guide

TWH, A-2300 Case Disposition

Revision 17-2; Effective April 1, 2017

A—2310 Notice to Applicants

Revision 15-4; Effective October 1, 2015

All Programs

Eligibility Determination Group (EDG) disposition produces the individual's notice of eligibility status. At the close of the interview or during processing of the application or renewal form, the EDG is pended, certified, sustained or denied. Advisors must give the individual one or more of the following notices:

- Form H1020 , Request for Information or Action — Form H1020 tells the individual the:
  - reason the case is pending;
  - action the individual or advisor must take;
  - date by which the individual or advisor must take action; and
  - date the advisor must deny the application/EDG if the individual does not take action, if applicable.

    Note: For Spanish-speaking only individuals, advisors must ensure that all comments provided are in Spanish. See Form H1020 instructions for translation of common pending phrases.

- **Form TF0001, Notice of Case Action**
  - If benefits have been approved, the notice informs the individual of:
    - the date benefits begin or Medicaid effective date;
    - the amount of benefits; and
    - the length of certification for Supplemental Nutrition Assistance Program (SNAP) EDGs.
  - If benefits have been denied, terminated or reduced, the notice informs the individual of:
    - the reason the advisor denied the application, denied the EDG or reduced benefits;
    - that a protective payee is required for Temporary Assistance for Needy Families (TANF);
    - the effective date of the action;
    - the individual's right to appeal;
    - the address and telephone number of free legal services available in the area; and
    - that the advisor used a credit report, if its use resulted in fewer benefits than the individual would have otherwise received.

If an application is denied because an individual failed to keep an appointment or furnish information, advisors provide what they must do to reuse the application.

Note: Eligibility for multiple programs is determined independently of each other. Advisors must not deny an application for one program based solely on the denial of another program unless the household fails to meet the eligibility requirements.

If the advisor issued a notice of eligibility for the one-time grandparent payment but State Office Database Support notifies the advisor that the individual is not eligible, Form TF0001, Notice of Case Action, is issued to notify the household that they are not eligible because they previously received the payment.

A—2320 Eligibility Dates and Benefit Amounts

Revision 08-1; Effective January 1, 2008

A—2321 Date Eligibility Begins

Revision 15-4; Effective October 1, 2015

TANF

TANF financial eligibility begins the earlier of the:

- certification date; or
- 30th day after the file date.

The certification date is the date the advisor disposes the TANF EDG. An applicant must receive benefits for the month that falls within 30 days of the file date, unless benefits prorate to less than $10.

See A-2411, OTTANF, and A-2412, Grandparent Payments.

The following examples show possible beginning dates for eligibility:

Example 1: A family applies April 9. The certification date is April 21. Benefits are prorated from April 21.

Example 2: A family applies on April 30. The certification date is May 29, and because of proration, benefits for May are less than $10. The grant effective date is June 1.

Example 3: A family applies April 9, but the advisor delays certification until May 15. Benefits are prorated from May 9 (30th day from the file date).

SNAP

SNAP eligibility begins on the day the valid application is received in the correct office unless:

- benefits prorate to less than $10;
- the household already received benefits that month; or
- the household is not eligible for the month of application but eligible for ongoing months.

Medicaid Programs

See A-820, Regular Medicaid Coverage, and A-830, Medicaid Coverage for the Months Prior to the Month of Application, for dates Medicaid eligibility begins.

A—2322 Benefits

Revision 15-4; Effective October 1, 2015

TANF

Advisors must:

- Base the benefit amount on household size and net income.
- Issue benefits for less than $10 only for:
  - supplemental payments; and
  - payments made after recoupment is processed.
- Issue One-Time TANF (OTTANF) benefits for $1,000 to eligible households, regardless of household size or income.
- Issue a One-Time Grandparent payment of $1,000 to eligible households, regardless of the household size or income.

SNAP

Advisors must:

- Base the household allotment on household size and net income.
- Not issue an initial month's prorated benefits for less than $10.
- Issue a prorated initial month's allotment and the following month's allotment at the same time for households who apply after the 15th of the month. See A-150, Combined Allotment Policy.
- Deny the EDG if net income results in zero allotment for the initial and ongoing months.

A—2323 Proration

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Do not issue prorated benefits of less than $10.

TANF

To calculate the prorated amount, advisors must:

- determine the household's **whole** monthly benefit based on household size and net income;
- determine the earlier of the certification date or the 30th day after the file date; and

- follow the instructions in C-112, How To Prorate TANF Grants.

Note: Advisors must not prorate OTTANF or One-Time Grandparent payments.

SNAP

Advisors base proration on the number of days between the file date and the end of the month. To calculate the prorated amount, advisors determine the:

- household's **whole** monthly benefit based on household size and net income; and
- **prorated** allotment from the proration table in C-1432, Prorated SNAP Allotments by Application Date, using the whole monthly allotment and date of application.

Note: Advisors never prorate benefits for any month after the application month.

To calculate prorations over $300, advisors must:

1. Subtract the date of application from 31.
2. Multiply the difference by the amount of the whole monthly allotment.
3. Divide that amount by 30.
4. Drop all cents.

If the date of application is the 30th or 31st, advisors divide the whole allotment by 30.

Example: A household applies June 17. The household's whole monthly allotment is $395.

1. 31 - 17 = 14
2. $395 × 14 = $5,530
3. $5,530 ÷ 30 = $184.33
4. Round to $184. The household's prorated allotment for June is $184.

Advisors must not prorate benefits if the household includes a member who meets both of the following criteria:

- is a seasonal or migrant farm worker (in or out of the workstream); and
- was certified for SNAP, in Texas or another state, the month before the household applied.

A—2324 Length of Certification

Revision 15-4; Effective October 1, 2015

TANF

TANF does not have a certification period. The EDG remains open until denied.

The Texas Integrated Eligibility Redesign System (TIERS) calculates the TANF periodic review due date from the date the advisor disposes the EDG as follows:

- Applications:
  - 11 months for payee EDGs with income of less than $3; or
  - five months for other EDGs.
- Reviews:
  - 12 months for payee cases with income of less than $3; or
  - six months for other cases.

One-Time Payments

OTTANF cases are not subject to periodic reviews. Applicants must reapply for subsequent benefits after the ineligibility period. See A-2400, One Time Payments. Grandparent OTTANF are not subject to further action.

SNAP

Non-Public Assistance (NPA) Households

Advisors assign households the longest certification period possible based on their eligibility and the predictability of their circumstances, according to the following table:

If the household ...	then certify the household for ...
meets the streamlined reporting (SR) criteria in A-2350, Streamlined Reporting Households,	six months. **Exception**: Certify SNAP for four or five months, if necessary, so the new SNAP certification period ends one month before the end of the Children's Medicaid certification period. This will allow state office to mail only one redetermination packet for both programs.
consists entirely of unemployable or elderly persons with stable circumstances and the household does not meet the SR criteria,	six to 12 months. **Example:** Households whose members receive Retirement, Survivors and Disability Insurance (RSDI), Supplemental Security Income (SSI), retirement pensions or disability payments may be certified up to 12 months if other household circumstances are expected to remain stable. **Note:** Pure SSI households are assigned a 36-month certification period.
does not meet the SR criteria and circumstances are unstable (including households with an able-bodied adult without dependents [ABAWD]),	three to six months.
is likely to become ineligible in the next two months due to an expected change and the household does not meet the SR criteria,	one or two months. **Example:** The household does not meet SR criteria and the individual indicates during the interview that someone in the household will start a new job, begin receiving unemployment benefits or move out of (or into) the household. **Exception:** If the household is certified for one or two months and the certification occurs **after** the 15th day in the last month of certification, extend the certification to the following month (unless the household is ineligible based on a change known at certification).

Notes:

- If a household meets the SR criteria, advisors must ensure that TIERS designates the EDG as SR and assigns a six-month certification period. This includes households with self-employment income.
- Advisors must give the individual Form H1010, Texas Works Application for Assistance — Your Texas Benefits, and Form H1830-R, Texas Works Renewal Notice, at recertification when assigning a:
  - one- or two-month certification period, or
  - three-month certification period and the case is certified after cutoff in the first benefit month.

Public Assistance (PA) Households

Most SNAP EDGs with associated TANF EDGs meet the SR criteria.

For non-SR households, advisors assign a certification period that meets the requirements listed above for Non-PA households and corresponds to the redetermination due date of the associated TANF EDG.

For SR households, advisors assign a six-month certification period regardless of whether the certification period corresponds to the redetermination due date of the associated TANF EDG.

TP 08

TP 08 has a 12-month non-continuous eligibility certification period. The estimated eligibility end date is estimated as follows:

- Applications — application month plus 11 months, and
- Redeterminations — 12 months from the last review date.

TP 43, TP 44 and TP 48

The certification period for a child is the earliest of:

- 12 months, or
- through the month of the child's 19th birthday.

For these Types of Assistance (TOAs), the first six-month period is a continuous eligibility period and the second six-month period is a non-continuous eligibility period. The estimated eligibility end date is estimated as follows:

- Applications — application month plus 11 months, and
- Redeterminations — 12 months from the last review date.

Emergency Medicaid

Emergency Medicaid ends the earlier of either the end date of the emergency condition or the last day of the application month.

TP 40

The end date is the last day of the second month following the expected delivery date. See A-825, Medicaid Termination, for information on pregnancies that terminate early or late.

Related Policy
Medicaid Termination, A-825
What to Report, B-621
Actions on Changes, B-631

TP 45

TIERS calculates an end date that is 12 months from the child's birth date. A newborn is continuously eligible for TP 45 through the month of the child's first birthday, as long as the child lives in Texas.

A—2330 Setting Special Reviews

Revision 16-2; Effective April 1, 2016

TANF and Medical Programs

Advisors assign a special review when certifying a household that anticipates a change affecting eligibility before the next redetermination.

SNAP, TANF and Medical Programs

Advisors set special reviews when the household:

- has questionable circumstances; or
- includes a pregnant household member whose baby is expected before the next redetermination. Advisors schedule the special review on the first day of the month after her baby is due.

Exception: Advisors must not set a special review for SNAP SR households.

SNAP

Advisors set a special review for SNAP households according to the following chart:

For households ...	assign a special review ...
not designated as streamlined reporting,	when the household anticipates a change affecting eligibility before the next redetermination.

For households ...	assign a special review ...
designated as streamlined reporting,	• when the household anticipates they will have an increase in income that will cause the household to exceed 130 percent of the Federal Poverty Income Limits (FPIL); • if at certification, the advisor is aware a household member will gain or lose alien status eligibility sometime during the certification period (for example, a lawful permanent resident [LPR] will reach the 5 years of qualifying immigrant status during the certification period); or • when the household reports that an ABAWD who is currently eligible but is not meeting the average 20 hours a week work/training requirement moves into the SR household and will exhaust the individual's time limits and become ineligible on or before the last month of the certification period.

TP 43, TP 44 and TP 48

If a change is reported during the continuous eligibility period, the advisor must schedule a special review in the first week of the sixth month of the certification period, before cutoff, so an expected change can take effect during the non-continuous eligibility period.

A—2330.1 Special Reviews for Known Changes

Revision 15-4; Effective October 1, 2015

SNAP

A known change is a change that the household reasonably anticipates will occur during the certification period.

Example: The individual has been employed in the past by the school district and will return to work at that job three months into the certification period.

Advisors must contact the household to confirm that a change occurred. If the household confirms that a change occurred, policy in B-600, Changes, applies. If the household confirms that no change occurred, the advisor must document in Case Comments the household's explanation to complete the special review.

If the advisor requests verification of the change on Form H1020, Request for Information or Action, Request for Information or Action, but the individual fails to respond, the advisor must consider the case situation questionable and follow procedures in B-635, Shortening Certification Periods as a Result of a Change, to shorten the certification period. **Exception:** Advisors must not shorten the certification period for SNAP SR households.

A—2330.2 Special Reviews for Questionable Changes

Revision 15-4; Effective October 1, 2015

SNAP

A questionable change is a change the household thinks may happen during the certification period or that the advisor expects to happen because the household's situation is unstable.

Example 1: The individual is unemployed at the time of the interview and is looking for work but does not have a definite job offer.

Example 2: The household expenses exceed income, and the individual cannot explain future management.

Advisors must contact the household to determine whether a change occurred. If the household confirms that a change occurred, the advisor follows policy in B-600, Changes. If the household confirms that no change occurred, the advisor documents the contact in Case Comments and the household's explanation to complete the special review.

Note: Advisors must not set a special review due to questionable changes for SNAP SR households.

Related Policy
Setting Special Reviews, A-2330
Streamlined Reporting Households, A-2350

A—2340 Adverse Action

Revision 13-2; Effective April 1, 2013

All Programs

Any household receiving a notice of adverse action has the right to request a fair hearing. In some situations households may continue benefits pending an appeal.

Related Policy
Fair Hearings, B-1000

A—2341 Denial of an Application

Revision 17-2, Effective April 1, 2017

All Programs

Denials are effective immediately. Advisors must provide the applicant with Form TF0001, Notice of Case Action, stating the reason for the denial. Advisors must follow the procedures and time frames in B-100, Processes and Processing Time Frames.

Note: Advisors determine eligibility for multiple programs independently of each other and do not deny an application for one program based solely on the denial of another program unless the household fails to meet the eligibility requirements.

Medical Programs

The system automatically sends individuals determined ineligible for Medicaid and the Children's Health Insurance Program (CHIP) at application to the Marketplace for an eligibility determination for federal health care coverage programs.

To qualify for the federal health care coverage programs, all individuals must first be determined ineligible for Medicaid and CHIP. Advisors must test whether an individual is eligible for all Medical Programs. The Texas Works Medical Programs Hierarchy, explained in A-132.1, Medical Programs Hierarchy, does this automatically for all clients at application.

Notes:

- Advisors must follow a manual process when retesting eligibility for a minor parent aging out of TP 44, a pregnant woman from TP 40 at the end of the certification period, or an individual at the end of the transitional Medicaid certification period, as explained in A-2342.1, Retesting Eligibility.
- Pregnant woman whose TP 40 coverage terminates prior to the end of their original certification period may be eligible for automatic retesting of eligibility for all Medical Programs as explained in A-825, Medicaid Termination.

A—2342 Denial at Redetermination

Revision 17-2; Effective April 1, 2017

TANF

Process TANF EDGs found ineligible at review following adverse action procedures.

SNAP

Denials are effective immediately. Advisors provide the household with Form TF0001, Notice of Case Action, stating the reason for denial.

Timely Redeterminations — If a household applies by the 15th of the last month of their certification period and is ineligible, advisors use the policy and procedures in B-120, Redeterminations, to deny the EDG.

Untimely Redeterminations — If a household applies after the 15th of the last month of their certification period and is ineligible, advisors use the policy and procedures in B-110, Applications, to deny the EDG.

Medical Programs

The system automatically sends individuals determined ineligible for Medicaid and CHIP at redetermination to the Marketplace for an eligibility determination for federal health care coverage programs.

To qualify for the federal health care coverage programs, all individuals must first be determined ineligible for Medicaid and CHIP. Advisors must test whether an individual is eligible for all Medical Programs. The Texas Works Medical Programs Hierarchy, explained in A-132.1, Medical Programs Hierarchy, does this automatically for all clients at redetermination.

Notes:

- Advisors must follow a manual process when retesting eligibility for a minor parent aging out of TP 44, a pregnant woman from TP 40 at the end of the certification period, or an individual at the end of the transitional Medicaid certification period, as explained in A-2342.1, Retesting Eligibility.
- Pregnant woman whose TP 40 coverage terminates prior to the end of their original certification period may be eligible for automatic retesting of eligibility for all Medical Programs as explained in A-825, Medicaid Termination.

TP 08

Before denying for missing a redetermination appointment, advisors must determine whether the individual is eligible for TP 07 in the denial effective month. If so, advisors provide TP 07 rather than denying the EDG.

TP 43, TP 44 and TP 48

Advisors process a denial if the household fails to provide pending verification by the 30th day from the file date or by cutoff in the last benefit month of certification, whichever is later. Advisors do not provide 13 days advance notice prior to denying the EDG.

When an advisor processes a renewal, which results in a shortened Medicaid certification period, the household may be eligible for expedited CHIP enrollment as explained in D-1711, Expedited CHIP Enrollment.

A—2342.1 Retesting Eligibility

Revision 15-4; Effective October 1, 2015

TP 44, TP 40, TP 07 and TP 20

The advisor must retest the following clients' potential eligibility for other Medical Programs by manually running the Texas Works Medical Program Hierarchy explained in A-132.1, Medical Programs Hierarchy, from the beginning:

- Minor parents aging out of TP 44, Children Ages 6-18;
- Individuals under TP 40, Pregnant Women, once their certification period ends; and
- Individuals terminated from TP 07 or TP 20, transitional Medicaid.

All other clients will flow through the hierarchy to either the next available program (for example, a child aging out of TP 48 will automatically be tested for TP 44) or will be referred to the Marketplace if determined ineligible for all other Medical Programs (for example, a non-parent child aging out of TP 44).

The system will not terminate eligibility of the individuals listed above at the end of the certification period. An advisor must take action to review the individual's eligibility and re-run the hierarchy to determine potential eligibility for other programs. Advisors must use the first day of the last month of the current certification period as the file date. Advisors should treat these cases like a redetermination without an actual renewal form. Except in the case of TP 40 where there may be an application, in which case advisors would process the case as they do redeterminations with renewal forms. Advisors must verify information as is currently done in the redetermination process.

The remaining individuals in the client's household composition are not re-evaluated for eligibility during a continuous eligibility period. Changes to household composition for the aging out of minor parents, end of pregnancy, or termination of transitional Medicaid coverage will be acted upon once the individuals transition from a continuous eligibility period to a non-continuous eligibility period.

Note: An interview is required when testing for TP 08.

A—2343 Advance Notice

Revision 15-4; Effective October 1, 2015

All Programs

After approval, advisors give households advance notice of adverse actions to deny, terminate, lower, or restrict existing benefits except for reasons listed in A-2344.1, Form TF0001 Required (Adequate Notice), and A-2344.2, No Form TF0001 Required.

A—2343.1 How to Take Adverse Action if Advance Notice Is Required

Revision 15-4; Effective October 1, 2015

All Programs

TIERS provides 13 days advance notice to the household after informing them of a denial or termination of ongoing benefits using Form TF0001, Notice of Case Action. The day Form TF0001 is sent is day zero of the adverse action period.

If the 13-day advance notice period:

- does not expire until after the last day of the month (regardless of whether the 13th day is a workday), the household is eligible for the same level of benefits the month after the notice was sent.
- expires between cutoff and the end of the month and the reduction or denial is effective the following month, advisors generate Form TF0001, Notice of Case Action. **Note:** Advisors do not deny TP 40 EDGs when taking adverse action for failure to provide postponed verification.

TANF

Advisors provide 13 days advance notice to the household using Form TF0001 before taking action to:

- establish a protective payee, or
- continue a protective payee because of mismanagement.

To establish a protective payee because the individual mismanaged TANF benefits, advisors follow adverse action policy above.

At complete redetermination, advisors re-evaluate the situation to determine whether the protective payee should continue. If the decision is to continue, the advisor notifies the individual by Form TF0001.

If the individual appeals this decision, the advisor issues TANF benefits to a protective payee until the hearing is completed.

A—2344 Adverse Actions Not Requiring Advance Notice

Revision 13-2; Effective April 1, 2013

A—2344.1 Form TF0001 Required (Adequate Notice)

Revision 15-4; Effective October 1, 2015

All Programs

The following situations require that the household be provided adequate notice:

- The individual's location is unknown, and the post office returns Texas Health and Human Services Commission (HHSC) mail with no forwarding address.
- The head of the household, authorized representative or other responsible household member:
  - in the HHSC advisor's presence (in the office or by telephone) verbally volunteers to withdraw; or
  - gives HHSC a written, signed report of change, and the advisor determines the:
    - exact amount of the reduced benefits, or
    - that the household is ineligible.

  Note: This includes situations in which the advisor receives Form H1028, Employment Verification, signed by the individual and completed by the employer.

- The household reports in advance they will move out of state.
- Employment and Training (E&T) noncooperation is received in the last benefit month.

Related Policy
How to Report, B-623
Sending Notice of Failure to Cooperate, A-1845.1

TANF and Medical Programs

In the following situations, advisors send Form TF0001, Notice of Case Action, without advance notice:

- The advisor denies or reduces benefits when an individual reaches the maximum age as described in A-220, TANF, and A-240, Medical Programs.
- The advisor confirms the individual's or payee's death when no relative is available to serve as new payee.
- The advisor reduces the grant or denies a Medical Program individual because the individual received a new TANF or SSI grant.
- The advisor imposes a full-family sanction because of noncooperation with one or more Personal Responsibility Agreement (PRA) requirements.
- The advisor denies a TP 08 individual because of noncooperation with medical support.
- The individual was admitted/committed to an institution and no longer qualifies for TANF or Medical Programs benefits.
- The individual was placed in skilled nursing care or intermediate care.
- The advisor denies a TANF or TANF-State Program (SP) EDG because the caretaker or second parent received their lifetime limit of 60 months.
- HHSC verifies an individual is certified for SSI or TANF in another state.
- A TANF or Medical Program child is removed from the home by court order or voluntarily placed in foster care by the legal guardian.

Related Policy
The Texas Works Message, A-1527

SNAP

In the following situations, advisors send Form TF0001 without advance notice:

- The household fails to provide verification postponed during expedited services, or provides postponed verification that results in lowered or denied benefits.
- The advisor discovers information an expedited household failed to report. The information:
  -
    - exists on the interview date,
    - results in lowered or denied benefits, and
    - is discovered between the time the application is approved with postponed verification and on or before the 30th day.
- A drug and alcohol treatment/group living arrangement facility loses its status as authorized representative or loses its certification.
- Centralized Benefit Services (CBS) contacts field staff to deny the SNAP EDG in order to certify the SNAP Combined Application Project (SNAP-CAP) EDG. **Note:** If the SNAP-CAP applicant is certified for SNAP with other household members, allow advance notice of adverse action before removing the individual from the existing SNAP EDG.

Related Policy
General Policy, A-710
Information Received During Expedited Application Processing, B-116.1

A—2344.2 No Form TF0001 Required

Revision 15-4; Effective October 1, 2015

All Programs

Form TF0001, Notice of Case Action, is not required in the following situations:

- the state or federal government initiates mass changes that affect the entire caseload or significant portions of the caseload, such as the annual Social Security cost-of-living adjustment.
- the household moves out of state and reports it afterward.
- the household gives HHSC a written, signed request to voluntarily withdraw.

TANF

Form TF0001 is not required when child support collected by the Office of the Attorney General exceeded the amount of the grant plus the $75 disregard. In these cases, state office sends Form H1718, Notice of Benefit Denial, to the individual.

SNAP

Form TF0001 is not required in the following situations:

- All members of a household have died.
- The individual's allotment changes from month to month during the certification period because of changes expected at the time of certification. In this situation, inform the individual on Form TF0001 at the time of certification that the household's allotment will vary.
- The individual applied for TANF and SNAP at the same time and received SNAP while waiting for approval of the TANF grant.

A—2350 Streamlined Reporting Households

Revision 16-2; Effective April 1, 2016

SNAP

All SNAP households meet the streamlined reporting criteria with the following exceptions:

- The household knows (at application or redetermination) they have a change that will make them ineligible within the next six months. For example, the household plans to move out of state due to a new job in two months. **Note:** Do not consider an anticipated change in household composition as a known change until it actually occurs.
- The household consists of members who are all elderly or who have a disability, and no member has earned income. These households include pure SSI and RSDI cases that normally receive a 12-month certification period. Use the criteria in B-430, Households with Elderly Members or Members with a Disability, to determine if a person is elderly or has a disability for SR. If all household members meet the criteria in B-430, at least one member must have earned income to be designated as SR.
- The household contains at least one non-exempt ABAWD. For SR purposes, an adult age 18 up to age 50 is not considered an ABAWD if exempt from the SNAP ABAWD work requirement due to:
  - disability;
  - having a child under age 18 (or is a member of a SNAP EDG where a household member is under age 18); or
  - pregnancy.

Notes:

-
  - A single-person household meets the SR criteria if the individual has a disability. If the disability is not obvious, the advisor should obtain Form H1836-A, Medical Release/Physician's Statement. This person does not have to meet the earned income stipulation to be designated as SR.
  - A single-person ABAWD living in a SNAP ABAWD waiver or non-E&T county does not meet the SR criteria.
  - In situations where a household member is working or training an average of 20 hours weekly and has a child under age 18 (or is a member of a SNAP EDG where a household member is under age 18), the advisor must exempt the household member as having a child under age 18 in the 18-50 Work Requirement screen.

Advisors must determine whether a household meets the SR criteria at application and redetermination. Advisors assign a certification period to SR households, as explained in A-2324, Length of Certification, and do not remove the SR designation at incomplete reviews. The household retains its SR designation throughout the certification period.

A—2351 Disqualified Members

Revision 16-2; Effective April 1, 2016

SNAP

Advisors must extend SR policy to households containing disqualified members. In a household containing all elderly and/or members with a disability, the household can meet the SR criteria, even if the disqualified member is the only person with earnings.

Advisors do not consider a disqualified member an ABAWD for purposes of determining SR status, even if the member is disqualified due to exhausting the individual's SNAP ABAWD time limits. Advisors consider only eligible household members for this purpose.

A—2360 Documentation Requirements

Revision 15-4; Effective October 1, 2015

All Programs

Documentation must be sufficient to support the advisor's decision for denying or terminating the EDG. Refer to C-940, Documentation, for requirements related to adverse action decisions.

If not obvious, advisors must document that:

- adequate notice was allowed according to policy in A-2344.1, Form TF0001 Required (Adequate Notice); or
- Form TF001, Notice of Case Action, was not required according to policy in A-2344.2, No Form TF0001 Required.

TANF and Medical Programs except Emergency Medicaid

Advisors must thoroughly document the reason for any special review and explain any information needed and the acceptable verification required to clear the review.

SNAP

Advisors must document the:

- reason for extending a certification period;
- reason for modifying the designators or override tab; and
- reason for setting a special review, thoroughly explaining why the special review was set, any information needed, and the acceptable verification required to clear the review.

Related Policy
Setting Special Reviews, A-2330
Documentation, C-940
The Texas Works Documentation Guide

TWH, A-2400, One Time Payments

Revision 17-3; Effective July 1, 2017

A—2410 General Policy

Revision 13-2; Effective April 1, 2013

A—2411 OTTANF

Revision 17-3; Effective July 1, 2017

TANF

One Time Temporary Assistance for Needy Families (OTTANF) provides $1,000 cash assistance for families in crisis. The intent of the OTTANF payment is to help solve a short-term crisis and divert households from ongoing TANF benefits. These families must

- meet all TANF eligibility requirements; and
- not currently receive TANF.
  Note: Households who are active on Type Programs (TP) 07, 20 or 37 may apply for OTTANF.

A household has an option of receiving TANF or OTTANF if it meets one of four crisis criteria. Households who choose this option are not eligible to receive TANF, TANF-SP, or OTTANF payments for 12 months.

The following type programs (TPs) identify OTTANF Eligibility Determination Groups (EDGs):

- **TP 71** – for a one parent household; and
- **TP 72** – for a two parent household based on incapacity or TANF-SP.

The following participation statutes are required for an OTTANF EDG:

- Eligible Adult – caretaker in an OTTANF household;
- Eligible Adult – second parent in an OTTANF household;
- Eligible Child – an eligible child in an OTTANF household; and
- Other Child – an SSI child

Related Policy
Certifying Children on Non-Parent Caretaker EDGs, A-223
One Time Temporary Assistance for Needy Families Acknowledgement, Form H1072

A—2412 Grandparent Payments

Revision 16-3; Effective July 1, 2016

TANF

Provide a $1,000 supplemental payment to a grandparent who meets all the following criteria:

- is 45 years of age or older. This includes those who turn 45 in the month the eligibility determination is made and couples in which one is 45 or older (regardless of which one is caretaker/payee).
- meets the TANF relationship requirement of a grandparent as specified in C-1440, Relationship Charts. This includes degrees of great or great-great.
- is the caretaker or payee (or spouse of the caretaker or payee) of a TANF-certified grandchild, or is the caretaker or spouse of a caretaker of a grandchild for whom the household received OTTANF, and the parent of the grandchild is not in the home.
- has a family gross income less than or equal to 200% Federal Poverty Limit (FPIL).
- has resources less than or equal to the TANF resource limit in A-1220, Limits, of $1,000.

Note: A grandparent who is a payee is only required to meet the eligibility requirements noted above to qualify for the grandparent supplement. To be certified as a TANF caretaker, the grandparent must meet all TANF requirements.

Once a grandparent receives a one-time grandparent supplement payment, the grandparent is not eligible to receive the payment for other grandchildren who move into the home at a later time. Additionally, another grandparent cannot receive the grandparent payment for a grandchild who has already received the payment.

The grandchild must currently receive TANF or be newly certified for TANF (including open and close certifications). **Note:** A grandparent does not qualify based solely on a grandchild in the home who receives SSI.

Related Policy
Certifying Children on Non-Parent Caretaker EDGs, A-223
Time Frames for Qualifying for Restored Benefits, B-820

A—2420 Eligibility Requirements

Revision 05-5; Effective October 1, 2005

A—2421 OTTANF Requirements

Revision 13-2; Effective April 1, 2013

TANF

OTTANF households must:

- be eligible for TANF and eligible to receive a TANF grant of $10 or more in any month from the application or through the certification month;
- not include a member who is disqualified or has an open PRA penalty; and
- meet one of four crisis criteria listed in A-2440, Determining Crisis Criteria (OTTANF).

Note: The household does not have to be eligible for ongoing TANF to qualify for OTTANF.

If the household opts for OTTANF but fails to provide additional information needed for OTTANF, certify the application for TANF or TANF-SP without recontacting the individual.

A—2421.1 Citizenship

Revision 05-5; Effective October 1, 2005

TANF

All adult members of the household and at least one child must meet TANF citizenship requirements to be eligible for OTTANF. A child who is an ineligible alien is a non-household member.

A—2421.2 Deprivation Based on Incapacity

Revision 05-5; Effective October 1, 2005

TANF

If a household claims incapacity, follow the procedures in A-1050, Deprivation Based on Incapacity, before offering OTTANF.

A—2421.3 Child Support

Revision 13-2; Effective April 1, 2013

TANF

Advisors must gather child support information as required for TANF EDGs. If the advisor processes the application as an OTTANF EDG, TIERS will not send the information to the Office of the Attorney General (OAG).

A—2421.4 Employment Services

Revision 05-3; Effective July 1, 2005

TANF

Required members must attend a workforce orientation before being offered OTTANF. Other employment services requirements do not apply to OTTANF.

A—2421.5 Personal Responsibility Agreement (PRA)

Revision 05-3; Effective July 1, 2005

TANF

Households must meet all TANF requirements, including the requirement to sign the PRA.

OTTANF applicants with an open PRA penalty must demonstrate cooperation to be eligible for OTTANF. See A-2100, Personal Responsibility Agreement.

A—2422 Requirements for Grandparent Payments

Revision 05-3; Effective July 1, 2005

A—2422.1 Determining the Budget and Certified Group

Revision 13-2; Effective April 1, 2013

TANF

Determining the Budget Group

To determine income eligibility, include the grandparents, grandchildren and any other children (biological or adopted) who meet the TANF age and relationship requirement and for whom the grandparent could apply for TANF. Persons included in the budget group may be disqualified or have a financial penalty.

Example: The household consists of Mr. and Mrs. Garza who are caring for two grandchildren, Chris, age 2 and Oscar, age 4. Chris and Oscar are cousins. Mr. and Mrs. Garza have two children, Rick, age 16, and Robert, age 19. Rick and Robert live at home. Mrs. Garza is an ineligible alien and is the payee on the TANF EDGs for her two grandchildren.

To determine income and resource eligibility for the one-time grandparent payment, include the following members in the budget group: Mr. and Mrs. Garza, both grandchildren, and Rick. Robert is not included because he does not meet the age requirement.

Determining the Certified Group

The certified group consists of the grandparent (and spouse of the grandparent) and grandchildren for whom the grandparent is the caretaker or payee on a TANF EDG.

Example: To determine the certified group of the Garza family noted in the example for the budget group, the certified group consists of: Mr. and Mrs. Garza, and both grandchildren. Rick and Robert are not included in the certified group.

A—2422.2 Income and Resource Guidelines

Revision 13-2; Effective April 1, 2013

TANF

Count the income and resources of all members of the budget group. Compare the household's gross income to the 200% FPIL. Do not allow any income deductions.

Compare the budget group's resources to the TANF resource limit noted inA-2412, Grandparent Payments.

Use TANF income and resource guidelines to determine countable and exempt income and resources.

Do not count the lump sum grandparent payment as income in the Supplemental Nutrition Assistance Program (SNAP), TANF, or Medicaid EDG. It is considered a resource of the TANF certified grandchild(ren), and is therefore also exempt from SNAP resources as explained in A-1248, Resources of TANF and SSI Recipients.

The supplement counts as a TANF benefit for purposes of determining the amount of child support owed to Texas.

A—2430 Who Is Not Eligible

Revision 05-5; Effective October 1, 2005

A—2431 Who Is Not Eligible for OTTANF

Revision 13-2; Effective April 1, 2013

TANF

Do not offer OTTANF to a household if any member:

- is disqualified;
- is an active TANF individual;
- has an open PRA noncooperation and fails to demonstrate cooperation within the allowed time period;
- does not meet citizenship requirements for TANF (see A-2421.1, Citizenship);
- is a caretaker or second parent who received OTTANF within the previous 12 months;
- is a caretaker or second parent who did not receive OTTANF in the previous 12 months but now lives with a household that received OTTANF in the previous 12 months and would have been a required member of the household; or
- is receiving Refugee Cash Assistance (RCA).

Notes:

- Consider an individual as being active in TANF if the individual applies for OTTANF during the individual's second noncooperation month.
- Do not provide OTTANF for months identified as a forfeit month because of noncooperation with the PRA.
- OTTANF applicants with an open PRA penalty must demonstrate cooperation to be eligible for OTTANF. See A-2100, Personal Responsibility Agreement.

A—2431.1 12-Month Ineligibility Period

Revision 17-3; Effective July 1, 2017

TANF

A caretaker or second parent certified for OTTANF is ineligible for TANF, TANF-SP or OTTANF for 12 months. The first month of the 12-month ineligibility period is the grant effective month. When a caretaker and/or second parent of an OTTANF EDG moves to a new household, the individual takes the 12-month ineligibility period status along with the move. Children are only ineligible for the OTTANF grant effective month.

Example 1:

Mary applies for and receives OTTANF for herself and child in December. In June, she marries a man with two children who do not receive TANF. Mary and her husband have a mutual child. The new household is not eligible for TANF or OTTANF until the following December because the ineligibility period follows the caretaker. The household can apply for medical programs.

Anyone who would have been a mandatory member of the TANF group at the time of certification is not eligible for TANF benefits during the 12-month ineligibility period.

Example 2:

Ms. King received OTTANF for herself and her two children with a grant effective date of September 2012. In December 2012, her child Ryan, who was living with his father, moves into her household. Ms. King applies for TANF for Ryan. Because Ryan would have been included in the budget group at the time of certification, he cannot receive OTTANF or TANF until September 2013.

Use the following chart to determine eligibility when minor parents move into or out of an OTTANF or TANF household.

If a minor parent ...	and moves ...	then the minor parent is ...
received OTTANF on a parent's EDG	out and applies for TANF for the minor parent and for the child,	eligible for OTTANF or TANF.
received OTTANF as a child in any household	in with a parent who receives TANF,	eligible for TANF after the OTTANF ineligible month.
received OTTANF as a caretaker	in with a parent who receives TANF,	eligible for TANF. **Note:** Contact the IEE/TIERS Technical Help Desk to address the removal of the ineligible date.
receives TANF as a caretaker	in with a parent who received OTTANF,	ineligible for TANF or OTTANF if the minor parent would have been a required member of the parent's EDG at the time OTTANF was certified.

A—2432 Who Is Not Eligible for One-Time Grandparent Payments

Revision 05-5; Effective October 1, 2005

TANF

A household is not eligible for the one-time grandparent payment if :

- the gross income for the household exceeds the income limit,
- the resources available to the household exceed the resource limit,
- they do not meet the age or relationship requirement, or
- they have already received the one-time grandparent payment.

A—2440 Determining Crisis Criteria (OTTANF)

Revision 05-4; Effective August 1, 2005

TANF

In addition to meeting all TANF requirements, the household must also meet one of the following four crisis criteria.

A—2441 Crisis Criteria One (TP 71 or 72)

Revision 07-3; Effective July 1, 2007

TANF

The caretaker or second parent must have a loss of any type of employment without regard to work history or certain dollar amount in the

- two months before application,
- application month, or
- process month.

Notes:

- If the household's income terminated in the process month and exceeded the TANF recognizable needs amount, the household may be eligible for OTTANF the month after the process month.
- As long as the individual meets the criteria above and is TANF-eligible, the individual may receive OTTANF regardless of the individual's current employment status.

Do not apply Crisis Criteria One if an applicant voluntarily quits a job, including self employment, without good cause.

Temporary leave without pay from a job does not constitute loss of employment.

Related Policy
Reasons for Good Cause, A-1861

A—2442 Crisis Criteria Two (TP 71)

Revision 07-3; Effective July 1, 2007

TANF

In a one-parent household, the:

- dependent child must have a loss of financial support from the legal parent or stepparent within the last 12 months before the application month or process month through death, divorce, separation or abandonment or through termination or reduction of financial support; and
- caretaker must have been employed within the 12 months before the application or process month.

Financial support, including child support, is assistance with basic living expenses like rent, utilities and food. Loss of financial support from a legal parent or stepparent must be verified.

A—2443 Crisis Criteria Three (TP 71 or 72)

Revision 13-2; Effective April 1, 2013

TANF

The caretaker or second parent graduated from a university, college, junior college or technical training school within the 12 months before the application or process month, and is unemployed or underemployed. The caretaker or second parent must:

- provide proof of degree or certificate of completion from a technical training school, junior college, college or university. This includes beauty, nursing or vocational school. The institution can be in or out of Texas;
- not currently be enrolled in an institution of higher learning; and
- have received TANF or an OTTANF benefit (in Texas) anytime in the 12 months before enrolling, or while attending a college, university, or technical training school. Attempt to verify prior receipt of TANF or OTTANF, but accept the individual's statement if TIERS records for that time are not available.

A—2444 Crisis Criteria Four (TP 71 or 72)

Revision 13-2; Effective April 1, 2013

TANF

The caretaker and/or second parent is currently employed but still meets TANF requirements and is facing a crisis situation in the

- two months before application,
- application month, or
- process month.

The crisis situations are:

- **Loss or potential loss of transportation** — The applicant is unable to get to a job. The loss of a vehicle can be because of needed repairs, lack of insurance, necessary inspection, repossession, or threat of repossession.
- **Loss or potential loss of shelter** — The household may lose shelter because of foreclosure, eviction, condemnation, or threat of any of these.
- **Medical emergency** (60 days or less) — Acaretaker/second parent has a medical emergency or is needed to provide temporary care for a household member who is ill or injured. The medical emergency can be for the applicant or a household member within the TANF degree of relationship. Do not apply this policy to individuals outside the home except for members who are in the hospital. A normal pregnancy or maternity leave is not a medical emergency.

A—2450 Issuing Benefits

Revision 05-4; Effective August 1, 2005

A—2451 Issuing OTTANF Benefits

Revision 13-2; Effective April 1, 2013

TANF

Use the same timeliness processing standards for OTTANF as for the TANF program. (See B-100, Processes and Processing Time Frames.)

A—2451.1 Reissuing Benefits

Revision 07-1; Effective January 1, 2007

TANF

Use Form H1008, Warrant Inquiry/EBT Benefit Conversion and Affidavit for Non-Receipt of Warrant, for lost or stolen OTTANF warrants.

If available, fax Form H1008-A to State Office Fiscal Management Services at 512-487-3400. Write "OTTANF" across the top of the form.

A—2451.2 Switching from OTTANF to TANF

Revision 17-3; Effective July 1, 2017

TANF

When an applicant opts for OTTANF then decides to receive TANF, use the chart below to determine how to issue benefits:

If ...	then ...

the OTTANF warrant has been issued but not cashed,	• if the applicant has received the warrant, instruct the applicant to return the warrant to HHSC.
	• contact the IEE/TIERS Technical Help Desk to address any issues with the removal of the ineligible dates by emailing IEE_HELP@hhsc.state.tx.us or calling 800-214-4175 (Option 1).
	  ○ If emailing, enter **Cancelling OTTANF Benefits When Client Was Erroneously Certified for OTTANF Instead of TANF/TANF SP** as the email subject line.
	  ○ If calling, tell the Help Desk representative that your issue relates to “Cancelling OTTANF benefits when client was erroneously certified for OTTANF instead of TANF/TANF SP.”
	• cancel the OTTANF warrant using Form H1008-A, Warrant Inquiry/EBT Benefit Conversion and Affidavit for Non-receipt of Warrant, and request issuance of TANF benefits for the OTTANF grant effective month using Form H1008-A.
	• document the reason for the switch.
	• record the Help Desk ticket number in **Case Comments.**

the OTTANF warrant has been cashed,	**do not** accept the $1,000 payment in the form of cash, cashier’s check or money order. The applicant is not allowed to switch in this situation.

A—2451.3 Switching from TANF to OTTANF

Revision 13-2; Effective April 1, 2013

TANF

Do not allow applicants to switch from TANF to OTTANF once the TANF EDG has been certified. **Exception:** Follow procedures below only if HHSC did not explain or offer the applicant the OTTANF option.

- Contact the IEE Help Desk via email at IEE_HELP@hhsc.state.tx.us or at 800-214-4175 (Option 1).
  - If emailing, enter **Cancelling TANF Benefits When Client Was Erroneously Certified for TANF/TANF SP Instead of OTTANF** as the email subject line.
  - If calling, tell the Help Desk representative that your issue relates to “Cancelling TANF benefits when client was erroneously certified for TANF/TANF SP instead of OTTANF.”
- Submit a referral to recoup the TANF/TANF SP benefits already issued.
- Withdraw TANF in the program page.
- Pull the case back into Complete Action (if appropriate).
- Record the Help Desk ticket number in **Case Comments.**

A—2452 Issuing One-Time Grandparent Payment

Revision 13-2; Effective April 1, 2013

TANF

Advisors must do inquiry into the Grandparent Payment System (GPS) to ensure the certified group members have not previously received a payment before certification.

A—2452.1 Reissuing Grandparent Payments

Revision 00-3; Effective April 1, 2000

TANF

When a household reports the one-time grandparent payment was lost, destroyed, stolen, or not received, complete Form H1084, Certification for Warrants Lost, Destroyed, Stolen, or Not Received. Have the grandparent caretaker/payee sign the certification. Send the certification to Fiscal Management Services.

A—2460 Verification Requirements

Revision 13-2; Effective April 1, 2013

TANF

For One Time Temporary Assistance for Needy Families (OTTANF) Payments:

- Verify the required members attended the workforce orientation.
- Verify the household has lost or will lose transportation due to:
  - needed repairs;
  - repossession or threat of repossession;
  - lack of insurance;
  - necessary inspection; or
  - driver license.

Verify these conditions if the loss occurred during the application month, two months prior to the application month, or the process month. Accept the individual's statement if unable to verify.

- Verify that the household has lost or will lose shelter due to:
  - foreclosure;
  - eviction; or
  - condemnation.

Verify these conditions if the loss occurred during the process month, application month, or two months prior to the application month. Accept the individual's statement if unable to verify.

- Verify:
  - the medical emergency;
  - that the medical emergency is temporary;
  - that the member (certified or not) is within the required degree of relationship; and
  - the member lives in the home.
- Verify:
  - parental relationship; and
  - loss of financial support from the legal parent or stepparent.
- Verify:
  - proof of graduation or certificate of completion from a college, university, junior college or technical training school.

- that the individual received TANF benefits in Texas. Accept the individual's statement if TIERS records for that time are not available.
- TANF benefits have been cancelled prior to certifying the OTTANF EDG. See A-2451.3, Switching from TANF to OTTANF.

For Grandparent Payments verify:

- the age of the grandparent;
- relationship;
- that the grandparent is a caretaker or payee (or spouse of a caretaker or payee) of a TANF-certified grandchild, and the parent of the child is not in the home;
- that the family has gross income less than or equal to 200% of the FPIL; and
- that the family resources are less than or equal to TANF resource limits inA-1220, Limits.

Related Policy
Questionable Information, C-920
Providing Verification, C-930

A—2470 Documentation Requirements

Revision 16-3; Effective July 1, 2016

TANF

Document OTTANF verifications and an explanation of the household situation in case comments.

Document that you informed the household of the one-time payment at application and whether the caretaker requested it or declined it.

Document which of the following crisis criteria the applicant meets to qualify for OTTANF:

- loss or potential loss of income;
- loss of spousal support;
- proof of graduation;
- loss or potential loss of transportation;
- loss or potential loss of shelter; or
- medical emergency.

When verification is unavailable, document:

- the individual's statement;
- the reason verification is unavailable; and
- efforts made to get verification.

For Grandparent Payments:

- document that you informed the household of the one-time grandparent payment at application or periodic review if the grandparent is potentially eligible and whether they requested it or declined it.
- if the grandparent requests the payment, document:
  - that the advisor inquired into the Grandparent Payment System to ensure the household did not previously receive a payment;
  - the household's income and resources; and
  - that the requesting household meets the eligible grandparent caretaker/payee criteria.

Related Policy
Documentation, C-940
The Texas Works Documentation Guide

TWH, A-2500, State Time Limits

Revision 17-3; Effective July 1, 2017

A—2510 General Policy

Revision 13-2; Effective April 1, 2013

TANF

State time limits determine the number of months certain individuals can receive TANF benefits.

The TANF Program and TANF State Program limit caretakers and second parents to a 60-month lifetime limit. When a caretaker or second parent receives 60 months of benefits, their entire household is ineligible.

Caretakers and second parents are also subject to a state time limit of 12, 24 or 36 months of benefits based on their work history and education. Other household members may continue to receive benefits after a caretaker or second parent reaches their 12-, 24- or 36-month time limit.

The individual's education and/or recent work experience determine(s) the individual's state time limit. There are three time limits, known as "tiers." Tiers and their corresponding state time limits are:

Tier	State Time Limit
5	12 months
6	24 months
7	36 months

Note: TIERS enters Tier 8 when the advisor does not enter enough information.

All certified caretakers and second parents, including minor parents certified as caretakers and second parents, receive a state time limit tier.

State time limits apply to the TANF cash benefits received by certified caretakers and second parents who have access to Choices employment services.

After the individual is notified to participate or voluntarily participates in the Choices program, each month the individual has an open Choices case and is certified as a TANF caretaker or second parent counts toward the state time limit.

When a TANF caretaker or second parent reaches their time limit, TIERS disqualifies the individual from receiving TANF in Texas for five years. The children on the TANF EDG remain eligible.

Exception: During the five-year freeze out period, disqualified individuals who meet the criteria for a hardship exemption may receive TANF.

Individuals may continue receiving TANF Level Medicaid and transitional child care benefits during the 12 months following their last state time limit month. (See A-840, Transitional Medicaid Coverage.)

A—2520 Time Limit Tiers

Revision 13-2; Effective April 1, 2013

A—2521 Initial Time Limit Tiers

Revision 13-2; Effective April 1, 2013

TANF

TIERS determines the initial time limit tier for all TANF caretakers or second parents, including those with a current employment service exemption:

- at application; and
- when adding an individual to the household.

A—2521.1 Determining the Time Limit Tier

Revision 13-2; Effective April 1, 2013

TANF

When advisors correctly identify education and work history status in the TANF TIER Level Details Logical Unit of Work (LUW), TIERS automatically determines the time limit tier for each certified caretaker and/or second parent. Accept the individual's statement of the grade completed.

TIERS prints the individual's state time limit information on TF0001, Notice of Case Action.

A—2522 Time Limit Tier Changes

Revision 13-2; Effective April 1, 2013

The time limit tier may change when:

- Choices staff determine a functional literacy level which affects the tier;
- the advisor makes an error in entering the correct education or work history level; or
- redetermining the education and/or work history level at reapplication if the individual missed one full month's benefits before the date of reapplication.

A—2522.1 Change in Time Limit Tier Because of Functional Literacy Level

Revision 13-2; Effective April 1, 2013

TANF

Choices staff determine and enter the individual's functional literacy level in the Choices automated system. This information overrides the initial time limit tier determined by the advisor when:

- the functional literacy level is lower than the individual's completed education level; and
- a change in tier allows the individual to receive additional months of TANF and Choices services.

A tier may not change to one lower than the individual's work history level.

When the Choices literacy level updates the individual’s tier level using the Choices automated interface, the advisor may not change the tier because of the education level.

A—2522.2 Change in Time Limit Tier Because of Error

Revision 13-2; Effective April 1, 2013

TANF

If an advisor initially entered incorrect information, correct the original work history months or the original education level in TIERS and select YES from the Correction drop-down menu. Do not update work history or education levels for changes that occurred since determining the initial tier.

If an advisor request State Office Data Integrity (SODI) to force change a tier from 5 or 6 to tier 7, the advisor must also request that SODI delete all months in the individual's Time Limited history that occur before the year's anniversary of the individual's Literacy Assessment Date. (See A-2532, Counting Months for Tier 7, for an example of how to determine the Literacy Assessment anniversary date.) If the individual does not have a Literacy Assessment Date, request the deletion of all months counted. **Exception:** Do not delete any months counted before the Literacy Assessment Date month in which the individual has a Choices penalty.

A—2522.3 Changes to Time Limit Tiers at Reapplication

Revision 13-2; Effective April 1, 2013

TANF

TIERS redetermines the time limit tier of a TANF caretaker or second parent at reapplication only if there has been at least one full month's break in benefits before the date of reapplication. **Note:** The individual may have more months or an equal number of months remaining in the individual’s new time limit, but would never have fewer months than the prior time limit.

A—2530 Counting TANF Months Toward State Time Limit

Revision 17-3; Effective July 1, 2017

TANF

TIERS tracks the number of months counted toward an individual's state time limit. TIERS uses the Notification Effective Date (NED) and counts a month toward an individual's state time limit each month the individual:

- receives TANF;
- is certified as a caretaker or second parent; and
- has an open Choices case without Choices good cause indicated, or is sanctioned for Choices non-participation.

The advisor must:

- evaluate the accuracy of the months counted toward the individual's state time limit; and
- contact the IEE/TIERS help desk to address any issues with the individual's time limit months counted.

Notes:

- The automated procedures for counting months for Tiers 5 and 6 are different than for Tier 7.
- See A-2533, Changes to State Time Limit Months Counted, for changes to the individual's time-limited months' history.
- In minimum service Choices counties, all individuals are considered exempt from Choices participation even when the advisor codes them as M – mandatory. TIERS counts months toward the individual's time limit if the Choices case status is Open.

A—2531 Counting Months for Tiers 5 and 6

Revision 13-2; Effective April 1, 2013

TANF

For individuals in Tier 5 or 6, TIERS counts months based on the Notification Effective Date (NED).

The Choices specialist enters a Notice Date in the Choices system as follows:

- the appointment date for an individual who is a mandatory Choices registrant, or
- the report date for an exempt volunteer.

TIERS adds one month to the notice date to compute the individual's TIERS Notification Effective Date. (See A-2533.3, Deleting Months When the NED Changes.)

TIERS counts the months toward the individual's state time limit (12 or 24 months) as follows:

If the individual's work registration status is ...	TIERS counts each month ...
mandatory participant	after the month the individual is notified to participate in the Choices program.
exempt	after the month the individual • volunteers, and • has an open Choices case.
sanctioned for Choices non-participation	the individual is sanctioned for refusing to participate in the Choices program.

Beginning with the NED month, TIERS counts each month the individual

- receives TANF,
- is certified as a caretaker or second parent, and
- has an open Choices case without Choices good cause indicated, or is sanctioned for Choices non-participation.

In addition, if an individual's work registration status is:

- mandatory registrant, or
- sanctioned for Choices non-participation, then

TIERS counts any months between the NED and the month the:

- Choices case opens, or
- individual is sanctioned.

A—2532 Counting Months for Tier 7

Revision 13-2; Effective April 1, 2013

TANF

For individuals in Tier 7, TIERS counts months beginning one year after the Choices functional literacy assessment. **Example:** The individual's Literacy Assessment Date month is 1/98 (month 0). TIERS adds 12 months and, if the Tier 7 individual meets the appropriate criteria, begins counting toward the state time limit with 2/99 (month 13.)

TIERS counts each month the individual

- receives TANF;
- is certified as a caretaker or second parent; and
- has an open Choices case without Choices good cause indicated, or is sanctioned for Choices non-participation.

If the individual does not have an open Choices case without Choices good cause indicated or is sanctioned for Choices non-participation, TIERS counts months beginning with the Notification Effective Date after the assessment anniversary date.

A—2533 Changes to State Time Limit Months Counted

Revision 13-2; Effective April 1, 2013

TANF

Evaluate the accuracy of the state time limit months counted if

- requested to do so by the individual, or
- Texas Works or Choices/Texas Workforce Commission staff discovers a possible error.

TIERS keeps a record of the individual's participation status, work registration status and work registration reason, which can change from month to month.

A—2533.1 Deleting Months When TANF Benefits are Cancelled or Recouped

Revision 13-2; Effective April 1, 2013

TANF

TIERS will remove a month counted toward the individual's state time limit when an overpayment referral is processed for a full month's benefits.

A—2533.2 Deleting Months in Error Situations

Revision 17-3; Effective July 1, 2017

TANF

Contact the IEE/TIERS Technical Help Desk to address any issues with the individual's Time Limited history in the following situations.

- The advisor discovers errors including incorrect work registration status or incorrect Choices penalties that result in months being counted erroneously. (**Example:** The advisor entered the individual mandatory instead of exempt while the individual was caring for a disabled child or the advisor deletes a Choices penalty in TIERS that was imposed in error.)
- Choices staff send notification that the individual's open Choices case status in TIERS is incorrect. (**Example:** The Choices automated interface sent a closed date for the Choices case status but the Choices case status is not showing closed in TIERS.)

A—2533.3 Deleting Months When the NED Changes

Revision 13-2; Effective April 1, 2013

TANF

An individual's NED may change for many reasons. A change in the NED may indicate that the Time Limited months counted before the new NED were counted in error.

Example: An exempt individual voluntarily participates in the Choices program for a few months and then stops participating. The advisor changes the individual's work registration code to mandatory when the individual is no longer eligible for the exemption. Choices then outreaches the individual and sends TIERS a new appointment date. The individual's original NED was created because the individual participated in Choices while exempt. When TIERS receives a new Choices appointment date, TIERS creates a new NED. However, all months counted before the new NED are accurate and should remain counted. Do not request that SODI delete these months.

A—2533.4 Adding State Time Limit Months

Revision 13-2; Effective April 1, 2013

TANF

The advisor should rarely request that SODI add months to the individual's Time Limited Months history. If there is a question concerning whether the months should be added, contact your regional Field Policy Specialist/mailbox (or other regional designee).

A—2540 State Time Limit Five-Year Freeze-Out Period

Revision 13-2; Effective April 1, 2013

TANF

Apply the following policies during an individual's state time limit five-year freeze-out period:

- TIERS disqualifies a caretaker or second parent from TANF for five years when the individual reaches the end of a state time limit. **Exception:** Certify the individual for TANF during the freeze-out period when the individual is eligible for a hardship exemption.
- A caretaker or second parent disqualified from TANF because of state time limit policies is eligible for TANF Level Medicaid (TP08) for the 12 months that follow the maximum allowable month of the individual's state time limit.

The state time limit and hardship information in TIERS is printed on TF0001, Notice of Case Action.

A—2541 State Time Limit Five-Year Freeze-Out End Date

Revision 13-2; Effective April 1, 2013

TANF

TIERS automatically calculates the end of the individual's state time limit five-year freeze-out period. TIERS displays this date on the individual’s Time Limit page in Individual Inquiry. SAVERR-stored data converted to TIERS can be found in the Time Limit functional area in TIERS. TIERS arrives at the TL Freeze-Out End Date by adding five years to the last state Time Limited month listed on client screen A3. The individual is potentially eligible for TANF without a hardship exemption the month following the TL Freeze-Out End Date in TIERS.

The advisor cannot change the TL Freeze-Out End Date. The individual's Freeze-Out End Date changes only when the state Time Limited months listed in TIERS are adjusted. The automated systems or the advisor adjusts these months using force change procedures.

A—2542 When TIERS Takes Action Automatically

Revision 13-2; Effective April 1, 2013

TANF

TIERS automatically takes the actions described in this section when the data for the caretaker or second parent indicates that the maximum allowable number of TANF months have been counted toward the individual's state time limit.

A—2542.1 Time Limit Disqualification

Revision 13-2; Effective April 1, 2013

TANF

TIERS disqualifies a certified caretaker or second parent who has used the maximum number of months allowed in a state time limit when:

- the individual is not exempt due to receiving hardship exemption from the state time limit;
- TIERS can correctly rebudget the TANF EDG without denying it.

TIERS follows budgeting procedures for a disqualified legal parent in A-1362.1, TANF — Budgeting for a Legal Parent Disqualified for Alien Status, Failure to Prove Citizenship, Noncompliance with the Unmarried Minor Parent Domicile Requirement or State Time Limits.

Exception: If the only eligible person(s) on the TANF EDG is the caretaker and/or second parent who used the maximum number of months in a state time limit, TIERS reruns eligibility for ineligible EDGs. All the children on these EDGs are disqualified because of noncompliance with employment services or receive:

- SSI;
- foster care payments; or
- adoption assistance payments.

A—2542.1.1 TIERS Procedures for SNAP EDGs When an Individual Times Out

Revision 13-2; Effective April 1, 2013

SNAP

After TIERS changes a TANF grant amount in the state time limit automated process, it:

- reruns eligibility and budgets the new TANF amount in the Supplemental Nutrition Assistance Program (SNAP) case; and
- sends a notice to the household stating the new SNAP amount.

A—2543 Hardship Exemptions

Revision 13-2; Effective April 1, 2013

TANF

An individual requests a hardship exemption by submitting Form H1010, Texas Works Application for Assistance – Your Texas Benefits, or asking to be added to the household's existing TANF or Medicaid EDG(s). Advise the household of these options whenever the individual expresses a need for assistance.

Certify a caretaker or second parent for TANF during the state time limit five-year freeze-out period when the individual:

- complied with Choices participation requirements while receiving TANF (the individual does not have a Choices penalty);
- is eligible for a hardship exemption; and
- otherwise meets TANF eligibility requirements.

There are three reasons for hardship exemptions:

Hardship	Work Registration Status
County	Time Limited Severe Economic Hardship
Employment	Time Limited Employment Hardship
Severe Personal	Time Limited Personal Hardship

A—2543.1 County Hardship Exemption

Revision 13-2; Effective April 1, 2013

TANF

HHSC designates specific Texas counties economically deprived using unemployment and other job-related criteria. HHSC lists these counties on the State Time Limit County Hardship List (C-320) and revises the list every three months.

A—2543.1.1 TIERS Action

Revision 16-2; Effective April 1, 2016

TANF

Using the State Time Limit County Hardship List, TIERS performs the following case actions:

If a certified TANF caretaker, or second parent ...	and the individual's residence county is ...	then TIERS ...

reaches the end of a state time limit
 	
(The individual does not have a hardship exemption from the state time limit.)
	on the county hardship list,	• changes the individual's work registration status to Code L (Time Limited Severe Economic Hardship, Lives in Economically Deprived County)
		• sends a notice to the household stating the
		  ◦ individual used the maximum number of TANF months allowed in the state time limit,
		  ◦ individual is currently eligible for TANF because the individual lives in a designated hardship county, and
		  ◦ HHSC reevaluates the county list periodically.

is exempt from the state time limit for county hardship (The individual has a work registration status of Code L, Time Limited Severe Economic Hardship, Lives in Economically Deprived County.)	on the county hardship list,	does not take action.

is exempt from the state time limit for county hardship
 	
(The individual has a work registration status of Code L, Time Limited Severe Economic Hardship, Lives in Economically Deprived County.)
	not on the county hardship list,	• disqualifies the caretaker or second parent from TANF beginning the month following the:
		  ◦ maximum allowable months of the individual's state time limit; and/or
		  ◦ last month the individual is eligible for a hardship exemption.
		• sends a notice to the household stating the:
		  ◦ individual used the maximum number of TANF months allowed in the state time limit,
		  ◦ individual was eligible for TANF because the individual lived in a designated hardship county, and
		  ◦ HHSC reevaluates the county list periodically.

A—2543.1.2 Advisor Action

Revision 13-2; Effective April 1, 2013

TANF

Determine the individual's eligibility for a county hardship exemption:

- at each of the household's TANF/Medicaid case actions;
- when the individual requests the exemption; or
- when removing an employment or severe personal hardship exemption.

Use the following chart when completing a case action during the individual's freeze out period:

If the individual ...	then ...

lives in a county on the State Time Limit County Hardship List,	• change the individual's work registration status to exempt from participation due to Time Limited Severe Economic Hardship, and
	• send a notice to the household stating the
	  ◦ individual is currently eligible for TANF because the individual lives in a designated hardship county, and
	  ◦ county list is reevaluated periodically.

no longer lives in a county on the State Time Limit County Hardship List,	remove the exemption.

A—2543.2 Severe Personal Hardship Exemption

Revision 13-2; Effective April 1, 2013

TANF

An individual may qualify for a severe personal hardship exemption when there is a disabling illness or injury of:

- self; or
- close family member.

Determine the individual's eligibility for a severe personal hardship exemption:

- when the individual requests the exemption;
- when the exemption is expected to end; and
- at each complete review until the exemption is removed.

A—2543.2.1 Disabling Illness or Injury of Self

Revision 13-2; Effective April 1, 2013

TANF

Exempt an individual for severe personal hardship for a disabling illness or injury to self when:

- the individual requests the exemption within 90 days after the illness or injury begins; and
- disability is established by:
  - approval of SSI or RSDI based on disability; or
  - completion of Form H1836-A, Medical Release/Physician's Statement.

After disability is established, review the individual's eligibility for the exemption:

- when the disability is expected to end (set a special review); and
- at each complete review until the exemption is removed.

Remove the exemption when the individual is no longer disabled. Advise the individual to report to HHSC within 10 days when the hardship situation changes. The individual may state that the disability has ended or Form H1836-A may show it has ended.

A—2543.2.2 Disabling Illness or Injury of Close Family Member

Revision 13-2; Effective April 1, 2013

TANF

Determine whether to exempt an individual for severe personal hardship for caring for a close family member who has a disabling illness or injury using the following procedures:

Step	Yes	No
1. Did the individual request the exemption within 90 days after the individual was needed in the home to care for the close family member? **Note:** The person needing care must live in the individual's home.	Go to Step 2.	STOP. Do not exempt the individual for severe personal hardship.
2. Is the individual related to the family member within the following degree of relationship? The persons providing the care and needing the care must be related in one of the following ways: ○ spouse (or second parent who is listed on the household's TANF EDG); ○ parent (legal, adoptive, natural, or step); ○ child (legal, adoptive, natural, or step); ○ sibling (legal, adoptive, natural, half, or step); ○ grandparent (extends to the degree of great-great-great); ○ aunt or uncle (extends to the degree of great-great); ○ niece or nephew (extends to the degree of great-great); ○ first cousin; ○ first cousin once removed; or ○ spouse of any person listed above. **Note:** These relationships extend to relatives of the individual's spouse.	Request proof of relationship and go to Step 3.	STOP. Do not exempt the individual for severe personal hardship.
3. Did the individual provide a doctor's statement that verifies ○ the disabling illness or injury of the family member, ○ that the individual is needed in the home for more than 30 days to care for the family member, ○ the beginning date when the individual is/was needed in the home to provide the care, and ○ the date the need for the individual's care in the home is expected to end?	STOP. Exempt the individual for severe personal hardship.	STOP. Do not exempt the individual for severe personal hardship.

Review the individual's eligibility for the exemption:

- at each complete review until the exemption is removed; and
- when the need for care is expected to end. **Note:** Set a special review for when the need for care is expected to end before the next complete review.

Remove the exemption when the individual is no longer needed in the home to care for the close family member. Advise the individual to report to HHSC within 10 days when the hardship situation changes.

A—2543.3 Employment Hardship Exemption

Revision 13-2; Effective April 1, 2013

TANF

Determine whether to exempt an individual for employment hardship using the following procedures:

Step	Yes	No
1. Did the individual request the exemption within 90 days after the ○ end of the individual's state time limit, or ○ last day of the individual's employment, or ○ individual's work hours were reduced?	Go to Step 2.	STOP. Do not exempt the individual for employment hardship.
2. Does the individual have ongoing monthly earnings (including self-employment earnings) of less than $168 or is unemployed?	Go to Step 3.	STOP. Do not exempt the individual for employment hardship.
3. Has the individual ○ been dismissed from a job or demoted for cause, ○ voluntarily quit a job or reduced hours of work, or ○ failed to accept a job offer paying at least $168 a month or an offer of additional work resulting in a total of at least $168 a month?	Go to Step 4.	Go to Step 5.
4. Did the individual have good cause according to the SNAP good cause criteria in A-1860, Determining Good Cause?	Document the good cause and go to Step 5.	STOP. Do not exempt the individual for employment hardship.
5. Does the individual meet the employer contact requirements described in Item A-2543.3.1, Initial Request, A-2543.3.2, Continuation of Exemption, and/or A-2543.3.3, Reapplication After Denial?	STOP. Exempt the individual for employment hardship.	STOP. Do not exempt the individual for employment hardship.

Determine the individual's eligibility for an employment hardship exemption:

- when the individual requests the exemption; and
- at each complete review until the exemption is removed.

A—2543.3.1 Initial Request

Revision 13-2; Effective April 1, 2013

TANF

An initial request is the first time an individual requests an employment hardship exemption after the:

- end of the individual's state time limit;
- last day of the individual's employment; or
- reduction of individual's work hours.

In addition, after the individual's employment hardship exemption is removed, the individual may request another initial employment hardship exemption when the:

- individual loses another job; or
- individual's work hours are again reduced.

An individual is eligible for an initial employment hardship exemption after contacting 40 employers in the 30-day period following the day the advisor explains the employer contact requirement to the household:

- during an interview; or
- on Form H1020, Request for Information or Action, when processing a report of change.

The advisor must give the individual Form H2776, Job Search Worksheet for TANF Employment Hardship Exemption, to help the individual provide documentation of the employer contacts. However, the individual may provide any available documentation that substantiates the:

- name, address, and telephone number of each employer contacted;
- person contacted;
- date of contact; and
- result.

Advise the individual that employer contacts may be made:

- in person;
- by telephone; or
- by other agencies on the individual's behalf. **Examples:** Texas Workforce Commission, labor organization and local workforce centers. The individual must provide documentation from the agency that made the contacts on the individual's behalf.

If, during the 30-day period, the individual ...	then ...

contacted 40 employers,	• exempt the individual for employment hardship,
	• provide the individual with one Form H2776 for each month that 40 contacts are required, and
	• advise the household that the individual
	  ○ must contact an average of 40 employers during each calendar month the individual is certified for TANF;
	  ○ must provide verification of the employer contacts at the next complete review; and
	  ○ will not be eligible for another employment hardship exemption during the freeze out period if the individual fails, without good cause, to meet the monthly 40 employer contact requirement.

did not contact 40 employers,	deny the request for an employment hardship exemption. **Note:** There is no good cause for not meeting this requirement. However, the individual may apply for the exemption again and receive a new 30-day period.

See A-2543.3.3, Reapplication After Denial, when a individual reapplies and was previously denied while receiving an employment hardship exemption.

A—2543.3.2 Continuation of Exemption

Revision 13-2; Effective April 1, 2013

TANF

At the complete review after the individual receives an employment hardship exemption, determine whether the individual contacted an average of 40 employers during each month the individual was certified for TANF. If the individual worked during one or more months in which the individual was required to meet the employer contact requirement, give the individual credit for two employer contacts for each day of the month worked.

If the individual did not contact an average of 40 employers a month, see A-2543.3.4, Good Cause for Not Contacting Employers While Receiving TANF.

If the individual ...	and, according to A-2543.3.4, the individual ...	then ...
contacted an average of 40 employers a month,	N/A	• continue exempting the individual for employment hardship, and • provide the individual with one Form H2776, Job Search Worksheet for TANF Employment Hardship Exemption, for each month through the month of the next complete review.
did not contact an average of 40 employers a month,	had good cause,	follow the procedures in the box above.
did not contact an average of 40 employers a month,	did not have good cause,	• remove the employment hardship exemption, and • advise the household that the individual is not eligible to receive this exemption again during the remainder of the individual's five-year freeze out period.

A—2543.3.3 Reapplication After Denial

Revision 13-2; Effective April 1, 2013

TANF

If an individual receiving a hardship exemption is denied for another reason and files an application:

- before missing one full month's benefits, use policy in A-2543.3.2, Continuation of Exemption;
- after missing at least one full month's benefits, use the following chart.

Request documentation that the individual contacted an average of 40 employers during each month the individual previously received TANF. Verify when questionable.

If the individual ...	and, according to A-2543.3.4, the individual ...	then ...
contacted an average of 40 employers a month,	N/A	follow the procedures in A-2543.3.1,Initial Request.
did not contact an average of 40 employers a month,	had good cause,	follow the procedures in A-2543.3.1, Initial Request.
did not contact an average of 40 employers a month,	did not have good cause,	• remove the employment hardship exemption, and • advise the household that the individual is not eligible to receive this exemption during the remainder of the individual's five-year freeze out period.

An individual who does not provide the documentation is the same as an individual who did not contact an average of 40 employers a month without good cause. If the individual provides the documentation later, consider the date the individual provides the documentation as a new request date.

A—2543.3.4 Good Cause for Not Contacting Employers While Receiving TANF

Revision 13-2; Effective April 1, 2013

TANF

Using prudent advisor judgment, determine and document good cause when the individual did not contact an average of 40 employers during each month the individual was certified for TANF with an employment hardship exemption.

The individual has good cause for not meeting the employer contact requirement when:

- the individual was temporarily incapacitated or ill, including the 90 days after giving birth; or
- there were no employers, or under the minimum number of employers required, within reasonable commuting distance; or
- there were circumstances beyond the individual's control (such as a disaster, or a death in the family).

A—2550 Notices

Revision 13-2; Effective April 1, 2013

A—2551 Client Notices

Revision 13-2; Effective April 1, 2013

TANF

Provide the household with a written explanation of the state time limit(s) for each certified caretaker and/or second parent, using the TF0001, Notice of Case Action.

TIERS provides:

- initial state time limit information:
  - at application; or
  - when adding a new caretaker or second parent to the household.
- information about the new state time limit when it changes because of:
  - reapplication; or
  - error.
- information that a penalty for Choices noncompliance causes ineligibility for a state time limit hardship exemption during the individual's five year freeze-out period at:
  - application; and
  - each complete review.
- the number of cash assistance months used out of the number allowed at each:
  - complete review; and
  - incomplete review.
- information that an individual with work registration status of exempt from participation due to time limited severe economic hardship is mandatory for Choices.

A—2552 TIERS Notices Sent to Clients

Revision 13-2; Effective April 1, 2013

TANF

TIERS notifies individuals on the TF0001, Notice of Case Action, for the state time limit reasons described in the chart below. When appropriate, the notices include information on hardships available during the freeze-out period.

If TIERS ...	then TIERS informs the household ...
• has no tier set and Choices sends the work history and education information for TIERS to set a tier, • indicates the individual's functional literacy level changes the tier, or • shows months counted toward the state time limit are before months already counted,	of the state time limits and/or a change in the time limits.
exempts an individual for county hardship at the end of the state time limit,	that the individual used the maximum number of TANF months, but will remain on TANF due to county hardship.
disqualifies the individual from TANF,	of the new TANF benefit amount and the hardships that are available during the disqualification period.
certifies a member for TANF Level Medicaid (TP 08),	of the specific months of transitional Medicaid eligibility and the reporting requirements.
adjusts Supplemental Nutrition Assistance Program (SNAP) benefits after adjusting the TANF benefit amount,	of the new SNAP amount or the denial of the SNAP case.
removes work registration status of exempt from participation due to time limited severe economic hardship,	that the individual is disqualified from TANF because the county is no longer a designated hardship county.
denies the TP 08 EDG at the end of the 12-month period,	of the end of transitional Medicaid coverage and to contact the advisor for Medicaid if household members are certified for Medicaid or TANF.

A—2560 TANF-SP 60-Month Time Limit

Revision 13-2; Effective April 1, 2013

A—2561 General Policy

Revision 13-2; Effective April 1, 2013

TANF-SP

Caretakers and second parents are limited to 60 months of TANF-SP benefits. Each caretaker and second parent has their own separate TANF-SP time limit clock. When a caretaker or second parent reaches the 60th month of the TANF-SP time limit (regardless of who reaches it first), deny the entire household at the end of the 60th month. Do not count TANF-SP benefits an eligible child receives toward the time limit if the child is later certified as a caretaker or second parent.

Months a caretaker or second parent receive TANF-SP do not count toward their federal time limit.

Related Policy
General Policy, A-1910

A—2562 Determining TANF-SP Time Limit Months

Revision 13-2; Effective April 1, 2013

TANF-SP

Effective October 2001, any month a caretaker or second parent receives a TANF-SP benefit counts toward their TANF-SP time limit (TANF-SP TL). Additionally, any TANF benefit that counts towards a caretaker's or second parent's federal time limit also counts toward their TANF-SP TL. Do not count TANF-SP benefits received in another state.

Do not count a month toward the TANF-SP TL if the household's grant is

- cancelled and not reissued,
- cancelled and reissued without including the caretaker and second parent's needs, or
- totally claimed as an overpayment.

A—2563 Tracking TANF-SP Time Limit Months

Revision 13-2; Effective April 1, 2013

TANF-SP

Effective October 1, 2001, a TANF-SP month counts for a caretaker and/or second parent when

- processing Form H1010 , Texas Works Application – Your Texas Benefits, and a TANF-SP benefit is issued,
- processing Form H1010 to:
  - add an adult recipient to the household, or
  - change an adult household member from a non-recipient to a recipient.

    Note: Each month a caretaker or second parent receives a cash benefit it is either a TANF benefit or TANF-SP benefit, but never both.

    Include all federal time limit months when determining a caretaker or second parent's total countable months of TANF-SP.

A—2563.1 Denying Clients at the End of the TANF-SP 60 Months

Revision 13-2; Effective April 1, 2013

A report that identifies when the 60th TANF-SP countable benefit is issued for a caretaker or second parent is generated and sent to state office. A TANF-SP 60-Month Time Limit memo is sent to the regions after cut-off of the 59th month.

Advisors determine if the caretaker or second parent has received 60 months of countable benefits by checking the TIERS Time Limit TANF State Summary.

If the countable months are correct the advisor must:

- document in case comments that the caretaker or second parent received his lifetime limit of TANF-SP benefits and the household is no longer eligible for TANF-SP,
- send TF0001, Notice of Case Action, with the following message:

  "Your household is no longer eligible for TANF-SP benefits because (name of the caretaker/second parent) has reached the end of the state time limit. Your household may still be eligible for Medicaid and Supplemental Nutrition Assistance Program (SNAP) benefits even if you are working. If you have any questions please contact your Texas Works advisor or call 1-800-252-9300."

  "Su casa ya no califica para recibir beneficios de TANF-SP porque (name of caretaker/second parent) alcanzó el tiempo límite estatal. Es posible que su casa todavía tenga derecho de recibir beneficios de Medicaid y beneficios de comida del Programa SNAP aunque usted esté trabajando. Si tiene alguna pregunta, por favor, comuníquese con el consejero de Texas Trabaja o llame al 1-800-252-9300."

A caretaker or second parent who is denied TANF-SP when either one or both parents receive the lifetime limit of TANF-SP, cannot be certified on another TANF-SP case. Benefits received as an eligible child do not count if the child is later certified as a caretaker or second parent.

See A-1930, Extended TANF and Hardship Exemptions, when an individual reaches their 60th month and applies for extended TANF.

A—2564 Client Notices

Revision 13-2; Effective April 1, 2013

TANF-SP

TIERS provides initial TANF-SP time limit information on TF0001, Notice of Case Action:

- at application,
- when adding a new caretaker or second parent, or
- at complete review if the caretaker/second parent have not previously been informed of the TANF-SP time limit.

A—2570 Verification Requirements

Revision 13-2; Effective April 1, 2013

TANF

For employment hardship exemptions:

- verify the hours worked and the pay received, if questionable; and
- accept the individual's documentation unless it is questionable. If the documentation is questionable, contact two or three employers for the period covered to verify the individual's records.

Related Policy
Questionable Information, C-920
Providing Verification, C-930

A—2580 Documentation Requirements

Revision 13-2; Effective April 1, 2013

TANF

Document the:

- individual's statement of the hours worked and the pay received when determining the time limit tier;
- reason for a hardship exemption (see A-2543, Hardship Exemptions); and
- reason why a hardship exemption was denied.

If the individual is a mandatory Choices participant, document that Choices requirements and the consequences of noncooperation were explained.

TANF-SP

Advisors must document that they informed the caretaker/second parent:

- of the TANF-SP 60-month time limit at application, periodic review (if not previously informed) or when adding a new caretaker/second parent to the household; and
- that federal time limit (FTL) months count toward the TANF-SP 60-month time limit.

Related Policy
Documentation, C-940
The Texas Works Documentation Guide

TWH, Part B, Case Management

TWH, B-100, Processing Time Frames

Revision 17-2; Effective April 1, 2017

B—110 Applications

Revision 13-3; Effective July 1, 2013

B—111 Reuse of an Application Form After Denial

Revision 15-4; Effective October 1, 2015

All Programs

Advisors use the original application form until it is 60 days old if an applicant reapplies after being denied for:

- missing an appointment;
- failing to furnish information/verification;
- failure to provide postponed verification; or
- failure to provide proof of U.S. citizenship.

Notes:

- If the information on the application form has changed or is more than 45 days old, the individual and advisor must update the form.
- If the application has been denied for missing an appointment, the denied application is reopened using the contact date as the new file date.
- Advisors do not request additional income verification when reopening a redetermination denied for failure to provide information. The original income verification the individual provided at the interview date is acceptable, unless the household indicates a change in income.

TANF and Medical Programs except TP 33, TP 34, TP 35, TP 43, TP 44 and TP 48

If an applicant reapplies after being denied for missing an appointment, the advisor uses the original application form until it is 60 days old.

TP 32 and TP 56

An application may be used more than one time for TP 56 and TP 32 applicants when *both* of the following conditions exist:

- the application interview or process date is after the application month, and
- the household states that it wishes to reapply and reuse an application form.

B—112 Deadlines

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

Advisors must provide Form TF0001, Notice of Case Action, to a denied applicant by the 45th day after the file date.

Advisors must ensure that certified applicants have access to benefits by the 45th day after the file date.

A-140, Expedited Service, may be used for TP 40 expedited Eligibility Determination Groups (EDGs).

A-147, Expedited Eligibility and Enrollment of Active Duty Military Members and Their Dependents, may be used for expedited time frames for medical program applicants with an active duty military connection.

Exceptions:

- For applications requiring medical verification, the total processing time the delay caused by obtaining Form H3038, Emergency Medical Services Certification, is not counted.

  Advisors must document the date that:
  - Form H3038 was sent to the practitioner or given to the applicant; and
  - medical information was received.
- For TANF reapplications with open Choices or school attendance penalties, a period of up to 40 days is excluded from timeliness calculations. The individual must demonstrate cooperation for 30 days before the advisor closes the penalty and processes the application.

SNAP

By the 30th day after the file date, the advisor must:

- deny or certify an application, and
- ensure that a certified applicant has an opportunity to participate.

Exception: For expedited service, see A-140.

Related Policy
Eligibility Dates and Benefit Amounts, A-2320
Children's Medicaid Redetermination Expectations, B-123.6

Medical Programs

Advisors must provide Form TF0001, Notice of Case Action, the same day eligibility is determined for certified applications, including those with spend down, no later than the 45th day from the file date.

B—113 Delay in Processing Applications

Revision 15-4; Effective October 1, 2015

All Programs

Advisors must follow policy below when an application is delayed until the 60th day after the file date:

If ...	then ...
the agency is at fault for not completing the application process by the 60th day after the file date and was also at fault for delaying it during the first 30 days after the file date,	the advisor must continue to process the original application and provide benefits retroactive to the file date (or the month the individual met all requirements, if later). If the applicant: • misses a Supplemental Nutrition Assistance Program (SNAP) appointment and fails to contact the office by the 10th day as noted on Form H1020, Request for Information or Action, to request a second appointment, the application is denied the following workday. The household loses eligibility for all past months and must reapply if they still want to receive benefits. • fails to provide all the required verification by the 10th day noted on Form H1020, then deny the application the following workday. If the household subsequently provides the missing verification within 10 days after the Form H1020 due date, reopen the application using the original file date. Otherwise, the household must reapply if they want to receive benefits.

If ...	then ...
HHSC was at fault in the first 30 days and the individual was at fault in the second 30 days,	deny the application on the 60th day after the file date and provide no benefits.
the individual was at fault the first 30 days and HHSC was at fault in the second 30 days,	the advisor must continue to process the original application and provide benefits retroactive to the month following the month of application (or the month the individual met all requirements, if later).

B—113.1 Not Held – Agency Fault

Revision 15-4; Effective October 1, 2015

All Programs except TP 33, TP 34, TP 35, TP 36, TP 40, TP 43, TP 44 and TP 48

If the advisor has not contacted the household for the interview either by telephone or for a face-to-face interview by the close of business on the scheduled appointment date, the advisor must mark the Task List Manager (TLM) "Check-In" task associated with the appointment as "Not Held-Agency Fault." This creates a subsequent reschedule task. The advisor must **not** mark the appointment as "Show" or "No Show" when the advisor has not been able to contact the household for the interview.

Note: This policy applies to applications and redeterminations for all programs that require an interview.

B—114 Missed Appointment

Revision 15-4; Effective October 1, 2015

All Programs except TP 33, TP 34, TP 35, TP 36, TP 40, TP 43, TP 44 and TP 48

For telephone interviews, the advisor must make at least two attempts to contact the applicant via telephone. Both attempts must be conducted within the time period listed on Form H1830, Application/Review/Expiration/Appointment Notice. Each attempt must be conducted at least 10 minutes apart. If no contact is made with the applicant after two attempts, the telephone interview is considered a missed appointment. The advisor must document the time of each attempt on the Appointment – Details page.

TANF and Medical Programs except TP 33, TP 34, TP 35, TP 36, TP 40, TP 43, TP 44 and TP 48

If the applicant misses the first appointment and does not contact the office on the appointment day, the application is denied no later than the next workday.

If on the appointment date the applicant arrives too late for the appointment or calls to reschedule the appointment (because the individual cannot keep the appointment), the advisor must offer the applicant a choice of a standby appointment or an opportunity to reschedule and keep the original file date.

If the applicant contacts the office by the 30th day after the file date to reschedule, the application is reopened using the date of contact as the new file date.

When a requested or required interview is scheduled within the 15-workday active duty military member policy but the applicant requests to reschedule the interview, staff must try to accommodate the rescheduled appointment within the 15-workday time frame. If, at the household's request, the interview is rescheduled after the 15-workday time frame, the advisor must document the reason for not scheduling the appointment within the required time frame.

Note: For requested interviews, if the applicant requests to be rescheduled, the household must be informed that an interview is not required and the processing of the application can begin without an interview. The application must not be denied if the household fails to show for the appointment when an interview is not required.

SNAP

If the applicant misses the first appointment, the advisor must send the applicant Form H1020, Request for Information or Action, on the same day and pend the application. The advisor must inform the applicant that it is the applicant's responsibility to request a second

appointment.

If on the appointment date the applicant arrives too late for the appointment or calls to reschedule the appointment (because the individual cannot keep the appointment), the advisor must offer the applicant a choice of a standby appointment or an opportunity to reschedule.

If the household misses an appointment and contacts the office on or before the 30th day after the file date, the advisor must reschedule the household for another appointment before the 30th day, if possible. If there are no appointment slots available, the advisor must schedule another appointment after the 30th day, but by the 45th day, and the application is kept pending. If the household keeps that appointment and is determined eligible, the original file date is used to provide benefits.

Note: When a household misses a scheduled appointment and subsequently submits another application, the advisor must consider the second application as a household's request to reschedule the missed appointment.

If the 30th day after the file date is a non-workday, the advisor takes the appropriate action on the following workday. This also must be the final due date on Form H1020.

Additionally, if necessary, hold the application past the 30th day to allow the household at least 10 days to contact the office for a second appointment. If the household does not contact the office by this deadline, the EDG is denied no earlier than the following workday.

Notes:

- The individual has until close of business (COB) on the final due date listed on Form H1020, Request for Information or Action, to contact the office (COB for the vendor if calling 2-1-1) to request another appointment.
- If a second or subsequent appointment is scheduled because the individual missed the appointment, the advisor must ensure that second and subsequent appointments have been correctly recorded on the Appointment – Details page.

See B-160, SNAP Timeliness Charts for Applications and All Redeterminations.

Related Policy
Interviews, A-131
Processing Redeterminations, B-122
Children's Medicaid Redetermination Expectations, B-123.6

TP 36 and TP 40

No appointment is required to process an application.

Note: For requested interviews, if the applicant requests to be rescheduled, the household must be informed that an interview is not required and the processing of the application can begin without an interview. An application must not be denied if the household fails to show for the appointment when interview is not required.

TP 33, TP 34, TP 35, TP 43, TP 44 and TP 48

No appointment is required to process an application or renewal unless the individual non-complies with the Health Care Orientation requirement or Texas Health Steps (THSteps) or information needed to determine eligibility can only be obtained through a telephone interview.

Note: For requested interviews, if the applicant requests to be rescheduled, the household must be informed that an interview is not required and the processing of the application can begin without an interview. An application must not be denied if the household fails to show for the appointment when interview is not required.

Related Policy
Scheduling Appointments, A-122.2
Interviews, A-131
Compliance Requirements, A-1531.5
Processing Children's Medicaid Redeterminations, B-123

B—115 Pending Verification on Applications

Revision 15-4; Effective October 1, 2015

All Programs

If more information/verification is required to complete an application, the household is allowed at least 10 days to provide the information/verification. The due date must be a workday.

Advisors request documents that are readily available to the household if the documents are anticipated to be sufficient verification. Each handbook section lists potential verification sources. C-900, Verification and Documentation, provides information on verification procedures.

The advisor must give the applicant Form H1020, Request for Information or Action, explaining:

- what is required,
- the date the verification is due, and
- the date the application will be denied if the verification is not received.

The day Form H1020 is sent is considered day zero of the pending period.

If the applicant does not provide the verification by the 30th day after the file date, or the next workday if the 30th day is not a workday, the application is denied no earlier than the:

- 30th day if the 30th day is a workday, or
- following workday if the 30th day is not a workday.

The final due date on Form H1020 must correspond with the 30th day if a workday, or the following workday if the 30th day is not a workday. The advisor must take the appropriate action on the final due date.

Exceptions:

- If necessary, the advisor may hold the application past the 30th day to allow the household at least 10 days to provide verification. If the household does not provide required verification by this deadline, the EDG is denied no earlier than the following workday. This includes situations in which the 10th day falls on the 30th day.
- If the eligibility factor in question does not affect eligibility of the entire household, the ineligible member(s) is disqualified and the remaining members are certified.

On an application denied for failure to furnish information or failure to provide postponed verification, if the household provides the required verification by the 60th day after the file date, the application is reopened using the date the individual provided verification as the file date.

TANF

For applications in pay for performance with a noncooperation for Choices or school attendance, the final due date is the 40th day from the date of interview. See A-2151, Open Penalty at Reapplication in Pay for Performance.

Note: When an application is pended for other eligibility verification in addition to the verification of Choices or school attendance cooperation, staff should continue to pend the TANF application until the final due date (40th day from the interview) before taking appropriate action on the TANF EDG.

TP 33, TP 34, TP 35, TP 43, TP 44 and TP 48

Advisors must check for any associated EDGs and use appropriate verifications from those EDGs when the applicant does not provide verification with the application form. Advisors use proof of alien status, income or deductions (if provided in the 90 days before the file date) from an associated SNAP, Medicaid or TANF EDG as verification for a child's Medicaid application or redetermination.

SNAP

If the applicant is eligible, the advisor must provide an opportunity to participate by the 30th day after the file date. If not possible, benefits are authorized with a priority issuance the day the applicant provides the required verification.

Related Policy
Expedited Service, A-140

B—115.1 Pending Verification for MA – Pregnant Women – Emergency

Revision 15-4; Effective October 1, 2015

TP 36

An application for a TP 36 is denied by the 45th day after the file date if the applicant:

- or her representative does not provide Form H3038, Emergency Medical Services Certification; Form H3038-P, CHIP Perinatal — Emergency Medical Services Certification; or other required verification; and
- had at least 10 days to provide the verification.

Advisors use the following chart to process the application for the individual's emergency condition if the required verification is received:

If the emergency condition occurs...	and Form H3038/H3038-P is received ...	then ...
during the month of application,	by the 45th day after the file date,	dispose the EDG using the original file date.
during the month of application,	after the EDG is denied but by the 60th day after the file date,	reopen the EDG, using the same application, as specified in B-111, Reuse of Application Form After Denial. Use the date Form H3038/Form H3038-P is received as the new file date.*
after the application month but by the 60th day after the file date,	by the 45th day after the file date,	use the date Form H3038/H3038-P is received as the file date.*
after the application month but by the 60th day after the file date,	after the EDG is denied but by the 60th day after the file date,	reopen the EDG, using the same application, as specified in B-111. Use the date Form H3038/H3038-P is received as the new file date.*

* Form H1113, Application for Prior Medicaid Coverage, is not required if processing the emergency coverage for a prior month.

B—116 Information Reported During Application Processing

Revision 15-4; Effective October 1, 2015

All Programs

In determining eligibility, the advisor must consider any information the individual reports between the application date and the decision date. The advisor must include any information the individual reports in the application decision process and send Form H1020, Request for Information or Action, if verification of the reported information is required to complete the application process, following procedures in B-115, Pending Verification on Applications.

Advisors must add a new household member the month the household member joins the household. For newborns, this is the:

- birth month for TANF and Medical Programs, and
- month the newborn comes home from the hospital for SNAP.

If the household has an existing case and submits a new application that includes new information, such as a new job, advisors must address changes that may impact eligibility for other programs.

Related Policy
Receipt of Duplicate Application, A-121.2
Receipt of Identical Application, A-121.3

B—116.1 Information Received During Expedited Application Processing

Revision 15-4; Effective October 1, 2015

SNAP

Advisors use the following chart to determine what action to take when the advisor receives information after certifying an expedited application with postponed verifications:

If, between the certification date and the date you release the hold ...	then ...
• an individual provides postponed verification that results in lowered or denied benefits; or • the advisor discovers information that existed on the interview date but the household failed to report, and the information results in lowered or denied benefits,	• determine eligibility and benefits using the new information; and • release the hold and deny or issue lowered benefits effective the hold month providing adequate notice of adverse action.
an individual reports a change that occurred after the certification date,	release the hold and issue benefits based on the originally requested information. Work the change using change policy in B-600, Changes, allowing advance notice of adverse action, if required.

Note: Advisors must send a fraud/overpayment referral, if applicable. See B-742, Texas Works Action on an Inadvertent Household Error/Misunderstanding or Intentional Program Violation (IPV).

Related Policy
Expedited Service, A-140
Action on Changes, B-631

B—120 Redeterminations

Revision 17-1; Effective January 1, 2017

Redetermination is the generic term in TIERS and the State Portal used to identify:

- periodic reviews of TANF;
- recertification of SNAP; and
- renewal TP 08, TP 43, TP 44, and TP 48.

Note: Certification periods and redeterminations for individuals on Medical Programs who are receiving TANF and SNAP may not align. If the household reports new information during a redetermination, such as a new job, advisors must address changes that may impact eligibility for other programs.

Redeterminations can be submitted through any of the channels explained in A-113, Application Requests and Submissions, and signed as explained in A-122.1 , Application Signature.

Related Policy
Application Requests and Submissions, A-113
Application Signature, A-122.1

TANF and SNAP

Form H1830-R, Texas Works Renewal Notice, is sent to households, along with Form H1010-R, Your Texas Benefits: Renewal Form, for redeterminations.

TP 08, TP 43, TP 44 and TP 48

The following forms are generated for clients during the automated renewal process explained in B-122.4.1, Automated Renewal Process:

- Form H1211, It's Time to Renew Your Health-Care Benefits Cover Letter;
  - Form H1020, Request for Information or Action, may be included with Form H1211;
- Form H1206, Health Care Benefits Renewal - MA*; and
- Form M5017, Documents to Send with Your Renewal Application.*

* The system generates these forms but does not automatically mail them to the client, as explained in B-121, Notice of Redetermination/Certification Expiration.

Form H1206, Health Care Benefits Renewal - ME, is mailed to the household when the individual receiving Medicaid for the Elderly and People with Disabilities (MEPD) is eligible to renew their benefits.

B—121 Notice of Redetermination/Certification Expiration

Revision 16-4; Effective October 1, 2016

TANF

TIERS Scheduling triggers the Texas Works renewal packet mail-out date in Correspondence 60 days before the review due date for approved Eligibility Determination Groups (EDGs).

Advisors must schedule an appointment after the household returns Form H1010-R, Your Texas Works Benefits: Renewal Form.

SNAP

TIERS Scheduling triggers the Texas Works renewal packet mail-out date in Correspondence during the first week of the month before last benefit month (LBM) of the approved EDG.

Advisors must schedule an appointment after the household returns Form H1010-R, Your Texas Works Benefits: Renewal Form. Advisors schedule the appointment no sooner than five days after the Form H1830-I, Interview Notice (Applications or Reviews), mail date, if possible.

For timely redeterminations, advisors schedule the first appointment early enough in the last benefit month to allow at least 13 days after the interview to ensure the EDG can be disposed by the last day of the certification period. This allows two days for Form H1020, Request for Information or Action, to be mailed from the central mail facility; 10 days after the H1020 issue date for the household to provide the information; and one additional day to process a denial for missed appointment, if applicable, in order to be timely.

Note: If the 10th day falls on a non-workday, the due date is the following workday.

Related Policy
Redetermination, B-476.1.6

TP 08, TP 43, TP 44 and TP 48

The system generates renewal correspondence automatically in the ninth month of the 12-month certification period.

The system generates and sends Form H1211, It's Time to Renew Your Health-Care Benefits Cover Letter, to the client with no advisor action. Form H1211 is dynamic based on the eligibility outcome and program.

The system generates Form H1020, Request for Information or Action, and sends it with Form H1211 when additional information or verifications are needed from the client to complete the renewal processing.

The system generates Form H1206, Health Care Benefits Renewal - MA, but does not automatically mail it to the client. Form H1206 is pre-populated with information from the client's case and may also include information from electronic data sources. There are different versions of this form depending on the type program in which the recipient is currently enrolled. Clients can access Form H1206 using the following methods:

- logging into YourTexasBenefits.com using a case access account and selecting the "Letters and forms" tab to view or print the form;
- dialing 2-1-1, selecting option 2, and requesting that Form H1206 be mailed to the client; or
- visiting a local office and receiving lobby assistance to access the form through YourTexasBenefits.com or having local office staff print a copy of the form.

The system generates Form M5017, Documents to Send with Your Renewal Application, to include with Form H1206.

Note: Form H1010-R, Your Texas Benefits: Renewal Form, must be accepted if it contains Modified Adjusted Gross Income (MAGI) client information and a signature. The signature provided on Form H1010-R is considered valid as long as it is provided by the certified client or an individual who is allowed to sign for the client, as explained in A-121, Receipt of Application. The advisor should enter the information provided on Form H1010-R and pend for any information that cannot be verified through electronic data sources.

When a new individual is added to a case, as described at B-641, Additions to the Household, or an individual is transferred to a different medical program, their review due date may be aligned with the review due date of another individual in the same medical program on the case and will be able to renew at the same time. If the review due dates are aligned after the system has initiated the automated renewal

process by requesting electronic data sources, the new individual or the individual who was transferred to a different type program will be mailed the following forms to complete the processing:

- H1830-R, Texas Works Renewal Notice; and
- H1010-R, Your Texas Works Benefits - Renewal Form.

B—122 Processing Redeterminations

Revision 15-4; Effective October 1, 2015

TANF

Advisors must process redeterminations before cutoff in the month:

- the redetermination date falls, if the redetermination is due on or before cutoff; or
- after the redetermination date, if the redetermination is due after cutoff.

When the Texas Works Renewal Packet Is Returned and a Packet Received Date Is Entered

If the household must provide verification to complete the redetermination, the household must be allowed at least 10 days to provide verification.

For telephone interviews, advisors must make at least two attempts to contact the applicant via telephone. Both attempts must be conducted within the time period listed on Form H1830-I, Interview Notice (Applications or Reviews). Each attempt must be conducted at least 10 minutes apart. If no contact is made with the applicant after two attempts, the telephone interview is considered a missed appointment. The advisor must document the time of each attempt on the **Appointment – Details** page.

If a household fails to keep a face-to-face or telephone interview appointment, the advisor must send Form TF0001, Notice of Case Action, to deny the EDG the workday following the scheduled appointment date.

If the individual contacts the office during the adverse action period, the advisor must reschedule the appointment to process the redetermination as soon as possible to avoid interruption of the benefit issuance cycle for the following month. The EDG is not reactivated and the EDG remains denied until the individual keeps the second appointment. A second Form TF0001 is not required if the individual misses the second appointment. If the individual keeps the appointment, the EDG must be processed as a Reactivation/Redetermination for correct eligibility determination and timeliness calculation.

When the Texas Works Renewal Packet Is Not Returned and/or a Packet Received Date Is Not Entered

TIERS runs a Mass Update (MU) on the fifth, sixth or seventh day of each month to terminate EDGs with due dates on or before cutoff of the current month.

For example: On July 5, the MU will terminate EDGs with a review due date on or before July cutoff.

Normal MU rules for exceptions may prevent an EDG from being terminated. Staff must process these EDGs online and verify that a Texas Works renewal packet has been sent and not returned.

When the Texas Works renewal packet is:

- not returned, go to Initiate Interview in Change Action mode; the advisor must run Eligibility and dispose the TANF EDG.
- returned, go to Initiate Interview in Ongoing mode; the advisor must enter the packet received date in the Miscellaneous Packet Received logical unit of work (LUW).

If the household returns Form H1010–R, Your Texas Works Benefits: Renewal Form, within the adverse action period, the advisor must schedule an appointment to process the complete redetermination. These EDGs must be processed as a Reactivation/Redetermination for correct eligibility determination and timeliness calculation.

Where to Find the Packet Received Date

In State Portal, the packet received date can be found in PT Inquiry in the EDG Details section in the column labeled **Recertification Packet Date**.

In TIERS, the packet received date can be found in two places in Data Collection:

- Miscellaneous Packet Received LUW, which can be viewed in any mode; and

- **Initiate Interview – Initiate Review** page, which can be viewed only in Complete Action mode.

Related Policy
Not Held – Agency Fault, B-113.1
The Texas Works Message, A-1527
Data Broker, C-820

SNAP

To reapply in a timely manner, the individual must submit the completed application form by the 15th day of the last month of the certification period. **Exception:** See B-122.1, SNAP Redeterminations Following a Short Certification.

When an individual misses a timely redetermination appointment, the advisor must send Form H1020, Request for Information or Action, on the day of the missed appointment but no later than the next workday. Form H1020 advises the household to contact the Texas Health and Human Services Commission (HHSC) before the end of the certification period to request a second appointment, or the application will be denied.

If the household contacts the office on or before the last workday of the last month of its certification period, the advisor must reschedule the household for a second appointment before the end of the certification period, if possible. If there are no appointment slots available, a second appointment should be scheduled no later than the **15th** day of the following month and the application kept pending. If the household keeps the second appointment and is determined eligible, the original file date is used and a full month's benefits are provided for the first month of the new certification period.

If the household **does not** contact HHSC by the last workday of the certification period to request a second appointment, the redetermination application is denied on the last workday of the certification period using adequate notice.

For telephone interviews, the advisor must make at least two attempts to contact the individual via telephone. Both attempts must be conducted within the specified time period listed on Form H1830-I. Each attempt must be conducted at least 10 minutes apart. If no contact is made with the individual after two attempts, the telephone interview is considered a missed appointment. The advisor must document the time of each attempt on the **Appointment – Details** page.

Note: When a household misses a scheduled appointment and subsequently submits another application, the second application is considered as a household's request to reschedule the missed appointment.

Advisors must process timely redeterminations by the last workday of the certification period. If the advisor pends the redetermination for verification, the household is allowed until the last workday of the month to provide the required verification before denial action is taken. The advisor must ensure that the individual's normal issuance cycle is not interrupted.

Exception: The redetermination is pended past the last workday of the month if necessary to allow the individual at least 10 days to provide requested verification. If the individual:

- provides verification before the end of the current certification month, then the action is processed by the last day of the month.
- provides verification after the end of the certification period but by the end of the 10-day period, the advisor must ensure that the household receives an opportunity to participate within five workdays of receipt of the verification, if eligible. If the household is not eligible, the denial is processed by the fifth workday after receipt of verification.
- does not provide verification by the end of the 10-day period, the redetermination is denied the next workday.

For households that miss the first appointment but keep the second appointment scheduled before the 15th day of the following month, if additional information is requested, the household is allowed at least 10 days to provide the requested verification. If the household:

- provides the verification on or before the due date on Form H1020, the advisor must ensure that the household receives an opportunity to participate within five workdays of receipt of the verification.
- does not provide the verification by the due date on Form H1020, the redetermination is denied the next workday.

See B-160, SNAP Timeliness Charts for Applications and All Redeterminations.

Situations in Which HHSC Fails to Timely Schedule the Redetermination Appointment

If the individual misses an appointment for a timely redetermination scheduled without enough time to allow the household 10 days to respond to the missed appointment notice before the end of the certification period, the advisor must, on the day of the missed appointment, send Form H1020 informing the individual to contact the office by the 10th day (or the following workday) to schedule a second appointment.

If the individual:

- fails to contact the office by the due date, the application is denied on the workday after the Form H1020 due date; or
- contacts the office by the due date to request another appointment, the advisor must schedule a second appointment within 10 days and keep the application pending for the second appointment.

Notes for SNAP policies in B-122:

- For missed appointments, TIERS notices are mailed from the central mail facility two days after being requested in TIERS, so the Form H1020 due date is 12 days after the request date.
- The individual has until close of business on the final due date listed on Form H1020 to contact the office (close of business day for the vendor if calling 2-1-1) to request another appointment.

Related Policy
Interviews, A-131
Missed Appointment, B-114
Redetermination, B-476.1.6
Children's Medicaid Redetermination Expectations, B-123.6
Not Held – Agency Fault, B-113.1

TP 08, TP 43, TP 44 and TP 48

These programs complete an administrative renewal process, explained in B-122.4, Medical Program Administrative Renewals.

TP 07 and TP 20

Recipients of TP 07 and TP 20 must be retested for eligibility in other Medical Programs following the policy explained in A-2342.1, Retesting Eligibility, at the end of their certification period. These individuals are referred to the Marketplace if they are determined ineligible for all other Medical Programs.

Related Policy
Retesting Eligibility, A-2342.1
Denied for Failure to Provide Information/Verification, B-122.3.2
Processing Untimely Redeterminations, B-124
Required Verification, C-910

B—122.1 SNAP Redeterminations Following a Short Certification

Revision 13-3; Effective July 1, 2013

SNAP

Advisors must provide eligible households with benefits by the 30th day after the last monthly full benefit was provided if the individual reapplied timely and was previously certified with a short certification. A short certification is defined as a SNAP certification in which the household is certified:

- for a one-month period; or
- in the second month of a two-month certification.

The household must reapply within 15 days of receiving Form H1830, Application/Review/Expiration/Appointment Notice, and the application for assistance to be considered timely.

Notes:

- This policy does not apply to households that are certified in the first month of a two-month certification. These households must continue to file their Form H1010 by the 15th of the last benefit month for a timely redetermination. Advisors must continue to process timely redeterminations on these cases by the last day of the current certification period.
- Advisors must continue to provide Form H1830 and an application for assistance to households that are certified in the first month of a two-month certification or after cutoff in the first month of a three-month certification, because these households will not receive a redetermination packet even though they are not considered to have received a short certification.

B—122.1.1 Calculating the 30-Day Period After the Last Monthly Full Benefit

Revision 15-4; Effective October 1, 2015

SNAP

To calculate the 30-day period, the advisor considers the date the individual received the last full benefit as day zero. If the 30th day falls on a non-workday, the advisor must complete the case by the last workday preceding the 30th day.

B—122.1.2 Determining the Date the Client Must File the Application for a Timely Redetermination Following a Short Certification

Revision 15-4; Effective October 1, 2015

SNAP

To calculate the date the individual must file the application to be considered timely, the advisor must count 15 days after the individual received Form H1830, Application/Review/Expiration/Appointment Notice, and the application for assistance. This date is known as the Short Certification Timely Due Date. If the 15th day falls on a weekend or a holiday, the individual must submit the application before the 15th day in order for it to be considered a timely redetermination.

Advisors must follow the chart below in determining a timely redetermination:

If Form H1830 and Form H1010 are...	then count 15 days ...
given to the individual in the office,	after the date the individual is given the forms.
mailed to the individual,	plus two days (17 days) after the date the forms are mailed.

To schedule timely redeterminations properly, scheduling staff need to know the due date on which the application must be submitted to be considered a timely redetermination. Therefore, when providing Form H1830 and Form H1010, Application for Assistance — Your Texas Benefits, at the time a short certification is completed, advisors must manually document the due date in the Short Cert. Timely Due Date box in the Agency Use Only section of Form H1010. Scheduling staff must then follow B-160, SNAP Timeliness Charts for Applications and All Redeterminations, to properly schedule the appointment.

B—122.1.3 Missed Appointments Following a Short Certification

Revision 15-4; Effective October 1, 2015

SNAP

For timely filed reapplications after a short certification, if an individual misses the appointment, the advisor must send the household Form H1020, Request for Information or Action, advising the household that the household must contact HHSC by the 30th day from the last month's full benefit issuance to request a second appointment.

If the household contacts HHSC on or before the 30th day after the last month's full benefit issuance, the advisor must reschedule the household for a second appointment before the end of the 30th day, if possible. If there are no appointment slots available, the second appointment is scheduled no later than the 45th day after the last month's full benefit issuance and the application is kept pending. If the household keeps the second appointment and is determined eligible, the original file date is used and full month's benefits are provided for the first month of the new certification period.

The advisor must hold the application past the 30th day after the last month's full benefit issuance to allow the household at least 10 days (or longer if the 10th day falls on a non-workday) to contact the office for a second appointment or to provide missing information/verification. The advisor must notify the household of the due date on Form H1020. When this 10-day due date is on or after the 30th day after the last month's full benefit issuance and the household fails to contact the office or provide missing information/verification by the due date, the application is denied the next workday. If the household does not contact HHSC by the 30th day to request a second appointment, the redetermination application is denied on the 30th day (or the last workday before the 30th day if the 30th day is not a workday).

If the household does not contact HHSC by the 30th day to request a second appointment, the redetermination application is denied on the 30th day (or the last workday before the 30th if the 30th day is not a workday).

B—122.2 HHSC Delays in Processing All Timely Redeterminations

Revision 13-3; Effective July 1, 2013

SNAP

If HHSC is at fault for not completing the redetermination process in a timely manner, staff must dispose the EDG the same day the advisor completes the eligibility redetermination. This ensures that benefits are available within 24 hours.

Example 1: A household's last benefit month is October. The household files the redetermination timely, but HHSC does not give the household an appointment until November. The advisor must dispose the EDG on the same day the eligibility redetermination is completed to ensure that benefits are available within 24 hours.

Example 2: A household's last benefit month is October. The household files the redetermination timely and provides all requested verification timely. Due to HHSC delay, the advisor does not complete the recertification process timely. The advisor must dispose the EDG on the same day that the eligibility redetermination is completed to ensure that benefits are available within 24 hours.

B—122.3 Delays Caused by Households

Revision 15-4; Effective October 1, 2015

TANF

When a redetermination is denied for a missed appointment or failure to provide information, the household is allowed until 60 days after the file date to schedule a second appointment or provide the missing information.

SNAP

When a timely redetermination is denied for a missed appointment or for failure to provide information, the household is allowed an additional 30 days after the end of the last benefit month to reschedule a missed appointment or to provide information or verification.

Related Policy
Verification Requirements, A-1370

B—122.3.1 Denied for Missed Appointments

Revision 15-4; Effective October 1, 2015

TANF and TP 08

The date the household requests another appointment is considered the new file date if the household requests a second appointment within 60 days after the original file date.

SNAP

The date the household requests another appointment is considered the new file date if the household requests to reschedule a missed appointment within 30 days after the end of the last benefit month. Benefits are prorated using the new file date.

B—122.3.2 Denied for Failure to Provide Information/Verification

Revision 15-4; Effective October 1, 2015

TANF

The date the household provides the missing information is the new file date if the household provides the missing information within 60 days of the original file date. If the EDG is reopened within 30 days of the denial, a new interview is not required. For TANF, a new Form H1073, Personal Responsibility Agreement, is not required if the EDG is reopened within 30 days of the denial.

SNAP

The date the household provides the information/verification is the new file date and a new interview is not required. Benefits are prorated using the new file date.

Advisors do not request additional income verification when following reuse of application policy for a redetermination denied for failure to provide information. The original income verification the individual provided at the interview date is acceptable, unless the household indicates a change in income.

TP 08, TP 43, TP 44 and TP 48

When a renewal is denied due to failure to provide information or verification and the information or verification is provided after the date of denial but by the 90th day after the last day of the last eligibility month, staff must reopen the existing case and not require a new application from the client. The date the information or verification is provided is the new file date.

Note: This may result in a gap in coverage.

B—122.4 Medical Program Administrative Renewals

Revision 17-2; Effective April 1, 2017

TP 08, TP 43, TP 44 and TP 48

An administrative renewal is initiated by the system and requires no advisor action. The administrative renewal process uses the automated renewal process, explained in B-122.4.1, Automated Renewal Process, to gather information from a client's existing case and from electronic data sources to determine whether the client remains potentially eligible for Medical Programs.

Exception: Children whose TP 44 eligibility is reinstated upon release from a juvenile facility and who are released to a household different than the one in which they were certified at the time of placement in a juvenile facility do not administratively renew. They must submit Form H1010-R, Your Texas Benefits: Renewal Form, in order for their Medicaid eligibility to be reviewed. For additional information regarding reinstatement see policy in A-826, Medicaid Reinstatement.

TP 08

At redetermination, clients must complete an interview. During the interview, the advisor should remind the client to use YourTexasBenefits.com to:

- create a case access account;
- complete the renewal;
- sign-up for email reminders and electronic correspondence; and
- find out when the next renewal is due.

Clients cannot be required to complete a face-to-face interview, but have the right to request one.

For TP 08 interviews, advisors must use the interview policy explained in A-131, Interviews (for TP 08).

B—122.4.1 Automated Renewal Process

Revision 15-4; Effective October 1, 2015

TP 08, TP 43, TP 44 and TP 48

The automated renewal process is the first step in an administrative renewal. The automated renewal process runs the weekend before cutoff in the ninth month of the certification period and does not require advisor action.

The process uses electronic data to automatically:

- assess the verifications required by type program for renewals;
- determine the eligibility outcome; and
- send the renewal correspondence to the client.

B—122.4.1.1 Verifications Required by Type Program for Renewals

Revision 15-4; Effective October 1, 2015

During the automated renewal process, the system checks for the required verification by program.

Automated Renewal Process: Verifications Required by Type Program for Renewals

TP 08, Parents and Caretaker Relatives Medicaid	• Residence • Income and Expenses • Immigration Status • Domicile • Full-time School Attendance, when the only dependent child(ren) is age 18
TP 43, Children Under Age One TP 44, Children Ages 6–18 TP 48, Children Ages 1–5	• Income and Expenses • Immigration Status • Texas Health Steps (only for TP 44 and TP 48) • Health Care Orientation

The automated renewal process attempts to verify income by determining whether the client's income information is reasonably compatible with income information available through electronic data sources, as explained in A-1370, Verification Requirements, Medical Programs.

When there are no earned income electronic data sources (TWC or TALX) available for the client, the automated renewal process checks to see whether there is a New Hire Report. When a New Hire Report exists with an employer's name and hire date that is not currently included in the client's income, the client must provide verification of income from the employer shown on the New Hire Report.

Immigration status is only verified during the automated renewal process if the client's immigration document expires during the current certification period.

B—122.4.1.2 Eligibility Outcomes

Revision 15-4; Effective October 1, 2015

Once available verifications are assessed, the system runs eligibility. The following chart lists the possible eligibility outcomes of the automated renewal process.

Automated Renewal Process: Eligibility Outcomes

Eligibility Potentially Approved	• All required eligibility information **can** be verified during the automated renewal process for the program. • No additional verification is required from a client. • Clients must review the information used to determine their eligibility. • Clients are only required to return a signed renewal Form H1206, Health Care Benefits Renewal, if the information on the renewal form is incorrect or there are changes to the client's case.
Additional Information Needed	• This outcome may be the result of two scenarios that **require additional verification** to determine whether the client remains eligible:

	◦ Electronic data sources indicate there is a change in income that **may** result in ineligibility for Medical Programs. ▪ The reasonable compatibility calculation result is “Need Info because ELDS above limit” or verification required for information found on the New Hire Report. ▪ The client must return a signed renewal Form H1206, Health Care Benefits Renewal, and all required verification(s) within 30 days. ◦ No electronic data is available for the client. ▪ The client must return a signed renewal Form H1206 and all requested verification(s). • SNAP or TANF benefits may be impacted if a member of the MAGI household is included in a SNAP or TANF budget group.
Eligibility Terminated*	• This outcome may be the result of two scenarios: ◦ The previous eligibility outcome was “Additional Information Needed” and eligibility was terminated because the client: ▪ did not submit required verifications within 30 days to show that income is under the limit, or ▪ submitted verifications that showed that income was over the limit. ◦ The client reported a change in income that was over the income limit, and eligibility was terminated before the automated renewal process was triggered.

* See A-2342, Denial at Redetermination, for more information on individuals found ineligible for Medical Programs at renewal.

B—122.4.1.2.1 Determining if Verification Is Required for SNAP or TANF During an Administrative Renewal

Revision 15-4; Effective October 1, 2015

TP 08, TP 43, TP 44 and TP 48

Verification is required for SNAP and TANF during the automated renewal process when:

- the eligibility outcome of the automated renewal process is “Additional Information Needed” and the reasonable compatibility calculation result is “Need Info because ELDS above limit” or the client is required to provide verification of information found on a New Hire Report; and
- an individual in the MAGI household is included in a SNAP or TANF budget group.

The client has 10 days to provide verification for SNAP and TANF. Based on the income type and electronic data source used during the automated income verification process, if the client does not provide verification by the 10th day, the system will automatically take the following action on the 11th day:

- **Deny** SNAP and TANF benefits for the following data sources:
  - Quarterly wage data from Texas Workforce Commission (TWC), or
  - New Hire Report data from the Office of the Attorney General (OAG).
- **Notify the advisor to adjust** SNAP and TANF benefits for the following data sources:
  - Earned income data from TALX,
  - Unearned Retirement, Survivors and Disability Insurance (RSDI) income data from the Social Security Administration (SSA), or
  - Unearned unemployment data from TWC.

Note: Earned income data from TALX, unearned RSDI data from SSA, and unearned unemployment data from TWC are valid verifications for SNAP and TANF. Since quarterly wage data from TWC and New Hire Report data from OAG are not valid verifications for SNAP and TANF, the client must provide verification for these types of income.

B—122.4.1.3 Renewal Correspondence

Revision 15-4; Effective October 1, 2015

TP 08, TP 43, TP 44 and TP 48

The system generates client correspondence according to the eligibility outcome of the automated renewal process and the action needed by the client.

The following chart lists the correspondence generated for each eligibility outcome of the automated renewal process and the required client response.

Automated Renewal Process: Renewal Correspondence

Eligibility Outcome	Correspondence and Required Client Response
Eligibility Potentially Approved	• Form H1211, It's Time to Renew Your Health-Care Benefits Cover Letter, notifies the client that they must review the information used to determine their eligibility on Form H1206, Health Care Benefits Renewal - MA. • The client is only required to return a signed renewal Form H1206 if the information on the form is incorrect or there are changes to the client's case. • Form M5017, Documents to Send with Your Renewal Application, is included with Form H1206. • No additional forms are sent with Form H1211. • Form TF0001, Notice of Case Action, is mailed to the client to notify him or her of the eligibility determination*.

Additional Information Needed	• Form H1211, It's Time to Renew Your Health-Care Benefits Cover Letter, and Form H1020, Request for Information or Action, are sent to the client.
	• Form H1211 notifies the client that they must return the following:
	  ○ Signed renewal Form H1206, and
	  ○ Required verification(s).
	• Form H1020 identifies all the required verification(s) needed to complete the renewal.
	• Form M5017, Documents to Send with Your Renewal Application, is included with Form H1206.
	
	Note: For TP 43, TP 44, and TP 48, Form H1014-A, Children's Health Care Benefits — Final Reminder, is sent if the eligibility outcome is "Additional Information Needed" and the client does not return his or her redetermination packet by the first calendar day in the 11th month of a 12-month eligibility period.

Eligibility Terminated	• If additional information is needed and the client **does not** return a renewal form by the 30th day from the date Form H1211 is mailed, eligibility is auto-disposed and denied. No advisor action is needed. • If additional information is needed and the client **does** return a renewal form by the 30th day from the date Form H1211 is mailed, the form is routed to local offices for processing and the advisor manually processes the renewal. • Form TF0001, Notice of Case Action, is mailed to the client to notify him or her of the eligibility determination*.

* Form TF0001, Notice of Case Action, is sent when a final eligibility determination has been made. Depending on the renewal status outcome and client action, final eligibility determinations may be made by advisors manually processing renewal documents or by the system automatically. Form TF0001 identifies the dates of the new certification period for Medicaid benefits, potential CHIP eligibility, or the denial reason for not recertifying the case.

B—122.4.2 Processing a Manual Renewal

Revision 15-4; Effective October 1, 2015

TP 08, TP 43, TP 44 and TP 48

The file date is the day that any local eligibility determination office receives an acceptable Medical Program renewal form. The following are considered acceptable Medical Program renewal forms:

- Form H1206, Health Care Benefits Renewal – MA
- Form H1206, Health Care Benefits Renewal – ME
- Form H1010-R, Your Texas Benefits: Renewal Form

A redetermination is considered timely if a renewal form is received by the first calendar day of the 11th month of the certification period. A redetermination is considered untimely if a renewal form is received after the first calendar day of the 11th month of the certification period and through the last day of the 12th month.

Note: If the first calendar day of the 11th benefit month falls on a weekend or a holiday and the redetermination is received on the following business day, the redetermination is considered timely.

Advisors must process redeterminations (received timely or untimely) by the 30th day from the date the renewal form is received **or** by cutoff of the last benefit month of the certification period, whichever is later. Advisors must follow the policy in B-123.4, Eligibility Transition from Medicaid to CHIP, when an individual returns a renewal form timely and is determined ineligible for Medicaid but eligible for CHIP.

Examples:

Medicaid coverage period is January through December. If the redetermination file date is:

- October 10, the redetermination must be completed by the December cutoff date to be considered processed timely.
- December 1, the redetermination must be completed by December 31 to be considered processed timely.

When HHSC receives an acceptable Medical Program renewal form, the advisor must review the information provided and determine whether the case needs to be updated to reflect the most recent information reported by the client on the form.

The advisor may only request information and verification needed to determine eligibility from the client when it is not available through electronic data sources. Verification previously provided must be used to renew eligibility when the verification is still valid. The advisor must determine whether there is any verification that can be used before requesting verification from the client.

The household must be allowed at least 10 days to provide missing information, and the due date must fall on a workday.

Note: Information reported during renewal processing may impact other benefit programs.

B—122.4.2.1 When a Medical Program Renewal Form Is Not Returned

Revision 15-4; Effective October 1, 2015

TP 08, TP 43, TP 44 and TP 48

When an acceptable Medical Program renewal form, explained in B-122.4.2, Processing a Manual Renewal, is not returned, the system automatically makes an eligibility determination through a mass update based on the eligibility outcome from the automated renewal process. This does not require the advisor to run eligibility or dispose the EDG.

Below are the eligibility outcomes during the automated process:

- Eligibility Potentially Approved — the client is auto-disposed and approved without advisor action. The file date is the date the EDG is auto-disposed approved, and the client is granted a new 12-month certification period.
- Additional Information Needed — the client is auto-disposed and denied without advisor action.

Note: When an individual submits income or expense verification without a signed acceptable Medical Program renewal form, advisors manually process information as a change to determine ongoing eligibility for the remainder of the certification period if the client is in a non-continuous period. A signed acceptable Medical Program renewal form is required if additional information is needed to complete the renewal during the automated renewal process.

B—123 Processing Children's Medicaid Redeterminations

Revision 15-4; Effective October 1, 2015

TP 43, TP 44 and TP 48

Renewals for TP 43, TP 44 and TP 48 use the correspondence and processing requirements explained in B-121, Notice of Redetermination/Certification Expiration (for TP 08, TP 43, TP 44 and TP 48), and B-122.4, Medical Program Administrative Renewals.

TP 44 and TP 48

TP 44 and TP 48 must follow the Texas Health Steps requirements explained in A-1531.5, Compliance Requirements.

Related Policy
Continuous Medicaid Coverage, A-832
Compliance Requirements, A-1531.5
Data Broker, C-820

B—123.1 Children's Medicaid Redetermination Due Dates

Revision 15-4; Effective October 1, 2015

TP 43, TP 44 and TP 48

Renewals for TP 43, TP 44 and TP 48 follow the administrative renewal process and use the timeliness guidelines explained in B-122.4, Medical Program Administrative Renewals.

Related Policy
Eligibility Transition from Medicaid to CHIP, B-123.4

B—123.2 Children's Medicaid Redetermination Processing Time Frames

Revision 15-4; Effective October 1, 2015

TP 43, TP 44 and TP 48

Renewals for TP 43, TP 44 and TP 48 follow the administrative renewal process and use the timeliness guidelines explained in B-122.4, Medical Program Administrative Renewals.

B—123.3 Reuse of Form H1014-R After Denial

Revision 15-4; Effective October 1, 2015

TP 43, TP 44 and TP 48

TP 43, TP 44 and TP 48 follow the policy for reusing renewal forms after the date of denial explained in B-122.3.2, Denied for Failure to Provide Information/Verification.

B—123.4 Eligibility Transition from Medicaid to CHIP

Revision 17-2; Effective April 1, 2017

TP 43, TP 44 and TP 48

When a child certified on TP 43, TP 44 or TP 48 is determined eligible for CHIP at the renewal and there is a delay in CHIP enrollment because of HHSC error and the redetermination packet was received timely, TIERS extends Medicaid eligibility for one or two additional months to allow the family time to complete the process and still retain coverage. The redetermination is considered timely when the redetermination packet is received by the first day of the 11th month and processed by HHSC by the 30th day from the file date.

If the family is solely responsible for the delay, Medicaid coverage is not extended when a child is determined eligible for CHIP.

Advisors use the following chart to determine when to extend Medicaid coverage:

If a child is ineligible for Medicaid but eligible for CHIP and the family ...	but HHSC ...	then, provide Medicaid coverage ...
completes the redetermination process timely,*	does not process the form by the 15th day of the 11th month,	for one additional month.
completes the redetermination process timely,*	does not process the form by the 15th day of the 12th month,	for two additional months.

* Timely means the redetermination form is received from the family by the first day of the 11th month and any required verification is received within specified time frames.

Related Policy
Medicaid Termination, A-825
Expedited CHIP Enrollment, D-1711

B—123.5 Processing a Redetermination for TP 45 - Transfer to TP 48

Revision 15-4; Effective October 1, 2015

Medical Programs

Advisors use this procedure to provide TP 45 coverage for a child whose TP 45 coverage ends and is eligible for TP 48 coverage.

If the family returns the redetermination packet and the child is eligible for TP 48, the advisor must initiate the review on the TP 45 EDG so that TIERS will build the TP 48 EDG after cutoff in the 11th month of the certification period. Children on TP 45 will be denied at the end of their certification period.

B—123.6 Children's Medicaid Redetermination Expectations

Revision 15-4; Effective October 1, 2015

Children's Medicaid

Staff must process Children's Medicaid redeterminations even if not requested on an associated SNAP application or redetermination, if the SNAP application or redetermination is received in the 10th, 11th or 12th month of a 12-month Children's Medicaid eligibility period.

Note: If the individual misses the appointment for a SNAP application or redetermination, staff **must** continue processing the Children's Medicaid redetermination, even if the Children's Medicaid program was not requested on the application.

The recipient must provide an application or redetermination application to process the Children's Medicaid redetermination if the SNAP application or redetermination is not received within the specified time frames.

Related Policy
Receipt of Application, A-121
Deadlines, B-112
Missed Appointment, B-114
Redeterminations, B-120
Processing Redeterminations, B-122

B—124 Processing Untimely Redeterminations

Revision 15-4; Effective October 1, 2015

SNAP

If an application form is not received by the time frames in B-122, Processing Redeterminations, the advisor uses the initial application processing time frames in B-112, Deadlines.

If the individual submits an untimely reapplication and misses a scheduled appointment, the advisor uses the charts in B-160, SNAP Timeliness Charts for Applications and All Redeterminations, for processing time frames. The advisor must inform the individual that it is the individual's responsibility to request a second appointment. Form H1020, Request for Information or Action, must be sent no later than the next workday, notifying the individual of the missed appointment and pending the application.

Note: If the individual misses an appointment that the agency scheduled untimely, a second appointment is scheduled if the individual contacts the office by the 10th day after the missed appointment date to request another appointment. Otherwise, the individual must reapply with a new file date.

For telephone interviews, advisors must make at least two attempts to contact the individual via telephone. Both attempts must be conducted within the specified time period listed on Form H1830-I, Interview Notice (Applications or Reviews). Each attempt must be conducted at least 10 minutes apart. If no contact is made with the individual after two attempts, the telephone interview is considered a missed appointment. Advisors must document the time and date of each attempt on the Appointment – Details page.

At the individual's request, HHSC must reschedule a second appointment even if it cannot be scheduled until after the 30th day. The individual does not have to show good cause for missing the first appointment.

If on the appointment date the applicant arrives too late for the appointment or calls to reschedule the appointment (because the individual cannot keep the appointment), the advisor must offer the applicant a choice of a standby appointment or an opportunity to reschedule.

Notes:

- If a second or subsequent appointment is scheduled because the individual missed the appointment, the advisor must ensure that second and subsequent appointments have been correctly recorded on the Appointment – Detail page.

See B-160, SNAP Timeliness Charts for Applications and All Redeterminations.

- Benefits are not prorated if an eligible individual submits an untimely reapplication because HHSC fails to provide Form H1830 timely. Benefits are provided from the first day of the month after the last benefits month (enter a file date of the first day of that month).

See A-2323, Proration, and an exception for seasonal and migrant farm workers.

- Advisors do not use application verification requirements when processing untimely redeterminations. Verification requirements are the same for all redeterminations whether filed timely or untimely. See C-912, Required Verification for SNAP.

TP 08, TP 43, TP 44 and TP 48

If a renewal form is not received by the date of denial in the 12th month of the certification period, the EDG is denied for failure to return a renewal packet. A renewal form received after the last day of the 12-month certification period must be treated as an application using application processing time frames. The file date is the day that any local eligibility determination office receives the renewal form.

If the renewal form is received after the date of denial but before the last day of the 12th month of the certification period, the advisor reopens the Medical Program EDG and processes as a renewal.

Related Policy
Missed Appointment, B-114

B—125 Processing Special Reviews

Revision 15-4; Effective October 1, 2015

All Programs

Special reviews are contacts with the household outside of the redetermination process. Staff may conduct special reviews by home visits, telephone, or by mailing individuals Form H1020, Request for Information or Action, or a letter.

TANF and Medical Programs

Advisors contact the household to determine whether a change occurred. If the household confirms that no change occurred, the advisor documents the contact. To clear the special review alert task, the advisor must be in Data Collection Initiate Interview in Special Review mode. If the household confirms that a change occurred, the advisor follows policy in B-600, Changes.

If the household fails to furnish verification requested on Form H1020 or misses an appointment scheduled for the special review, the advisor must send Form TF0001, Notice of Case Action, to begin adverse action.

If the individual contacts the office during the adverse action period, the advisor must reschedule the appointment to process the review as soon as possible to avoid interruption of the benefit issuance cycle for the following month. A second Form TF0001 is not required if the individual misses the second appointment. If the individual does not keep the second appointment, the advisor uses the time frame of the original Form TF0001 to determine the effective date of the denial.

Related Policy
Setting Special Reviews, A-2330

B—125.1 Due Dates

Revision 15-4; Effective October 1, 2015

All Programs

An alert for a special review is triggered in TIERS, which generates a task in Task List Manager (TLM) for the special review.

TANF and Medical Programs

Advisors process special reviews before cutoff in the month:

- the review date falls, if the review is due on or before cutoff; or
- after the review date, if the review is due after cutoff.

SNAP

Advisors process special reviews by cutoff of the month the review date falls.

B—126 Processing Desk Reviews

Revision 15-4; Effective October 1, 2015

SNAP

A desk review is the processing of a timely or untimely filed SNAP redetermination application without scheduling or conducting an interview with the household. A SNAP redetermination may be completed by processing a desk review when all of the following criteria are met:

- the household's current SNAP certification period is six months or less;
- the current and new SNAP certification periods combined will not exceed a total of 12 months; and
- eligibility for the current SNAP certification was determined without using the desk review process.

Exceptions: Staff must conduct an interview when the household:

- has a member who is receiving or is applying for TANF or TP 08;
- failed to complete the application form sufficiently enough (as determined by the local office) to process without an interview;
- has a member with an intentional program violation (IPV) disqualification; or
- lives in a drug/alcohol treatment center, homeless shelter, family violence shelter or group living arrangement.

Advisors begin processing a SNAP redetermination as a desk review within seven calendar days after the Packet Received Date (day zero) and issue either Form H1020, Request for Information or Action, or Form TF0001, Notice of Case Action, to the household within the same seven calendar days.

Note: When a SNAP redetermination Packet Received Date is the 10th through the 15th calendar day of the Last Benefit Month, the advisor must ensure that Form H1020 or Form TF0001 is sent to the household early enough to allow the household 10 days to provide missing information, while still allowing time for the final case action to be timely. Timeliness for Desk Reviews is calculated the same as if an interview was held.

Related Policy
Processing Redeterminations, B-122
Processing Untimely Redeterminations, B-124

B—130 Changes

Revision 02-1; Effective January 1, 2002

See B-600, Changes, for procedures and time frames for processing changes.

B—140 Summary of Due Dates for Form H1020, Request for Information or Action

Revision 15-4; Effective October 1, 2015

All Programs

The due date and final due date entries are shown in the following table. **Note:** If the 10th or 30th day falls on a non-workday, the due date is the next workday. If the due date is not an HHSC workday (on a weekend or a holiday), the due date advances to the next HHSC workday.

TANF

EDG Action	Due Date	Final Due Date
Application	10 days	• 30 days, or • 10th day if 10 days end after 30th day
Complete redetermination	10 days	10 days
Incomplete redetermination (including the addition of a household member)	10 days	10 days

SNAP

EDG Action	Due Date	Final Due Date
Application	10 days*	• 30 days, or • 10th day if 10 days end after 30th day
Untimely redetermination (including adding a person at untimely redetermination)	10 days*	• 30 days, or • 10th day if 10 days end after 30th day
Timely redetermination (including adding a person at timely redetermination)	10 days*	• last workday of last benefit month, or • 10th day if 10 days end after last benefit month
Incomplete redetermination (including adding a person at incomplete redetermination)	10 days	10 days

* For SNAP EDGs pended for a missed appointment, the 10-day due date is calculated from the date the form is mailed, usually two days after the H1020-MA is triggered by TIERS or TLM entries. The two additional days for mail time when sending a Form H1020-MA in TIERS is only applicable to SNAP EDGs pended for a missed appointment.

TP 08, TP 43, TP 44 and TP 48

EDG Action	Due Date	Final Due Date
Application	10 days	• 30 days, or • 10th day if 10 days end after 30th day
Complete redetermination	10 days	• 30 days or by cutoff in the last benefit month of certification, whichever is later; or • 10th day if 10 days end after 30th day
Incomplete redetermination (including the addition of a household member)	10 days	10 days

TP 40

EDG Action	Due Date	Final Due Date
Application	10 days	• 15 work days, or • 10th day if 10 days end after 15th work day

TA 31, TP 34, TP 35, TP 36, TP 56 and TP 32

EDG Action	Due Date	Final Due Date
Application	10 days	• 30 days, or • 10th day if 10 days end after 30th day

B—150 Avoiding Invalid Denials Related to Missing Information and Missed Appointments

Revision 15-4; Effective October 1, 2015

All Programs

Staff must ensure that correspondence is sent to the individual's current address. This requires updating the address in the system if the individual has reported a new address on an application form or a change of address is pending in the Task List Manager or TIERS.

Staff should make two telephone call attempts at least 10 minutes apart during the appointed time frame listed on Form H1830-I, Interview Notice (Applications or Reviews), before determining a telephone interview is a missed appointment. Advisors must document the times and dates of the attempted telephone calls on the Appointment – Details page.

An EDG is denied for failure to furnish information only if:

- the due date on Form H1020, Request for Information or Action, has expired;
- the information was requested on Form H1020; and
- there is confirmation that the requested information is not in the office (front desk, mail room, fax machine, etc.) or imaged and available through the State Portal. *Follow local procedures for locating submitted verifications.*

An EDG is not denied for missed appointment if:

- a second appointment has already been scheduled;
- the denial is before the final due date on Form H1020 for applications and timely redeterminations;
- the agency failed to make the telephone call for a telephone interview or failed to call within the specified time listed on Form H1830-I; and
- the individual files another application after missing the initial appointment. Treat the new application as a request to reschedule a missed appointment. Reschedule a timely redetermination appointment before the end of the certification period, if possible. If there are no appointment slots available, schedule the second appointment no later than the 15th day of the following month.

SNAP Denial Reminders

B—160 SNAP Timeliness Charts for Applications and All Redeterminations

Revision 13-3; Effective July 1, 2013

SNAP

The charts in this section may be used as a guide to determine when appointments must be scheduled and benefits provided for the case action to be reported as timely. The charts detail required actions and due dates in the following type situations:

- applications and untimely redeterminations,
- timely redeterminations after a regular certification period, and
- timely redeterminations after a short certification period.

SNAP Applications and Untimely Redetermination

If …	then …
• the household keeps the first appointment; **or** • the household misses the first appointment, keeps the second appointment on or before the 30th day, and the application is not pended for verification; **or** • the household misses the first appointment, keeps the second appointment, and the application is pended for verification and verification is provided timely on or before the 30th day;	• if eligible, ensure the household has an opportunity to participate by the 30th day after the file date; **or** • if not eligible, deny the application by the 30th day after the file date. **Note:** If the 30th day is a non-workday, take appropriate action the following workday.
• the household misses the first appointment and fails to request a second appointment by the 30th day after the file date; **or** • the household misses the first appointment, keeps a second appointment and the application is pended for verification with a Form H1020, Request for Information or Action, due date before the 30th day and the household fails to provide verification timely; **or** • the household misses the first appointment and misses a second appointment scheduled on or before the 30th day and by the 30th day the household does not request another appointment;	deny the application on the 30th day after the file date (or the following workday if the 30th day is a non-workday).
the household misses the first appointment and keeps a second appointment after the 30th day and the application is not pended for verification;	dispose on the day of the interview. If the household is: • eligible, ensure the household has an opportunity to participate on the interview date; **or** • not eligible, deny the application on the interview date.

If …	then …
the household misses the first appointment and keeps a second appointment, and the application is pended for verification with a Form H1020 due on or after the 30th day and the household provides verification before the 30th day;	dispose by the 30th day: • if eligible, ensure the household has an opportunity to participate by the 30th day; **or** • if not eligible, deny the application by the 30th day.
the household misses the first appointment and keeps a second appointment, and the application is pended for verification and the household provides it timely on or after the 30th day;	dispose on the day the verification is provided. If the household is: • eligible, ensure the household has an opportunity to participate on the day verification is provided; **or** • not eligible, deny the application on the day verification is provided.
the household misses the first appointment and keeps a second appointment, and the application is pended for verification with a Form H1020 with a due date on or after the 30th day and verification is not provided timely;	deny the application on the workday after the Form H1020 due date.
the household misses the first appointment and a second or subsequent appointment scheduled after the 30th day is also missed;	deny the application on the day of the missed second or subsequent appointment.
misses the first appointment, misses the second appointment scheduled on or before the 30th day, and, by the 30th day, requests and is scheduled a third appointment after the 30th day;	dispose/process: • on the day of the interview if the application is not pended for information/verification; **or** • on the day the information or verification is received if the EDG was pended and the information is provided, **or** • on the workday after the Form H1020 due date if the EDG was pended and the information was not provided.

Timely SNAP Redeterminations After a Regular Certification Period

If …	then …
• the household keeps the first timely appointment; **or** • the household misses the first timely appointment, keeps the second appointment on or before the last workday of the certification period, and the application is not pended for verification; **or** • misses the first appointment, keeps the second appointment, and verification is provided timely on or before the last day of the certification period;	• if eligible, dispose/process the redetermination application by the last workday of the certification period; **or** • if not eligible, deny the redetermination application by the last workday of the certification period. **Note:** If the last day of the certification period is not a workday, take action the last workday before the end of the certification period.
• the household misses the first appointment and fails to request a second appointment by the last workday of the certification period; **or** • the household misses the first appointment and misses a second appointment scheduled on or before the last workday of the certification period, and by the last workday of the certification period the household does not request another appointment;	deny the application on the last workday of the certification period.
• the household misses the first appointment and misses a second or subsequent appointment scheduled on or before the 15th of the month after the last benefit month; **or** • the household misses the first appointment and keeps a second appointment on or before the 15th of the month after the last benefit month, and the application **is**	dispose the recertification application on the day of the second (or subsequent) appointment.

not pended for verification;	

the household misses the first appointment and keeps a second appointment on or before the 15th of the month after the last benefit month, and the application **is pended** for verification with a Form H1020 and the household **provides verification timely**;	• if verification was **provided by the last workday** of the certification period, process **by the last workday** of the certification period; **or**
	• If verification was **provided by the Form H1020 due date but after the certification period:**
	  ○ if eligible, ensure the household has an opportunity to participate **within five workdays after receipt of the verification**; **or**
	  ○ if not eligible, deny the application **within five workdays after receipt of the verification**.

the household misses the first appointment and keeps a second appointment on or before the 15th of the month after the last benefit month, and the application **is pended** for verification with a Form H1020 and the household **fails to provide** verification by the final due date;	• if the Form H1020 due date was before the last workday of the certification period, deny the application on the last workday of the certification period; **or** • if the Form H1020 due date was on or after the last workday of the certification period, deny the application on the workday following the due date on Form H1020.
the household misses the first appointment and also misses a second or subsequent appointment scheduled after the end of the certification period;	deny the application on the day of the missed second appointment.

the household misses the first appointment and also misses a second appointment scheduled on or before the end of the certification period, and by the last workday of the certification period the household requests another appointment and is scheduled a third appointment after the end of the certification period;	• if the application is not pended or if the household misses the appointment, dispose/process the application on the day of the appointment; **or**
	• if the EDG is pended:
	  ○ dispose/process within five workdays after the receipt of information/verification, if the pended information is provided; **or**
	  ○ deny the application on the workday following the Form H1020 due date, if the pended information is not provided.

Timely SNAP Redeterminations After a Short Certification Period

If…	then…
• the household keeps the first appointment; **or** • the household misses the first appointment, keeps a second appointment on or before the 30th day after the last month's full benefit issuance, and the application is not pended for verification; **or** • the household misses the first appointment, keeps a second appointment, and the application is pended for verification and verification is provided timely on or before the 30th day after the last month's full benefit issuance;	• if eligible, process the redetermination by the 30th day; **or** • if not eligible, deny the application by the 30th day. **Note:** If the 30th day is not a work day, take action on the last workday before the 30th day.
• the household misses the first appointment and fails to request a second appointment by the 30th day after the last month's full benefit issuance; **or** • the household misses the first appointment and also misses a second appointment scheduled on or before the 30th day, and by the 30th day (or last workday before the 30th day) the household does not request another appointment;	deny the application on the 30th day (or the last workday before the 30th day if the 30th day is not a workday).

• the household misses the first appointment and also misses a second or subsequent appointment scheduled on or before the 45th day after the last month's full benefit issuance; **or** • the household misses the first appointment and keeps a second appointment on or before the 45th day and the application **is not pended** for verification;	dispose the recertification application on the day of the second (or subsequent) appointment.

the household misses the first appointment and keeps a second appointment on or before the 45th day after the last month's full benefit issuance, and the application **is pended** for verification with a Form H1020 and the household **provides verification timely**;	• if verification was **provided by the 30th day** after the last month's full benefit issuance, process **by the 30th day**.
	• if verification was **provided by the Form H1020 due date but after the 30th day** after the last month's full benefit issuance:
	  ○ if eligible, ensure the household has an opportunity to participate **within five workdays after receipt of the verification; or**
	  ○ if not eligible, deny the application **within five workdays after receipt of the verification**.

the household misses the first appointment and keeps a second appointment on or before the 45th day, and the application **is pended** for verification with a Form H1020 and the household **fails to provide** verification by the final due date;	• if the Form H1020 due date was before the 30th day after the last month's full benefit issuance, deny the application on the 30th day. • if the Form H1020 due date was on or after the 45th day, deny the application on the workday following the due date on Form H1020.
the household misses the first appointment and misses a second or subsequent appointment scheduled after the 30th day from the last month's full benefit issuance;	deny the application on the day of the missed second or subsequent appointment.

the household misses the first appointment and misses a second appointment scheduled on or before the 30th day, and, by the 30th day of the certification period, the household requests and is scheduled for a third appointment after the 30th day;	• if the application is not pended or if the household misses the appointment, dispose/process the application on the day of the appointment; **or**
	• if the case is pended:
	  ○ dispose/process within five workdays after the receipt of information/verification, if the pended information is provided; **or**
	  ○ deny the application on the workday following the Form H1020 due date, if the pended information is not provided.

B—161 DataMart Reports

Revision 13-3; Effective July 1, 2013

All Programs

DataMart provides a series of online reports accessed through the State Portal. The reports are used as monitoring tools for various EDG action activities for cases in TIERS (including timeliness of those activities). See C-840, DataMart.

B—170 Documentation Requirements

Revision 15-4; Effective October 1, 2015

All Programs

Advisors must document the reason(s) for delays in processing an application and advisor action as explained in B-113, Delay in Processing Applications.

For missed telephone interviews, advisors must document on the Appointment – Details page the time of each call when attempting to contact the applicant according to policy in B-114, Missed Appointment; B-122, Processing Redeterminations; and B-124, Processing Untimely Redeterminations.

Related Policy
The Texas Works Documentation Guide

TWH, B-200, Issuing Benefits

Revision 18-1; Effective January 1, 2018

B—210 General Policy

Revision 15-4; Effective October 1, 2015

TANF

The Texas Health and Human Services Commission (HHSC) issues Temporary Assistance for Needy Families (TANF) benefits via Electronic Benefit Transfer (EBT) or warrant. The agency issues all one-time benefits via warrant.

Related Policy
Medicaid Eligibility, A-800
Issuing OTTANF Benefits, A-2451
Issuing One-Time Grandparent Payment, A-2452

SNAP

HHSC issues all Supplemental Nutrition Assistance Program (SNAP) benefits by EBT.

B—220 Benefits

Revision 05-2; Effective April 1, 2005

B—221 Types of Benefits

Revision 11-3; Effective July 1, 2011

TANF and SNAP

There are five types of benefits:

- initial,
- ongoing,
- supplemental,
- retroactive, and
- restored.

See Glossary for definitions of these terms.

B—222 Issuing Methods

Revision 13-3; Effective July 1, 2013

TANF and SNAP

SNAP and TANF benefits are issued using the Texas Integrated Eligibility Redesign System (TIERS).

Benefits authorized in TIERS via Eligibility or Benefit Issuance functional areas are issued by EBT.

B—222.1 Mailing Addresses for Issuing Benefits

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

Advisors issue benefits to the individual's physical address, unless the individual:

- is temporarily living at another address;
- has a post office box or general delivery address;
- has a guardian; or
- provides a good reason for a different mailing address, showing the individual would suffer hardship if benefits were mailed to their physical address.

Advisors should not use a local eligibility determination office address or an employee's physical address as a mailing address, unless the employee is a TANF applicant or recipient.

SNAP

The individual's physical address is the preferred mailing address to enter in TIERS. The individual may use another mailing address, however, if the individual believes it is more secure or the individual has no physical address.

All Programs

Notes:

- If an individual has a post office box and physical address, both are entered in TIERS, unless the household resides in a shelter for battered persons.
- The U.S. Postal Service does not forward TANF warrants or Medicaid Eligibility and Health Information Services (MEHIS) cards.

B—230 Electronic Benefit Transfer (EBT)

Revision 15-4; Effective October 1, 2015

TANF and SNAP

HHSC issues benefits by EBT and contracts with one or more vendors who perform EBT functions.

When an advisor certifies a household, HHSC establishes and deposits benefits in the household's EBT account(s). Staff issues a Lone Star Card to the individual or their representative. These cardholders access benefits using the card and a Personal Identification Number (PIN).

Staff uses TIERS to send information to the EBT system.

The EBT process includes:

- establishing a primary cardholder and EBT account(s);
- establishing a secondary cardholder, if requested;
- issuing a Lone Star Card;
- requesting that the individual select his PIN or issuing a pre-assigned PIN;
- replacing a card and/or PIN, if required; and
- individual training.

B—231 Establishing the Primary Cardholder (PCH)

Revision 15-4; Effective October 1, 2015

TANF and SNAP

The PCH is the household member or EBT representative designated to have primary responsibility for security and access to the household's benefits in the EBT account. Each case has only one PCH. Staff generally establishes the case name as the PCH, even if the individual is a disqualified member.

Exceptions: If an EBT representative is a PCH who is not the case name, establish the PCH in the following situations:

- If the TANF Eligibility Determination Group (EDG) has a protective payee or representative payee, establish this person as the PCH.
- If a SNAP individual is a resident of a drug and alcohol (D&A) treatment/group living arrangement (GLA) facility and the D&A/GLA facility is the individual's authorized representative (AR), establish the AR as the PCH.

If the TANF and SNAP EDGs have...	then...
the same EDG name,	establish the EDG name as the PCH for both EDGs. **Note**: Ensure that the name, date of birth, sex and Social Security number (SSN) match exactly.
different EDG Names,	each EDG must have a different PCH.

B—231.1 When to Send a PCH Record

Revision 15-4; Effective October 1, 2015

TANF and SNAP

HHSC must send a PCH record to the EBT system on an active EDG, even if pending the final case action, or on an application when the advisor:

- certifies a TANF or SNAP application;
- transfers a Medical Programs EDG to TANF;
- changes an EDG name;
- adds, deletes, or changes a TANF protective payee or representative payee;
- adds, deletes, or changes the SNAP AR for a D&A/GLA facility; or
- changes a SNAP AR type from a D&A/GLA facility to an individual (in or out of the household) when the AR name stays the same.

Note: The EDG name becomes the PCH. If the advisor changes the SNAP AR type from an individual to a D&A/GLA facility, the AR becomes the PCH. See B-440, Drug and Alcohol Treatment (D&A)/Group Living Arrangement (GLA) Facilities.

Advisors do not send a record if:

- pending the TANF or SNAP application due to a missed appointment; or
- pending a change or complete action when the household does not appear to be eligible for TP 01/61.

B—231.2 Establishing a PCH Record and an EBT Account

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Advisors must send a PCH record to the EBT system to establish a benefit account in the cardholder's name. The advisor must establish the account before issuance staff can issue a Lone Star Card and PIN.

B—231.3 Sending a New PCH Record

Revision 15-4; Effective October 1, 2015

TANF and SNAP

A new PCH record may be sent to the EBT system to establish an account in the following two manners:

- Through TIERS using Real Time Interface or Batch file; or
- Via the Administrative Terminal Action (ATA) – The advisor completes Part I of Form H1175, Authorization for Administrative Terminal Application Action, to authorize this process only if they:
  - need to change the PCH on a denied EDG or an EDG being denied; or
  - cannot send the record through TIERS due to automation problems.

Exception: If the EBT system receives a benefit record before the PCH record, the EBT system uses the benefit record to create a PCH record. This usually occurs on TANF and SNAP EDGs when:

- the advisor fails to submit Form H1175, Part I, to the EBT clerk; or
- the EBT clerk fails to enter the data from Part I of Form H1175 on the same day the advisor disposes the EDG.

The advisor must not send another PCH record.

B—231.4 Updating the PCH Record

Revision 13-3; Effective July 1, 2013

TANF and SNAP

TIERS updates existing PCH records on active cases any time the advisor changes the cardholder's biographical data or address and completes the benefit issuance logical unit of work. The EBT system receives an update file sent from TIERS overnight that updates the record the next day.

Note: The advisor may initiate action to merge PCH records via the ATA when a household's TANF and SNAP PCH record information fails to match. See B-261.3.2, Merging Primary Cardholder Records.

B—232 Establishing a Secondary Cardholder

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Advisors establish a secondary cardholder only after HHSC certifies an application. **Exception:** If the advisor certifies an individual for one program and pends the other, the individual may authorize a secondary cardholder for both accounts.

The PCH may authorize:

- a secondary cardholder for only one benefit account;
- a different secondary cardholder for each benefit account; or
- the same person as the secondary cardholder for both the cash account and the food account.

The following three methods may be used to establish a secondary cardholder:

- the PCH requests it via the Lone Star Help Desk;
- the PCH requests it from the local office issuance staff; or
- the advisor authorizes the secondary cardholder via the ATA.

Only the PCH may authorize a secondary cardholder, except in the emergency situations described in B-232.3, Secondary Cardholders Established by the Advisor.

Employees involved in certification or issuance may serve as a secondary cardholder on another household's account only if the supervisor gives written approval.

B—232.1 Secondary Cardholder Established by the Lone Star Help Desk

Revision 15-4; Effective October 1, 2015

TANF and SNAP

The PCH may contact the Lone Star Help Desk any time after certification to add, delete, or change a secondary cardholder.

When the help-desk staff receives a request to add or change a secondary cardholder, the staff mails a Second Cardholder request form to the PCH. The PCH must complete, sign, obtain the secondary cardholder's signature, and return the form to the vendor to authorize a secondary cardholder.

When the vendor's staff receives the completed form, the staff mails the secondary cardholder's Lone Star Card to the PCH who must give the card to the secondary cardholder. The secondary cardholder then calls the Lone Star Help Desk to register the card.

If the PCH requests the deletion of a secondary cardholder, Lone Star Help Desk staff terminates access of the secondary card immediately.

B—232.2 Secondary Cardholder Established by Issuance Staff

Revision 13-3; Effective July 1, 2013

TANF and SNAP

When the advisor establishes a PCH on a certified application, the PCH may authorize a secondary cardholder.

The PCH must bring the secondary cardholder to the office, complete the Second Cardholder request form, give the form to issuance staff, and provide proof of identity. The advisor completes Form H1172, EBT Card, PIN and Data Entry Request. Before establishing the secondary cardholder on the ATA, issuance staff ensures the Second Cardholder request form is completed and signed by both the PCH and secondary cardholder.

The PCH may add or change a secondary cardholder using this procedure any time after certification.

B—232.3 Secondary Cardholders Established by the Advisor

Revision 01-3; Effective April 1, 2001

TANF and SNAP

The advisor may establish a secondary cardholder with supervisory approval in the emergency situations described in this section.

B—232.3.1 Secondary Cardholder Authorization by a Household Member Other than the PCH

Revision 01-3; Effective April 1, 2001

TANF and SNAP

With supervisory approval, the advisor may establish account access for a new individual if:

- the household needs to set up a secondary cardholder; and
- the PCH cannot complete and sign the Second Cardholder request form (due to injury, illness, etc.).

The advisor obtains a completed Second Cardholder request form signed by another responsible household member or the AR if there is no other responsible household member. The advisor and supervisor sign below the individual's signature.

The advisor completes Form H1172, EBT Card, PIN and Data Entry Request, for issuance staff to enter the data from the Second Cardholder request form into the ATA to establish a secondary cardholder record.

B—232.3.2 Secondary Cardholder Authorization by the Advisor

Revision 15-4; Effective October 1, 2015

TANF and SNAP

When benefits for children remain in an EBT account and the PCH is not able or available to access the benefits, the advisor may use the following chart to determine whether the advisor may establish a secondary cardholder.

Step			Action
1	Did the only household member with account access die, become incapacitated, or abandon the children?	No	Stop. Take no further action.
-	-	Yes	Go to Step 2.
2	Is there another responsible household member who may be established as the PCH?	No	Go to Step 3.
-	-	Yes	Establish the other responsible household member as the PCH.
3	Are the children in the care of another person?	No	Stop. Take no further action.
-	-	Yes	Authorize account access to the new caregiver using the procedures that follow in this section.

The advisor:

- uses the Second Cardholder request form to authorize the new caregiver as a secondary cardholder;
- completes the individual (PCH) information section of the form; and
- signs at the bottom in the section marked "Your Signature." The supervisor signs under the advisor's signature.

The new caregiver completes and signs the second cardholder information section. The advisor completes Form H1172, EBT Card, PIN and Data Entry Request, and refers the person to issuance staff.

Note: The new caregiver must make a separate application for benefits in order to continue receiving them.

B—233 Issuing a Lone Star Card

Revision 15-4; Effective October 1, 2015

TANF and SNAP

The advisor requests Lone Star Card issuance when:

- a new PCH record is established on applications or active EDGs; or
- the office establishes a secondary cardholder.

For pended applications, advisors may request Lone Star Card issuance immediately after the interview.

Exception: When the advisor interviews a PCH by phone, a request for the EBT vendor to mail the Lone Star Card and training materials to the PCH is required with some exceptions. Advisors follow procedures in B-233.2.2, Applicants Interviewed by Phone.

Related Policy
Applicants Interviewed by Phone, B-233.2.2
Special Certification Situations, B-240
Drug and Alcohol Treatment (D&A)/Group Living Arrangement (GLA) Facilities, B-440
Residents in Family Violence Shelters, B-450
Prepared Meal Services, B-460

B—233.1 When to Reuse a Lone Star Card

Revision 15-4; Effective October 1, 2015

TANF and SNAP

A Lone Star Card from a previous certification in which the individual was the PCH may be used if the same EDG number is used.

A previously issued Lone Star Card may not be used if it was:

- deactivated because it was reported lost or stolen;
- issued to someone who was later removed as primary or secondary cardholder on the account; or
- issued to someone for an EDG, which was later denied and purged, and the EBT account was closed.

Note: Advisors may use ATA inquiry to determine whether the cardholder may use the Lone Star Card to access benefits for a particular EDG. Staff may use this inquiry to validate card access after verifying the individual's identity. Form H1172, EBT Card, PIN and Data Entry Request, is not required.

B—233.2 Issuing Lone Star Cards for PCHs

Revision 15-4; Effective October 1, 2015

TANF and SNAP

To issue a Lone Star Card, the advisor:

- completes Form H1172, EBT Card, PIN and Data Entry Request; and

- refers the PCH to issuance staff.

When issuing Lone Star Cards in the office, issuance staff must verify the identity of the person receiving the card to ensure the individual is the person listed on Form H1172. If issuing the card directly to a cardholder, issuance staff also ensures the individual signs the back of the card.

If the advisor pends the application and does not issue the Lone Star Card, the advisor must:

- explain to the individual that after receiving the Lone Star Card, the individual must call the Lone Star Help Desk to register it; and
- postpone sending Form H1172 to issuance staff.

If the advisor later certifies the application, the advisor must give a completed Form H1172 to issuance staff to:

- request mail-out of a Lone Star Card and training material to the PCH; and
- flag the cardholder record to require card registration.

Exception: When the advisor interviews a PCH by phone, the advisor is required to request that the EBT vendor mail the Lone Star Card and training materials to the PCH with some exceptions. Advisors follow procedures in B-233.2.2, Applicants Interviewed by Phone.

B—233.2.1 Applicants Interviewed in the Office

Revision 15-4; Effective October 1, 2015

TANF and SNAP

If the advisor interviews the PCH and certifies or pends the application at the initial interview, the advisor must follow the procedures in B-233.2, Issuing Lone Star Cards for PCHs.

If the advisor interviews someone other than the PCH and certifies or pends the application at the initial interview, the advisor must give a completed Form H1172, EBT Card, PIN and Data Entry Request, to issuance staff to:

- request issuance of a Lone Star Card to the person being interviewed; and
- flag the cardholder record to require card registration.

If a person leaves the office without picking up a Lone Star Card or the advisor later certifies an application for which card issuance was postponed, issuance staff takes the actions listed in the following chart:

If the PCH ...	then ...
has a secure mailing address,	• mail the Lone Star Card and training material to the PCH's address,* • flag the cardholder record to require card registration, and • note this procedure on Form H1172.
does not have a secure mailing address,	• note on the bottom of Form H1172 that issuance staff did not issue a card, and • send Form H1172 to the Document Processing Center (DPC) in Austin for imaging.

* **Exception:** For expedited applications in situations that require mailing a Lone Star Card, the PCH may pick up the card in the office. If the PCH is unable to come to the office due to illness or disability, the issuance staff may issue the:

- AR a secondary cardholder card following special procedures in B-232.3, Secondary Cardholders Established by the Advisor, if possible; or
- PCH's card to the AR with supervisory approval on Form H1172, documenting the need for this procedure and noting that the card requires registration.

If the cardholder returns for the card, issuance staff:

- must complete and sign a new Form H1172, and
- issue the Lone Star Card following regular procedures.

Note: Staff must not use whiteout or other correction fluid on Form H1172. If fixing an error or a wrong date, mark through the error with a single line and make the correction.

B—233.2.2 Applicants Interviewed by Phone

Revision 15-4; Effective October 1, 2015

TANF and SNAP

If the advisor interviews a household by phone, mail issuance is required except:

- for households who are certified for expedited SNAP benefits;
- when the card must be issued in the local office to meet timeliness standards; or
- when the card must be issued to an authorized representative for residents of drug and alcohol treatment centers and group living arrangement facilities.

If the household is interviewed by phone and is:	then:
eligible for expedited SNAP benefits, or interviewed on or after the 25th day after the file date for SNAP benefits,	staff must instruct the individual to go to the local office and pick up the Lone Star Card for timely access. **Note**: The Lone Star Card can be mailed at the individual's request if unable to go to the local office.
determined to be eligible at the interview or pended for missing information and does not meet the above criteria,	staff must inform the individual during the interview that their Lone Star Card will be mailed to them within the next week.
denied at the interview,	staff do not request issuance of the Lone Star Card.

When pending an application, the advisor must explain the following to the person being interviewed:

- The requested information must be provided and eligibility determined before TANF cash benefits or SNAP food benefits will be deposited into the EBT account.
- A Lone Star card and training materials will be mailed to the PCH. Call the Lone Star Help Desk at 1-800-777-7328 to register the card.
- A PIN selection is necessary to access their EBT account.
- After receiving a notice of eligibility, the individual should call the Lone Star Help Desk to check the food benefit account balance.

Notes:

- Advisors must remember to refer to policy in B-234.3, Initial PIN Issuance Procedures for Individuals with Barriers that Prevent PIN Self-Selection.
- It is important that the applicant understands receipt of a Lone Star Card does not mean the household is eligible for SNAP or TANF, or that SNAP food benefits or TANF cash benefits are currently available in the EBT account.

Related Policy
Initial PIN Issuance Procedures for Individuals with Barriers that Prevent PIN Self-Selection, B-234.3

B—233.2.3 Applicants Interviewed by Phone in a Location Different Than Interviewing Worker

Revision 15-4; Effective October 1, 2015

If an advisor is conducting a phone interview for a household in another location, the local office may need to issue EBT cards to the household.

Staff must continue to follow the policy in B-233.2.2, Applicants Interviewed by Phone, along with the policy below.

If the household needs a new Lone Star Card, the interviewing advisor must:

- determine whether the agency must mail a new card to the household or issue it in a local eligibility office following policy in B-233.2.2;
- give the individual the address and contact information for the local HHSC office based on the household's residential ZIP code using the office locator in the State Portal; and
- tell the household that the PCH (or person being interviewed) must provide proof of identity in order to get an EBT card.

Notes:

- The EBT system may purge the EDG after 90 days if HHSC does not issue benefits. The EBT system may purge the EDG after one year if there are no EBT transactions. The advisor must request issuance of a new card in either situation.
- If the household needs a replacement card, staff must follow policy in B-235, Lone Star Card Replacement.

When a local eligibility office must issue a new Lone Star Card, the eligibility office issuing the EBT card must:

- verify through TIERS inquiry that an advisor in another location conducted an interview;
- verify that the individual meets one of the criteria for local office issuance, or one of the criteria in B-235;
- verify the identity of the PCH;
- issue the EBT card and materials following the approved local office procedures;
- make sure the EBT card is registered to the correct EDG number;
- send all required EBT forms to the Austin DPC to be imaged following procedures in the Support Tools section of the Eligibility Services State Processes document; and
- continue to follow established security and reconciliation procedures.

Note: When an individual comes into the local office asking for an EBT card, EBT issuance staff may complete Form H1172, EBT Card, PIN and Data Entry Request, but must get an advisor or supervisor sign-off.

B—233.2.4 Applicants Interviewed by Home Visit

Revision 15-4; Effective October 1, 2015

TANF and SNAP

If the advisor certifies or pends the application at the initial interview and interviews the PCH, the advisor must explain to the individual that:

- HHSC will mail a Lone Star Card and training material; and
- after receiving the Lone Star Card, the PCH must call the Lone Star Help Desk to register it.

Upon returning to the office, the advisor sends the PCH record and gives a completed Form H1172, EBT Card, PIN and Data Entry Request, to issuance staff to:

- request mail-out of a Lone Star Card and training material to the PCH; and
- flag the cardholder record to require card registration.

The advisor may also use the EBT issuance procedure described in the following chart:

Step	Action
1	Request that issuance staff performs ATA inquiry to see if HHSC previously issued a Lone Star Card and, if so, write down the personal account number (PAN).
2	Use Form H1173, EBT Card Issuance and PIN Self-Selection/Issuance Log, to log out a Lone Star Card and PIN packet to deliver to the household during the home visit.
3	During the interview, ask the PCH if they still have the Lone Star Card and still remember their PIN.
4	If the PCH has a Lone Star Card and remembers his PIN, then compare the previously recorded PAN to ensure the card is valid. If so, the PCH may continue to use their Lone Star Card and PIN.
5	If the PCH needs an initial Lone Star Card/PIN issuance or a replacement: • give the PCH the Lone Star Card; • explain that the individual must select a PIN through the Lone Star Help Desk Automated Voice Response (AVR) unit*; and • record the PAN and, if applicable, PIN control number on Form H1172 to report back to issuance staff upon returning to the office.

*** Exception:**

If the individual has a barrier that prevents the individual from selecting a PIN, the advisor must issue a pre-assigned PIN. Barriers include, but are not limited to:

- a physical or mental disability,
- the lack of access to a touchtone phone,
- the unavailability of the AVR, or
- the inability to use the AVR.

The individual's statement regarding barriers that prevent the individual from self-selecting a PIN is acceptable.

Centralized Benefit Services individuals continue to receive PIN packets.

If the advisor certifies the application but interviews someone other than the PCH, the advisor may follow either of the previous procedures and provide the explanations to the person being interviewed.

B—233.3 Issuing Lone Star Cards to EBT Representatives

Revision 15-4; Effective October 1, 2015

TANF

A TANF protective payee must come to the office to be issued a Lone Star Card. **Exception:** If the protective payee is unable to come to the office, issuance staff may mail the Lone Star Card to the protective payee's address indicated by the advisor on Form H1172, EBT Card, PIN and Data Entry Request.

SNAP

Advisors follow the procedures for authorized representatives in B-440, Drug and Alcohol Treatment (D&A)/Group Living Arrangement (GLA) Facilities.

B—233.4 Issuing Lone Star Cards to Secondary Cardholders

Revision 15-4; Effective October 1, 2015

TANF and SNAP

When establishing a secondary cardholder at the local office as explained in B-232, Establishing a Secondary Cardholder, through B-232.3.2, Secondary Cardholder Authorization by the Advisor, issuance staff also issues a Lone Star Card to the secondary cardholder. Form H1172, EBT Card, PIN and Data Entry Request, and the Second Cardholder request form are used to serve as card issuance authorization. The secondary cardholder must come to the office and provide verification of identity to obtain the Lone Star Card.

B—233.5 Card Registration

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Card registration is a process by which a cardholder requests account access for a new Lone Star Card. Lone Star Help Desk staff normally completes this procedure and verifies the caller's identity before authorizing access.

A cardholder must register a new Lone Star Card (initial or replacement) by calling the Lone Star Help Desk if the card is:

- mailed to the cardholder; or
- given to someone other than the PCH.

Lone Star Cards issued directly to the PCH do not require registration.

B—233.5.1 Issuance Staff Procedures

Revision 15-4; Effective October 1, 2015

TANF and SNAP

When policy requires registration for a card that HHSC issues at the local office, issuance staff places a registration sticker on the card and takes the actions in the following chart.

If ...	then ...
mailing the card,	provide a Lone Star Card mailer with it.
issuing the card to someone other than the PCH,	explain that the PCH must call the Lone Star Help Desk to register the card after receiving it.

B—233.5.2 Special Card Registration Procedures

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Staff must register a PCH's card if the cardholder has a barrier, such as a hearing impairment or language barrier which prevents the PCH from registering the card through the regular Lone Star Help Desk process.

To complete registration of a Lone Star Card in the local office, the PCH must come to the office, verify the PCH's identity, and show their card to the local office EBT site coordinator or designated staff (other than the EBT clerk). The coordinator/staff then:

- completes Form H1175, Authorization for Administrative Terminal Application Action, to authorize registration; and
- gives it to the EBT clerk to register the card via the ATA. The EBT clerk verifies that the cardholder has the same card as shown on the ATA and changes the card status to "registered."

B—234 Personal Identification Number (PIN) Selection and Issuance

Revision 18-1; Effective January 1, 2018

TANF and SNAP

In addition to the Lone Star Card, a cardholder must have a PIN to access benefits in the household's EBT account(s). The cardholder selects their PIN through the Lone Star Help Desk AVR unit.

Exceptions:

- If the cardholder has a barrier that prevents them from selecting a PIN, the advisor may issue a pre-assigned PIN. Barriers include, but are not limited to:
  - a physical or mental disability;
  - the lack of access to a touchtone phone;
  - the unavailability of the AVR; or
  - the inability to use the AVR.

The cardholder's statement regarding barriers that prevent them from self-selecting a PIN is acceptable.

- Centralized Benefit Services individuals will continue to receive PIN packets.

Local offices are encouraged to promote individual PIN self-selection to provide increased security and convenience for the cardholder and reduce the number of PIN packets issued and replaced. If possible, the local office allows the cardholder to use the PIN pad device to complete PIN self-selection and provides training/assistance regarding the process upon the individual's request.

Advisors must ensure that the cardholder selects or receives a PIN when:

- issuing the initial Lone Star Card;
- the PIN is compromised; or
- the cardholder forgets the PIN.

When the advisor postpones issuing a Lone Star Card on a pended application, the advisor must also postpone the PIN self-selection/issuance process.

After initial PIN selection/issuance, a cardholder may select a new PIN at any time by calling the Lone Star Help Desk AVR unit.

Related Policy
Special Certification Situations, B-240
Drug and Alcohol Treatment (D&A)/Group Living Arrangement (GLA) Facilities, B-440
Residents in Family Violence Shelters, B-450
Prepared Meal Services, B-460

B—234.1 Personal Identification Number (PIN) Selection and Issuance Procedures

Revision 15-4; Effective October 1, 2015

TANF and SNAP

The advisor:

- explains the PIN-selection process during the initial interview;
- determines if the individual has a barrier that prevents the individual from using this process;
- completes Form H1172, EBT Card, PIN and Data Entry Request, marking the method of PIN selection/issuance; and
- refers the PCH to issuance staff.

If the advisor postpones issuing a Lone Star Card on a pended application, the advisor must postpone sending Form H1172 to issuance staff. If the advisor later certifies the application, the advisor sends the completed Form H1172 to issuance staff showing the method of PIN selection/issuance.

The advisor follows the same procedures when setting up a secondary cardholder in the local office. In addition, the advisor uses Form SCRF, Second Cardholder Request Form, to serve as authorization for PIN selection/issuance. The advisor sends this form to the Austin DPC for imaging and storage in the repository. The PCH must go with the secondary cardholder to the local office to authorize PIN selection/issuance, except in the emergency situations described in B-232.2, Secondary Cardholder Established by Issuance Staff.

If a cardholder has a problem remembering a pre-assigned PIN, the advisor should encourage the individual to choose a new PIN. If the PCH still has a problem remembering the PIN, issuance staff refers the cardholder to the advisor to discuss assigning a secondary cardholder.

A new PIN is not required for a Lone Star Card replacement unless the PIN has been forgotten or compromised.

B—234.2 Initial PIN Self-Selection Procedures

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Before a cardholder self-selects a PIN, issuance staff explains that the individual must call the Lone Star Help Desk from a touch-tone phone and follow the prompts. The cardholder should be advised to be prepared with a four-digit PIN that can be easily remembered, the cardholder's biographical data, and the Lone Star Card.

B—234.2.1 Initial PIN Self-Selection Procedures for TANF Protective and Representative Payees

Revision 15-4; Effective October 1, 2015

TANF

If a TANF protective or representative payee will self-select a PIN, the advisor:

- makes the appropriate entries on the Issuance – Details page by indicating there is an alternate payee and subsequently adding the TANF protective or representative payee to the Alternate Payee – Summary page; and
- completes Part I of Form H1175, Authorization for Administrative Terminal Application Action, and sends Form H1175 to the EBT clerk to enter additional data to the PCH record through the ATA.

At the time of disposition, advisors must ensure that TIERS has successfully included the PCH record for the TANF protective or representative payee by reviewing the Issuance – Details page and the Alternate Payee – Summary page.

Note: Because the PCH must use biographical data to access PIN selection through the Lone Star Help Desk AVR system, the EBT clerk must enter the additional data to the PCH record using the Form H1175/ATA process. TIERS does not collect this data on TANF protective or representative payees; therefore, TIERS cannot send this information to the EBT system.

EBT staff securely files the signed, original Form H1175.

Advisors follow all other regular procedures for PIN self-selection.

B—234.3 Initial PIN Issuance Procedures for Clients with Barriers that Prevent PIN Self-Selection

Revision 18-1; Effective January 1, 2018

TANF and SNAP

When a cardholder receives a pre-assigned PIN because of a barrier that prevents the person from choosing a PIN, the advisor completes Form H1172, EBT Card, PIN and Data Entry Request, to request that issuance staff have the vendor mail a PIN packet.

If interviewing someone other than the primary cardholder (PCH), the advisor gives a completed Form H1172 to issuance staff to request mail-out of a PIN packet to the PCH's address.

If a cardholder leaves the office without picking up a PIN packet, or if the advisor later certifies an application for which the advisor postponed card and PIN issuance, issuance staff take the actions listed in the following chart.

If the PCH ...	then ...
has a secure mailing address,	• Request that the vendor mail a PIN packet.*
does not have a secure mailing address,	• note on the bottom of Form H1172 that issuance staff did not issue a PIN packet; and • send Form H1172 to the DPC in Austin for imaging.

* **Exception:** For expedited applications in situations that require mailing a PIN packet, the PCH may self-select a PIN by using the PIN pad device at the local office.

If the cardholder returns for the PIN packet, issuance staff:

- must complete and sign a new Form H1172; and

- issue the PIN packet following regular procedures.

Note: Advisors must not use whiteout or other correction fluid on Form H1172. A single line should be drawn through any error to make the correction.

B—234.4 PIN Security

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Advisors must instruct individuals **not** to:

- write their PIN on their Lone Star Card sleeve;
- keep their PIN near their Lone Star Card; or
- share their PIN with anyone else.

B—235 Lone Star Card Replacement

Revision 14-4; Effective October 1, 2014

TANF and SNAP

An EBT vendor or HHSC replaces a Lone Star Card when a cardholder has an open EBT account and cannot access the account because the person's Lone Star Card was lost or stolen or does not work properly.

If a primary or secondary cardholder reports a Lone Star Card is lost, stolen, damaged or not working, an EBT vendor mails the replacement card to the PCH's TIERS address within two calendar days of the request. If the TIERS address is not current, the help desk refers the individual to 2-1-1 to update the address.

In certain situations, the local office replaces Lone Star Cards. The same policies and procedures for replacing cards for PCHs apply to the secondary cardholders, except that the PCH must accompany the secondary cardholder to the local office to authorize the replacement, as required in B-232.2, Secondary Cardholder Established by Issuance Staff.

SNAP

In an effort to reduce trafficking, the EBT vendor tracks the number of replacement cards issued in a 12-month period. After the initial card issuance to a PCH or secondary cardholder, when a household requests four replacement cards within 12 months, the EBT vendor produces a report for the print vendor. The print vendor sends the household an excessive replacement card notice. The notice advises the household that:

- four replacement cards were issued in a 12-month period; and
- if the household requests a fifth replacement card, the Office of Inspector General (OIG) will receive notification and may investigate the case.

The notice also provides a reminder of what constitutes trafficking.

The excessive replacement card notice directs households to contact 2-1-1 for any questions regarding the notice. Households inquiring about the notice at local offices should be reminded of appropriate EBT card use and the penalties for trafficking.

The EBT vendor produces a monthly report for OIG identifying households that request a fifth replacement card.

B—235.1 Lone Star Card Replacement Procedures

Revision 18-1; Effective January 1, 2018

TANF and SNAP

When a cardholder contacts the local office to request a Lone Star Card replacement, advisors determine the correct action using the following chart:

If the card ...	then ...
does not work,	issuance staff inquire on the ATA to ensure the card is correctly connected to the account.
was destroyed in a household disaster as described in B-344, Destroyed Food,	issuance staff replace the card only if the household needs access to its account immediately and cannot wait for a replacement by mail. Verify the disaster as explained in B-344.
is lost or stolen,	refer the cardholder to the Lone Star Help Desk. Help-desk staff freeze the person's Lone Star Card and send a replacement by mail.*

* **Exceptions:** Issuance staff replace Lone Star Cards via the ATA for cardholders, including Centralized Benefit Services (CBS) recipients, if:

- the household is certified for a SNAP application that requires a priority issuance. The advisor refers the individual to issuance staff for an immediate replacement. To provide a written referral, the advisor may annotate in the comment section of Form TF0001, Notice of Case Action, "Priority Issuance — card replacement needed." The local office cannot require an appointment to replace the card in this situation.
- the individual cannot obtain a replacement from Lone Star Help Desk staff because the EBT system does not reflect the cardholder's correct biographical information or current mailing address.
- the household does not have a secure mailing address. A local eligibility determination office is not a secure mailing address for this purpose.
- the individual has not received a previously requested replacement from the Lone Star Help Desk within seven calendar days after the order date reflected on the ATA. Staff must highlight these replacements on Form H1173, EBT Card Issuance and PIN Self-Selection/Issuance Log, and report them to the regional director or designee at the end of each month.

When replacing Lone Star Cards, Form H1172 is not required. Issuance staff verifies the identity of the person requesting the replacement and logs the replacement on Form H1173. See Form H1173 instructions.

B—236 PIN Replacement

Revision 18-1; Effective January 1, 2018

TANF and SNAP

If the cardholder reports they forgot their PIN or that the PIN has been compromised, the cardholder should be referred to the Lone Star Help Desk AVR to select a PIN. If the cardholder is unable to self-select a PIN after two attempts, a help-desk operator offers to:

- provide training/assistance in the PIN self-selection process; or
- mail a PIN packet to the PCH's address if the individual has a barrier that prevents the individual from self-selecting a PIN.

If the cardholder is unable to self-select a PIN because incorrect biographical data was entered, the AVR refers them to 2-1-1 for PIN replacement.

B—236.1 PIN Replacement Procedures

Revision 18-1; Effective January 1, 2018

TANF and SNAP

When a cardholder requests a PIN replacement, advisors may use the procedures in the following chart:

If the cardholder ...	then ...
reports that their PIN is compromised or forgets their PIN,*	refer the cardholder to the Lone Star Help Desk to select their PIN through the AVR.

If the cardholder ...	then ...
reveals their PIN to staff,	issuance staff must immediately have the cardholder self-select a new PIN.

* **Exception:** Issuance staff use the ATA to replace the PIN with a vendor-mailed PIN packet if a cardholder has a barrier that prevents the individual from self-selecting a PIN, for these situations and in each situation described under the exceptions for card replacement.

B—237 Returned Lone Star Cards and PIN Packets

Revision 18-1; Effective January 1, 2018

TANF and SNAP

When Lone Star Cards or PIN packets are returned to the office, issuance staff logs the card/PIN packet as returned on the Void/Return Log. A person designated in the regional security procedures immediately destroys and disposes of the card/PIN packet before a witness. See the *Security and Accountability Handbook, Appendix VIII.*

If the Lone Star Card is returned ...	then the local office ...
in person,	• determines the reason for the return; and • takes the appropriate case action.
by mail,	takes the appropriate case action to ensure the address is current.

B—238 Erroneous PIN Entry

Revision 15-4; Effective October 1, 2015

TANF and SNAP

If someone makes five attempts in a 24-hour period to use a Lone Star Card with the wrong PIN, the system temporarily deactivates the card. This security measure helps to prevent fraudulent use of a stolen card. To reactivate the card:

- the cardholder must call the Lone Star Help Desk; or
- issuance staff reset the PIN count using the ATA.

B—239 Client EBT Training Policy

Revision 13-3; Effective July 1, 2013

TANF and SNAP

HHSC must instruct the cardholder about their rights and responsibilities related to EBT.

B—239.1 Advisor Interview Requirements for Client Training

Revision 18-1; Effective January 1, 2018

TANF and SNAP

The advisor gives the individual:

- Form H1184, Here Is Your Lone Star Card;
- Form H1185, Important Information About Your Lone Star Card; and
- the Second Cardholder request form.

The advisor also discusses the following issuance-related items with applicants during the interview, even if the application is pended:

- the need for a Lone Star Card and PIN as explained in B-233, Issuing a Lone Star Card, and B-234, Personal Identification Number (PIN) Selection and Issuance;
- how and where to use the Lone Star Card, including the use of TANF and/or SNAP benefits and keeping receipts;
- availability and procedures for designating secondary cardholders;
- availability of initial and ongoing benefits (circle/highlight the cardholder's specific TANF and/or SNAP availability date on Form H1184, Here Is Your Lone Star Card;
- Lone Star Card and PIN security and responsibility for benefits in the EBT account;
- when to contact the advisor/clerk vs. card issuance staff or the EBT vendor (point out written explanations on Form H1019, Report of Change, and on Form H1185, Important Infomation About Your Lone Star Card;
- dormant account procedures;
- cashing out TANF benefits before moving out of Texas and procedures for using the Lone Star Card to access TANF and/or SNAP benefits in other states as explained in B-351, Moves Out of State; and
- advising the individual to read the training pamphlet while waiting for card and/or PIN issuance and to ask issuance staff if the individual still has questions about EBT.

B—239.1.1 Client Fee Policy

Revision 18-1; Effective January 1, 2018

SNAP

For SNAP, there are no fees.

TANF

For TANF, there is never a fee for:

- a purchase;
- a cash withdrawal with a purchase;
- a cash only withdrawal under $50; or
- the first two cash-only withdrawals of $50 or more per cash account per calendar month.

The advisor uses Form H1184, Here Is Your Lone Star Card, to explain the TANF cash-back fee policy to the individual.

- After the second cash-only withdrawal of $50 or more in a calendar month, stores may choose to charge a fee of up to 50 cents for each additional cash-only withdrawal of $50 or more.
- The store subtracts the fee from the cash the cardholder requests.
- The cardholder may determine whether the store can charge a fee for a cash withdrawal based on the authorization number on the receipt. The following chart from Form H1184 may be used to explain this policy to the individual.

Lone Star Card Fees	
Using TANF to buy items.	No fee.
Getting cash back when using TANF to buy items.	No fee.
Taking $49 or less out of your TANF account.	No fee.
Taking $50 or more out of your TANF account.	Two free per month, then 50 cents each.

B—239.2 Issuance Staff Requirements for Client Training

Revision 18-1; Effective January 1, 2018

TANF and SNAP

Issuance staff gives the PCH or person interviewed a card sleeve.

When the local office establishes someone as a secondary cardholder, issuance staff provides the person with all the training materials, except the Second Cardholder request form.

Issuance staff also provides more detailed training if the cardholder requests it or does not understand how to use the Lone Star Card.

B—240 Special Certification Situations

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Advisors follow the procedures in this section for households with special needs.

Related Policy
Drug and Alcohol Treatment (D&A)/Group Living Arrangement (GLA) Facilities, B-440
Residents in Family Violence Shelters, B-450
Prepared Meal Services, B-460

B—241 Applications Processed by Hospital-Based Advisors

Revision 18-1; Effective January 1, 2018

TANF and SNAP

As specified in the regional security procedures, advisors use the following local office procedures for the EBT activities listed:

- Lone Star Card issuance and PIN self-selection/issuance – use procedures in B-233, Issuing a Lone Star Card, and B-234, Personal Identification Number (PIN) Selection and Issuance; and
- transmittal of PAN via Form H1172, EBT Card, PIN and Data Entry Request, to issuance staff for data entry.

B—242 Itinerant Advisor Site

Revision 15-4; Effective October 1, 2015

TANF and SNAP

As specified in the regional security procedures, use the following local office procedures for the EBT activities listed:

- Lone Star Card issuance and PIN self-selection/issuance – use procedures in B-233.2.4, Applicants Interviewed by Home Visit; and
- transmittal of PAN and, if applicable, PIN control number via Form H1172, EBT Card, PIN and Data Entry Request, to issuance staff for data entry.

B—242.1 Expedited Applications

Revision 18-1; Effective January 1, 2018

TANF and SNAP

If the person is entitled to expedited SNAP benefits, staff:

- issues the Lone Star Card and training material;
- asks the person to select a PIN through the Lone Star Help Desk AVR or issues a vendor-mailed PIN packet if they have a barrier that prevents them from self-selecting a PIN;
- obtains the individual's signature on Form H1172, EBT Card, PIN and Data Entry Request, to verify the PAN number of the Lone Star Card; and
- ensures:
  - the PCH record is created;
  - PAN is entered; and
  - benefits are issued the same day.

B—242.2 Card/PIN Replacements

Revision 18-1; Effective January 1, 2018

TANF and SNAP

If a person served by an itinerant advisor contacts the local office and qualifies for a replacement card and/or PIN from the local office, the person has two options for local office replacement:

- travel to the nearest eligibility determination office to get the replacement and self-select a PIN using the PIN pad device; or
- have the advisor bring a replacement during the next visit to the itinerant site. EBT staff records the replacement on Form H1173, EBT Card Issuance and PIN Self-Selection/Issuance Log, with an "R" code in the first column. The EBT clerk must data enter the replacement PAN and/or PCN into the ATA upon the advisor's return to the office.

Note: The person may also choose to obtain the replacement card via the Lone Star Help Desk and/or self-select a PIN through the help-desk AVR.

B—243 Centralized Benefit Services (CBS) Cases

Revision 15-4; Effective October 1, 2015

SNAP

Follow procedures in this section for CBS cases.

Related Policy
Centralized Benefit Services (CBS) Section, B-474

B—243.1 Centralized Benefit Services (CBS) Case Changes

Revision 15-4; Effective October 1, 2015

SNAP

Local office staff must not attempt to:

- issue benefits on a CBS case;
- make other changes to a CBS case; or
- make changes to the biographical data of a CBS individual.

When regional staff dispose a case when a SNAP-Supplemental Security Income (SNAP-SSI) or SNAP-Combined Application Project (SNAP-CAP) EDG is present, TIERS will not allow the advisor to dispose the CBS EDG. A task is generated for CBS staff to dispose the CBS EDG on the same day. If the client has lost SSI benefits, the EDG would no longer be considered SNAP-SSI or SNAP-CAP and can be disposed by non-CBS staff.

B—243.2 Initial Lone Star Card and PIN Issuance for New PCHs

Revision 13-3; Effective July 1, 2013

SNAP

CBS makes a change on a SNAP EDG requiring a new PCH record when a household:

- is assigned a new EDG name; or
- moves in or out of a D&A treatment center or GLA that serves as an AR.

When CBS sends a new Supplemental Nutrition Assistance Program Combined Application Project (SNAP-CAP) PCH record to the EBT system, the EBT vendor responsible for card issuance automatically mails the new cardholder a Lone Star Card, PIN, and training material.

CBS staff also have the capability to send a request through the ATA, which authorizes the EBT vendor to mail a Lone Star Card and EBT training materials (and PIN packet, if desired) to a new PCH.

B—243.3 Lone Star Card Replacement

Revision 15-4; Effective October 1, 2015

SNAP

When a CBS case cardholder requests a Lone Star Card replacement, the individual must call the Lone Star Help Desk to request a replacement by mail.

Exception: CBS individuals may obtain replacement Lone Star Cards in the local office if they meet those replacement criteria. See B-235.1, Lone Star Card Replacement Procedures.

B—243.4 PIN Replacement

Revision 18-1; Effective January 1, 2018

SNAP

When a CBS case cardholder requests a PIN replacement, they must call the Lone Star Help Desk AVR to select a new PIN.

If the cardholder is unable to self-select a PIN after two attempts, a help-desk operator offers to:

- provide training/assistance in the PIN self-selection process; or
- mail a PIN packet to the PCH's address if the cardholder has a barrier that prevents them from self-selecting a PIN.

B—244 Homeless

Revision 15-4; Effective October 1, 2015

TANF and SNAP

If the office permits homeless individuals to use the local eligibility determination office as their mailing address, the office must follow their regional security procedures to process EBT-related mail. Staff must also advise these individuals to come to the local office if they require a Lone Star Card or PIN replacement.

SNAP

Homeless individuals may use SNAP benefits to purchase prepared meals. Procedures are included in B-462, Prepared Meals for Homeless.

B—245 SNAP Applications Filed with the Social Security Administration (SSA)

Revision 13-3; Effective July 1, 2013

SNAP

The advisor must follow procedures for phone interviews. See B-233.2.2, Applicants Interviewed by Phone.

B—250 EBT Benefit Issuance

Revision 05-4; Effective August 1, 2005

TANF and SNAP

HHSC credits benefits to the cash or food account by sending a benefit record to the EBT system. This section describes the availability of those benefits for use by the cardholder.

B—251 Monthly Benefit Issuance Schedule

Revision 13-3; Effective July 1, 2013

TANF and SNAP

HHSC sends the files of benefit records for monthly issuances to the EBT system after cutoff each month.

TANF

TANF monthly benefits issued via EBT are available on a staggered basis over the first three days of the month, based on the last number in the EDG number, as follows:

Last digit of TANF EDG number	Day
0, 1, 2, 3	1
4, 5, 6	2
7, 8, 9	3

SNAP

SNAP monthly benefits are available on a staggered basis over the first 15 days of the month, based on the last number in the EDG number, as follows:

Last digit of the SNAP EDG number	Day
0	1
1	3
2	5
3	6
4	7
5	9
6	11
7	12
8	13
9	15

B—252 Benefit Issuance on Applications

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Advisors provide benefits according to the timeliness standards in B-112, Deadlines. Benefit issuances for certified applications are available immediately upon being credited to the account. Benefits requested after cutoff for the next month are available on the first day of the next month, except for SNAP-combined allotments.

SNAP

The advisor may issue EBT SNAP benefits very quickly in situations that meet the HHSC criteria for a priority issuance. Advisors may request priority issuances only for SNAP benefits in three situations:

- expedited applications,
- regular applications certified on or after the 25th day, and
- benefits ordered by a hearing officer decision that requires a priority issuance to meet timeliness requirements.

The system credits benefits to the individual's account within one hour.

B—253 Methods for Sending Benefit Records

Revision 15-4; Effective October 1, 2015

TANF and SNAP

A benefit record may be sent two ways to the EBT system. TANF benefit records are sent only from TIERS. SNAP benefit records are normally sent only from TIERS, but priority issuances may also be sent by manual ATA entry.

1. TIERS — This is the primary method of sending TANF and SNAP benefit records to the EBT system to credit a benefit to the individual's account.

- Real time interface – credits the account right away, or
- Overnight batch file – credits the account by the next day.

2. Manual ATA entry — Use this process only to issue priority SNAP benefits when TIERS is unavailable.

Note: Manual ATA entry must have supervisor approval.

TANF and SNAP

When the advisor certifies an application, the EBT system credits:

- SNAP priority issuances to the individual's account within one hour after EDG disposition; and
- TANF benefits and SNAP benefits that are not priority issuances to the individual's account by 8 a.m. CST the day after the EDG is disposed.

B—254 Benefit Issuance When TIERS Is Unavailable

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Two types of "TIERS unavailable" cases are:

- TIERS Down – TIERS is completely unavailable and the application/case cannot be accessed.
- TIERS Read-Only – TIERS is in read-only mode and workers can access TIERS.

When TIERS is Down or is Read-Only, staff must:

- perform the interview;
- manually complete essential information on appropriate handbook forms;
- provide the client with manual notice; and
- enter information into TIERS Data Collection pages once TIERS becomes available.

B—254.1 Priority Issuances

Revision 15-4; Effective October 1, 2015

SNAP

When TIERS is Down or is Read-Only, staff must:

- obtain the individual's signature on Form H1855, Affidavit for Nonreceipt or Destroyed Food Stamp Benefits;
- complete Form H1175, Authorization for Administrative Terminal Application Action, for ATA entry;
- receive approval by supervisor and EBT regional coordinator; and
- send all case-related information and forms to the Data Processing Center for imaging.

When TIERS becomes available (fully operational), staff must complete data entry of case materials in TIERS and follow the normal flow for missing information received after an interview.

Staff designated in the regional security procedures must reconcile ATA benefit record entries.

B—255 Priority Issuances Using the Administrative Terminal Application (ATA)

Revision 15-4; Effective October 1, 2015

SNAP

To send the benefit record via ATA data entry, the advisor:

- obtains the individual's signature on Form H1855, Affidavit for Nonreceipt or Destroyed Food Stamp Benefits;
- completes Form H1175, Authorization for Administrative Terminal Application Action, for ATA entry; and
- receives approval by supervisor and EBT regional coordinator.

Staff designated in the regional security procedures must reconcile ATA benefit record entries.

B—256 Discrepancies on Benefit Records Sent via the ATA

Revision 15-4; Effective October 1, 2015

SNAP

When there is a discrepancy between the benefit records in TIERS and the EBT system, advisors may use the following chart to determine how actions are processed in TIERS and the EBT system:

If the benefit amount reported to TIERS is ...	then ...
more than the amount authorized on the ATA,	the EBT system updates the household's benefit account to reflect the amount reported in TIERS.
less than the amount authorized on the ATA,	TF-07E-01, EBT Reconciliation Exception Report, is produced and sent to the EBT regional coordinators for distribution.

Related Policy
TF-07E-01, EBT Reconciliation Exception, B-262.5
Advisor Action on TF-07E-01, B-262.5.1

B—260 Administrative Terminal Application (ATA)

Revision 13-3; Effective July 1, 2013

TANF and SNAP

The ATA allows direct access to the EBT system through a web-based program. Designated staff, other than the EBT clerk, must completeForm H1172, EBT Card, PIN and Data Entry Request, or Form H1175, Authorization for Administrative Terminal Application Action, to authorize action on the ATA.

B—261 ATA Functions

Revision 02-1; Effective January 1, 2002

TANF and SNAP

Designated staff uses the ATA to perform authorized functions. There are multiple functions that can be performed using the ATA; therefore, there are multiple levels of access secured by individual sign-on IDs.

B—261.1 Issuing a Lone Star Card and PIN or Enabling PIN Self-Selection

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Designated local office staff uses the ATA to issue Lone Star Cards and/or PINs or enable PIN self-selection when:

- establishing a new PCH,
- replacing a Lone Star Card and/or PIN, or
- establishing a secondary cardholder in the local office.

The advisor completes Form H1172, EBT Card, PIN and Data Entry Request, Part I, to:

- request issuance of a Lone Star Card, and/or
- indicate that the cardholder will select their PIN, or
- request issuance of a PIN.

B—261.2 Creating a Cardholder Record

Revision 13-3; Effective July 1, 2013

TANF and SNAP

Designated staff uses the ATA to create a secondary cardholder record in the local office.

The advisor completes Form H1175, Authorization for Administrative Terminal Application Action, Part I, to establish a new cardholder record via the ATA.

B—261.3 Splitting and Merging Primary Cardholder Records

Revision 13-3; Effective July 1, 2013

TANF and SNAP

Designated local office staff uses the ATA to split and/or merge PCH records.

B—261.3.1 Splitting Primary Cardholder Records

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Designated staff uses the ATA to split primary cardholder records when EBT accounts are incorrectly linked.

EBT accounts may be incorrectly linked when the advisor fails to correctly reassign a denied TANF EDG number. As a result, the EBT system links the food account to a cash account with a denied EDG number.

The advisor completes Form H1175, Authorization for Administrative Terminal Application Action, Part IV, to request that designated staff separate the incorrectly linked accounts.

B—261.3.2 Merging Primary Cardholder Records

Revision 18-1; Effective January 1, 2018

TANF and SNAP

Designated local office staff uses the ATA to merge PCH records when the EBT system cannot link them because of discrepancies in the cardholder's biographical data.

Discrepancies may occur in the cardholder's biographical data when the advisor does not correctly match the EDG name, date of birth (DOB), sex, or SSN on an individual's TANF and SNAP EDG. As a result, the EBT system cannot merge the two PCH records into one record with a link to both accounts and the cardholder needs a Lone Star Card for each account.

If the individual wants to use one card to access both accounts, the advisor completes Form H1175, Authorization for Administrative Terminal Application Action, Part V, to authorize the merge. When the cardholder has one card for the cash account and another for the food account before the merge, the ATA user indicates which card the individual wants to use. After completing the merge, the EBT system automatically disables the card not chosen and it must be destroyed.

Note: Advisors must not attempt a merge if the individual has any outstanding manual voucher purchases that must be reconciled by the EBT vendor. If the ATA displays the message, "NEED TO SETTLE OUTSTANDING VOICE AUTHORIZATION," the advisor should notify the EBT site coordinator.

B—261.4 Updating a Primary Cardholder Record

Revision 13-3; Effective July 1, 2013

TANF and SNAP

When data on the PCH record needs to be updated on the EBT system, issuance staff use the ATA to update it if the cardholder's EDG is no longer active in TIERS.

The advisor completes Form H1175, Authorization for Administrative Terminal Application Action, Part III, to authorize the PCH record update via the ATA.

B—261.5 Creating a SNAP Benefit Record

Revision 01-7; Effective October 1, 2001

SNAP

HHSC strictly limits the use of the ATA for SNAP benefit authorization to system downtime that prevents the timely issuance of priority SNAP benefits, or as specified in the regional security procedures.

Advisors must complete Form H1175, Authorization for Administrative Terminal Application Action, Part II, to authorize benefit data entry into the ATA following established sign-off procedures.

Designated staff completes ATA data entry only after receipt of Form H1175.

B—261.6 Performing ATA Inquiry

Revision 01-7; Effective October 1, 2001

TANF and SNAP

Designated local office staff uses the ATA to perform benefit record inquiry or validate that a particular Lone Star Card is active. The advisor completes Form H1172, EBT Card, PIN and Data Entry Request, Part I, to request validation of a previously issued Lone Star Card.

Designated regional staff uses the ATA to perform transaction history inquiry.

B—261.7 Changing an EDG Number

Revision 18-1; Effective January 1, 2018

TANF and SNAP

EDG numbers cannot be changed, but multiple EDGs can be entered and connected to the same card.

B—261.8 Requiring Card Registration or Registering a Lone Star Card

Revision 01-3; Effective April 1, 2001

TANF and SNAP

This section explains when designated local office staff uses the ATA to require card registration or register a Lone Star Card.

B—261.8.1 Requiring Card Registration

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Designated local office staff uses the ATA to require card registration when:

- issuing a card to someone other than the PCH, or
- mailing a card.

B—261.8.2 Registering a Lone Star Card

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Designated local office staff uses the ATA to register a Lone Star card if using the special procedures for a PCH with a barrier that prevents the PCH from registering his card through the regular Lone Star Help Desk process.

If ...	then ...
• issuing a card to someone other than the PCH, or • mailing a card,	the advisor completes Form H1172, EBT Card, PIN and Data Entry Request, Part I, indicating that card registration is required.
using the special procedures for a PCH with a barrier that prevents him from registering his card through the regular help desk process,	the local office EBT site coordinator or designated staff, other than the EBT clerk, completes Form H1175, Authorization for Administrative Terminal Application Action, Part VI, to authorize registration.

B—261.9 Reactivating a Lone Star Card

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Lone Star Help Desk staff or designated local office staff uses the ATA to reset the PIN count and reactivate a card that was deactivated because the cardholder entered the wrong PIN five times in a 24-hour period.

B—262 Reconciliation

Revision 01-7; Effective October 1, 2001

This section provides general information about reconciliation. For details, see the *Security and Accountability Handbook.*

B—262.1 Reconciling Administrative Terminal Application (ATA) Benefit Records to Forms H1175

Revision 15-4; Effective October 1, 2015

SNAP

Each day EBT staff designated in the regional security procedures prints the local Administrative Terminal Report. This report contains a list of benefit records manually entered on the ATA, sorted by ATA user. A designated individual(s) must check these entries against Form H1175, Authorization for Administrative Terminal Application Action, on a daily basis to ensure accuracy.

B—262.2 Reconciling Benefit Records

Revision 14-2; Effective April 1, 2014

SNAP

Each day EBT staff use the list of benefit issuances on the Administrative Terminal Report to reconcile the ATA benefit record entries with Form H1175, Authorization for Administrative Terminal Application Action, within five days to correspond to the benefit records sent via the ATA, state office sends exception reports (TF-07E-01/TG-37E-1) to field offices to clear within established time frames. Regional monitoring and tracking procedures apply.

To avoid exception reports, EBT staff must ensure that advisors report issuances via TIERS within three working days.

B—262.3 Reconciling ATA Card Issuances to Form H1172

Revision 01-7; Effective October 1, 2001

TANF and SNAP

Each day, designated staff uses the list of card issuances on the Administrative Terminal Report to reconcile cards issued with Form H1172, EBT Card, PIN and Data Entry Request.

If the office has problems reconciling these, staff report the problem to the supervisor and to the regional EBT security staff, if necessary, to complete reconciliation.

B—262.4 TF-36, More Than One SNAP Benefit Authorized

Revision 13-3; Effective July 1, 2013

SNAP

After all issuances for a benefit month have been reconciled, state office produces TF-36 and sends copies to the Fiscal Division and the regional director.

B—262.4.1 Advisor Action on TF-36

Revision 15-4; Effective October 1, 2015

SNAP

Advisors review each SNAP EDG listed on the report to determine how the duplicate issuance occurred (individual error, suspected fraud, coding error), and if applicable, whether the household correctly completed Form H1855, Affidavit for Nonreceipt or Destroyed Food Stamp Benefits, before the duplicate issuance.

If there is an overpayment and ...	then ...
a signed Form H1855,	submit Form H4834, Individual or Recipient Provider Fraud Referral/Status Report, with the original Form H1855 to the regional Office of Program Integrity, Claims Investigation.
no signed Form H1855,	initiate a nonfraud recovery. Refer to B-730, How to File an Overpayment Referral.

After each multiple issuance is reviewed, report individual case findings and recovery actions to the regional TF-36 coordinator.

B—262.5 TF-07E-01, EBT Reconciliation Exception

Revision 14-2; Effective April 1, 2014

SNAP

When an ATA issuance cannot be reconciled with the TIERS database, state office generates and sends a TF-07E-01 to the supervisor of the employee who processed the last case action. This report serves as the clearance document to report case findings and actions taken.

B—262.5.1 Advisor Action on TF-07E-01

Revision 15-4; Effective October 1, 2015

SNAP

Advisors check the case record to determine:

- the reason for the reconciliation exception, and
- whether the amount of benefits provided to the household is correct.

If the amount of benefits is incorrect because of an ...	then ...
overpayment,	initiate recovery. See B-730, How to File an Overpayment Referral.
underpayment,	restore benefits. See B-800, Restored Benefits.

B—263 Security

Revision 01-3; Effective April 1, 2001

TANF and SNAP

HHSC allows only authorized staff with special permissions to enter data onto the ATA. Staff are designated by office and they must ensure that information entered remains confidential.

HHSC controls the level of access by the sign-on ID of the individual user. Designated employees have authorizations that allow updates to all or part of the system. Other users have inquiry access only.

Refer to the *Security and Accountability Handbook* for additional information on security.

B—270 Management of Automation Processes

Revision 13-3; Effective July 1, 2013

The EBT regional coordinator for each region reviews information for each user on a monthly basis and provides verification to Lone Star Business Services by the 15th of each month.

B—280 EBT Material Inventory/Distribution

Revision 04-7; Effective October 1, 2004

B—281 Vendor-Produced Material

Revision 18-1; Effective January 1, 2018

An EBT vendor provides supplies of most EBT-related materials, including:

- Lone Star Cards;
- PIN packets;
- Lone Star Card registration stickers;
- Lone Star Card mailers;
- Lone Star Card sleeves;
- Form H1184, Here Is Your Lone Star Card;
- Form H1185, Important Information About Your Lone Star Card; and
- Secondary cardholder request forms.

To order vendor-produced items, designated local office staff completes a request for Lone Star materials and sends it to the EBT regional coordinator for secure and non-secure items.

The EBT regional coordinator or authorized regional staff emails the order to the vendor and Lone Star Business Services. Refer to the *Security and Accountability Handbook* for specific requirements for security and accountability of Lone Star Cards.

TWH, B-300, Account Maintenance

Revision 18-1; Effective January 1, 2018

B—310 General Policy

Revision 13-3; Effective July 1, 2013

TANF and SNAP

After HHSC certifies an Eligibility Determination Group (EDG), the advisor uses specific procedures to maintain the Electronic Benefit Transfer (EBT) account and resolve problems.

For information about establishing accounts, see B-200, Issuing Benefits.

B—330 Cancelling Benefits

Revision 04-3; Effective April 1, 2004

B—331 Cancelling Benefits in EBT Accounts

Revision 13-3; Effective July 1, 2013

TANF and SNAP

When a Temporary Assistance for Needy Families (TANF) or Supplemental Nutrition Assistance Program (SNAP) household moves out of state before the end of the month, advisors must cancel the next month's benefits.

TANF

When a TANF household moves out of state on or after the first of the month but before accessing that month's TANF benefits, the cardholder should use the Lone Star Card to access the TANF benefits at retailers in other states. See B-350, Using Benefits Out of State.

If the cardholder cannot find a retailer that accepts the Lone Star Card, HHSC may mail a benefit conversion warrant (full month's benefit amount only) to the household's new address. The advisor determines if the household accessed that month's benefits via Administrative Terminal Application (ATA) inquiry. Determine if the household accessed that month’s benefits by performing Administrative Terminal (AT) inquiry.

When the agency receives the report of the move:

- deny the EDG, and
- advise the individual to withdraw the balance from the EBT account.

Use the following chart to determine the correct action on the next month's benefits.

If the household is ...	then ...
ineligible for the next month's benefits because the household left the state before the end of the previous month,	cancel the next month's benefits.

eligible for the next month's benefit but unable to use the Lone Star Card out of state,	• cancel the next month's benefits, and • reissue with a warrant to the new address.

Do not consider a benefit cancelled until you confirm it as cancelled via TIERS inquiry.

See A-2533.1, Deleting Months When TANF Benefits are Cancelled or Recouped, when cancelling benefits for an individual whose months count toward a time limit.

SNAP

HHSC cannot cancel benefits in a food account once the availability date is reached.

When the agency receives a report that the individual moved out of state, follow policy in A-740, Moves Out of Texas, and A-750, Temporary Visits Out of Texas, to determine whether to consider the move temporary or permanent. If the move is permanent, deny the EDG.

The cardholder can use the Lone Star Card to access benefits at retailers in other states. See B-350.

Use the TIERS Benefit Issuance – Maintain EBT Benefits – EBT Cancellation pages to cancel the next month's benefits.

Do not consider a benefit cancelled until it is confirmed as cancelled via TIERS inquiry.

B—332 Cancelling Benefits Not Issued by EBT

Revision 13-3; Effective July 1, 2013

TANF

If an individual returns a warrant,

- give the individual the original Form H4100, Money Receipt; and
- send the first copy of Form H4100, the warrant, and Form H1008-A, Warrant Inquiry/EBT Benefit Conversion and Affidavit for Non-receipt of Warrant, explaining the reason for the returned warrant to Fiscal Management, Mail Code 3500.

B—340 Replacing Benefits

Revision 13-3; Effective July 1, 2013

TANF and SNAP

HHSC issues benefits via warrant or EBT. Staff replaces TANF warrants in certain situations and TANF or SNAP benefits issued via EBT in rare situations.

Related Policy
Destroyed Food, B-344

B—341 Replacement of Benefits Issued via EBT

Revision 04-3; Effective April 1, 2004

TANF and SNAP

EBT systems and procedures are designed to minimize loss and theft of individual benefits. As a result, HHSC is rarely liable for a replacement due to loss of benefits from an EBT account.

HHSC replaces benefits issued via EBT when lost through unauthorized use of the account only if the loss occurred:

- after the individual reports the Lone Star Card lost or stolen;
- because of local eligibility determination office card/PIN issuance error; or
- because of an unlawful or other erroneous action on the part of HHSC or an HHSC contractor.

Do not replace benefits withdrawn from an account before the individual reports the Lone Star Card lost or stolen.

B—341.1 Procedures for Replacing EBT Benefits

Revision 18-1; Effective January 1, 2018

TANF and SNAP

If a person receiving EBT reports benefits are stolen or lost from the individual's EBT account, refer the person to the Lone Star help desk. The help desk staff researches the account credits and debits and works with state office staff to determine if any unauthorized use occurred. If state office staff determines a replacement is due because of unauthorized access or card issuance error, the replacement is authorized. See B-382.2, Balance Disputes, for resolution procedures.

If a loss occurs because of a card/PIN issuance error, go through regional channels to contact state office Lone Star Business Services (LSBS) by email at EBT_Operations@hhsc.state.tx.us.

B—342 Non-Receipt of TANF Warrants

Revision 13-3; Effective July 1, 2013

TANF

If an individual reports that a warrant was lost, stolen, or not received, check TIERS inquiry to see if the warrant was returned to Fiscal Management Services (FMS). If necessary, update the individual’s address in TIERS.

When the warrant is returned to state office, FMS staff checks inquiry for a new address and immediately re-mails the check.

B—342.1 Procedures for Replacing TANF Warrants

Revision 13-3; Effective July 1, 2013

TANF

Send Form H1008-A, Warrant Inquiry/EBT Benefit Conversion and Affidavit for Non-Receipt of Warrant, to FMS if:

- the individual does not receive the warrant by the 10th day after HHSC mailed it; and
- inquiry shows the warrant was not returned to FMS.

Exception: Send Form H1008-A immediately if it is obvious that a warrant was stolen or destroyed. Indicate under "Comments" the reason for this special processing request.

The advisor may:

- fax Form H1008-A to FMS at 512-487-3400; or
- send Form H1008-A via email. See the Electronic Transmittal section of Form H1008-A instructions for email addresses.

To check on the status of Form H1008-A, the advisor may call Fiscal Management at 512-487-3435.

After receiving Form H1008-A, FMS:

- completes TIERS inquiry to verify warrant information/status; and
- obtains the warrant payment status from the State Comptroller.

B—342.1.1 Warrant Not Cashed

Revision 13-3; Effective July 1, 2013

TANF

If the warrant was not returned to FMS or cashed, FMS:

- notifies the State Comptroller to cancel the warrant;
- receives notification from the State Comptroller when the warrant is cancelled; and
- issues a replacement warrant. The word "Replacement" is printed in the upper right corner above the warrant number on the face of the warrant. TIERS inquiry identifies replacement warrants in Benefits Issuance under Issuance Status as “Issued” and Benefit Type as “Replacement."

If the individual reports receipt of the original warrant after the advisor sends Form H1008-A, Warrant Inquiry/EBT Benefit Conversion and Affidavit for Non-receipt of Warrant, call FMS at 512-487-3435 to discontinue the inquiry/replacement process. Instruct the individual not to cash the warrant until Fiscal Division notifies the advisor that it discontinued the replacement process.

B—342.1.2 Warrant Cashed

Revision 13-3; Effective July 1, 2013

TANF

If the warrant was cashed, Fiscal Division:

- updates warrant status in TIERS; and
- sends the advisor:
  - a cover memo with instructions;
  - a copy of the warrant;
  - Form 6059-A, Determination of the Validity of a Forgery Claim; and
  - Form 6059-B, Affidavit of Forgery.

The advisor:

- investigates to determine if the warrant was forged and if the individual received the benefit from the warrant; and
- completes Form 6059-A to document the determination.

If the advisor determines the warrant was ...	then the advisor ...
forged,	• completes Form 6059-B • requests that the individual sign the form, and • returns Forms 6059-A and B to FMS.
not forged,	sends only Form 6059-A to FMS.

FMS:

- requests that the State Comptroller charge the warrant back to the original cashing establishment;
- updates the TIERS warrant history when the Comptroller notifies HHSC that the warrant was charged back;

- prepares and submits a cancellation voucher to the State Comptroller;
- updates the TIERS warrant history when the Comptroller notifies HHSC that warrant was cancelled; and
- issues a replacement warrant.

B—343 Non-Receipt of One-Time Payments

Revision 01-3; Effective April 1, 2001

TANF

If a household reports nonreceipt of a one-time payment, use the procedures in this section to reissue the benefits.

B—343.1 Reissuing Grandparent Payments

Revision 01-3; Effective April 1, 2001

TANF

If a household reports it did not receive the one-time grandparent payment, the advisor:

- completes Form H1084, Certification for Warrants Lost, Destroyed, Stolen, or Not Received;
- requires the grandparent caretaker/payee to sign the certification on the form; and
- sends it to FMS.

B—343.2 Reissuing OTTANF Benefits

Revision 12-1; Effective January 1, 2012

TANF

Use Form H1008-A, Warrant Inquiry/EBT Benefit Conversion and Affidavit for Non-Receipt of Warrant, to request reissuance of lost or stolen OTTANF warrants.

The advisor may fax Form H1008-A to FMS at 512-487-3400. Write "OTTANF" across the top of the form.

B—344 Destroyed Food

Revision 01-5; Effective July 1, 2001

SNAP

A household disaster may result from a fire, flood, tornado, accident, or other similar events that affect only that household or any number of households. Do not consider damage or destruction resulting from household neglect, such as damaged caused by pets or children, as a disaster.

When the individual reports that food purchased with SNAP benefits was destroyed in a household disaster, issue a replacement unless

- the individual failed to report the loss within 10 days of the food being destroyed; or

- the individual was issued an allotment under special Food and Nutrition Service (FNS)-approved disaster-issuance procedures in the same month as the replacement request.

There is no limit on the number of replacements for destroyed food.

B—344.1 Procedures for Replacing Destroyed Food

Revision 13-3; Effective July 1, 2013

SNAP

To issue a replacement for destroyed food, take the following steps:

Step	Action
1	Require the head of household, spouse, or responsible household member to sign Form H1855, Affidavit for Nonreceipt of/Destroyed Food Stamp Benefits. The advisor may mail Form H1855 to the individual for signature if no responsible household member can come to the office because of • age or disability, or • distance (that is, the individual lives more than 30 miles from the office) and the individual is unable to appoint an authorized representative to bring the form to the office. Issue a replacement only when the local office receives the completed and signed Form H1855 within 10 days of the request for replacement.
2	Verify the disaster and date by contacting a collateral source, such as the fire department or Red Cross, or by visiting the individual's home.
3	Issue a replacement benefit via TIERS – Benefit Issuance – Request Manual Issuance. **Note:** Authorized staff receive an alert to approve the issuance.

B—350 Using Benefits Out of State

Revision 18-1; Effective January 1, 2018

TANF

Texans who leave the state should be able to use the Lone Star Card to access TANF benefits at retailers in other states.

People from other states may use EBT cards to access TANF benefits at retailers in Texas. When local office staff receive inquiries, advise the cardholder to try the card at stores that accept EBT cards in Texas. If it does not work, advise the person to contact the help desk of the state that issued the card.

SNAP

Texans who leave the state can use the Lone Star Card to access SNAP benefits at retailers in other states.

People from other states may use their EBT cards to access SNAP benefits at retailers in Texas. When local office staff receive inquiries, advise the cardholder to try the card at stores in Texas that accept SNAP benefits. If it does not work, advise the person to contact the help desk of the state that issued the card.

B—351 Moves Out of State

Revision 13-3; Effective July 1, 2013

TANF

If the household reports a move or temporary absence from Texas, follow the policy in A-740, Moves Out of Texas, and A-750, Temporary Visits Out of Texas, to determine whether to consider the move temporary or permanent.

The cardholder should be able to use the Lone Star Card to access benefits at retailers in other states. Advise the individual of the following:

- Withdraw any amount of benefits remaining in the cash account before leaving.
- Take your Lone Star Card.

  Note: If the individual reports that the individual does not have a Lone Star Card, advise the individual to contact the Lone Star Help Desk.

- In order to use cash benefits that were not accessible before the move, try the card at stores that accept EBT in other states. Ask if the store charges a fee and the amount of the fee. Verify and accept any fees before completing the cash withdrawal.
- Call the Lone Star Help Desk at 1-800-777-7EBT (1-800-777-7328) if your Lone Star Card does not work. The Lone Star Help Desk assists the cardholder in finding an out-of-state retailer that accepts the Lone Star Card. **Note:** If the cardholder cannot find a retailer that accepts the Lone Star Card and moved out of state on or after the first of the month but before accessing that month's TANF benefits, HHSC may mail a benefit conversion warrant (full month's benefit amount only) to the household's new address. The Lone Star Help Desk will advise these cardholders to contact the local eligibility determination office. See B-331, Cancelling Benefits in EBT Accounts.

SNAP

If the household reports a move or temporary absence from Texas, follow the policy in A-740 and A-750 to determine whether to consider the move temporary or permanent.

The cardholder can use the Lone Star Card to access benefits at retailers in other states. Advise the individual of the following:

- Take your Lone Star Card.

  Note: If the individual reports that the individual does not have a Lone Star Card, advise the individual to contact the Lone Star Help Desk.

- In order to use SNAP benefits, try the card at stores that accept SNAP in other states.
- Call the Lone Star Help Desk at 1-800-777-7EBT (1-800-777-7328) if your Lone Star Card does not work. The Lone Star Help Desk assists the cardholder in finding an out-of-state retailer that accepts the Lone Star Card.

B—352 Households Shopping Out of State

Revision 13-3; Effective July 1, 2013

TANF and SNAP

Cardholders can use the Lone Star Card out of state. As a result, some households may continue to use benefits without reporting an out-of-state move. Households receiving benefits in Texas who shop out of state consistently, without shopping in Texas, may no longer meet residency requirements. See A-740, Moves Out of Texas, and A-750, Temporary Visits Out of Texas.

B—353 Out-of-State Shopping (OSS) Reports

Revision 13-3; Effective July 1, 2013

TANF and SNAP

State office produces a Non-Border OSS Report and a Border OSS Report monthly. Both reports list Lone Star Card usage for households that:

- shopped out of state in the last 60 days;
- did not shop in Texas during that period; and
- have active EDGs.

The Border OSS Report lists households with Lone Star Card usage in states that border Texas (Arkansas, Louisiana, Oklahoma and New Mexico). The Non-Border OSS Report lists households with Lone Star Card use in states that do not border Texas.

State office sends the Non-Border OSS report to Eligibility Operations each month for appropriate action as a potential change in Texas residence. This data also is included in a combined Data Broker report if the OSS occurred in the prior 12 months.

The Border OSS Report is not sent to Eligibility Operations each month for clearance. The data is included in a combined Data Broker report if the OSS occurred in the prior 12 months. EDGs that appear on the Border OSS Report must be cleared at a complete action after a household submits an application or redetermination.

B—353.1 Advisor Action on OSS Report Activity

Revision 13-3; Effective July 1, 2013

TANF and SNAP

Clearing Non-Border OSS Report Activity as a Change Action

Send the household Form H1020, Request for Information or Action, requesting verification of the household's address.

Exception: Clearing Non-Border OSS activity as a change action is not required when the household's most recent OSS activity occurred in the:

- month prior to the periodic review month or in the periodic review month of the household's TANF Eligibility Determination Group (EDG); or
- next to last benefit month or last benefit month of the household's SNAP EDG.

Clearing Non-Border OSS Report Activity at a Complete Action

The household must provide verification of the household's address when:

- the most recent OSS occurred within six months of the current interview/desk review month and
- the OSS occurrence listed in the report was not previously cleared.

The interview/desk review month is month zero.

Note: Take action on any associated Medical Program EDG.

After a household has been asked to provide verification of the household's address, take the following action.

If the ...	then ...
household provides verification of the household's address,	determine continued eligibility for all programs based on residency requirements.
household does not provide verification of the household's address,	deny the SNAP EDG and any associated TANF/Medical Program EDGs for failure to provide verification.
agency receives returned mail with no forwarding address and the household cannot be located,	deny the SNAP EDG and any associated TANF/Medical Program EDGs for unable to locate.

Clearing Border OSS Report Activity

The requirement to clear the Border OSS Report only applies at a complete action. This report must be cleared at a complete action when a household submits an application or redetermination and the OSS activity in the report makes the household's address questionable.

Example: A household living in Texas near the Arkansas border and shopping in Arkansas may not be questionable. A household living in Austin and shopping in Arkansas would be questionable.

When a household's address is questionable, follow the policy outlined above for clearing a Non-Border OSS Report Activity at a Complete Action. If necessary, send the household Form H1020, Request for Information or Action, requesting verification of the household's address.

B—354 Card Replacements for Cardholders Who Are Out of State

Revision 13-3; Effective July 1, 2013

TANF and SNAP

If a Texas individual who is out of state reports that the individual's Lone Star Card was lost or stolen, advise the individual to contact the Lone Star Help Desk at 1-800-777-7EBT (1-800-777-7328).

B—360 Dormant Accounts

Revision 13-3; Effective July 1, 2013

B—361 Dormant Account Policy

Revision 13-3; Effective July 1, 2013

TANF and SNAP

The EBT system changes an account status to dormant when a cardholder does not access the account for a specified period depending on:

- the type of benefits; and
- if applicable, the monthly benefit amount.

The EBT system notifies TIERS when changing the account status to dormant. TIERS does not place the EDG in suspense status if the EBT account becomes dormant.

The cardholder has access to the EBT account after it is dormant.

TANF

The EBT system changes an account status to dormant when a cardholder does not access the account for three months.

SNAP

The EBT system changes an account status to dormant if a cardholder does not access the account for:

- three months; or
- six months, when the household received an issuance of less than $20 for the previous calendar month.

B—362 Advisor Action on Dormant Accounts

Revision 13-3; Effective July 1, 2013

TANF and SNAP

Advisors take no action on EBT accounts that become dormant.

Exception: For Supplemental Nutrition Assistance Program Combined Application Project (SNAP-CAP) EDGs, if the advisor verifies the EBT account is dormant, the advisor must attempt to contact the individual to determine if the individual is having trouble accessing the benefits. Advisors mail Form H1030, Supplemental Nutrition Assistance Program (SNAP) Lone Star Card Assistance.

If the individual fails to contact the advisor by the due date on Form H1030, the advisor must attempt to contact the individual by telephone. If the individual does not respond to either Form H1030 or to telephone calls, advisors take no further action. Advisors must document all attempts to contact the individual.

Related Policy
Shortening Certification Periods as a Result of a Change, B-638

B—370 Expunged Benefits

Revision 13-3; Effective July 1, 2013

TANF and SNAP

Expungement is a process in which HHSC removes unused TANF or SNAP benefits from an EBT account and returns them to the state or federal government.

B—371 Expungement Policy

Revision 13-3; Effective July 1, 2013

TANF

HHSC expunges TANF benefits if:

- the household does not access its cash account for one year (The entire balance is removed.); or
- benefits remain in an active or dormant account past their availability period.

The availability period is two fiscal years after the benefit was issued. HHSC expunges these benefits at the end of each fiscal year (August 31).

SNAP

HHSC expunges:

- SNAP benefits remaining from a particular month's issuance when the:
  - household does not access the account for one year; and
  - benefit was issued more than one year before the expungement file is processed; or
- the entire food account when the advisor denies a one-person household because of death.

B—372 Advisor Procedures for Expunged Benefits

Revision 13-3; Effective July 1, 2013

TANF and SNAP

The advisor explains expungement policy to individuals who inquire about these benefits. Except for death denials, refer individuals who dispute the expungement or believe it was in error to the Lone Star help desk at 1-800-777-7EBT (1-800-777-7328).

SNAP

The advisor is responsible for expungements resulting from death denials. If the advisor causes the expungement by processing a denial erroneously, the advisor restores benefits (rounding down to the nearest dollar if the balance includes 49 cents or less, and rounding up if it includes 50 cents to 99 cents) using a manual issuance in TIERS.

B—380 EBT Problem Resolution

Revision 04-7; Effective October 1, 2004

TANF and SNAP

The local office uses the following procedures to handle EBT-related inquiries from retailers and individuals.

B—381 Retailer Inquiries

Revision 18-1; Effective January 1, 2018

TANF and SNAP

Refer retailers who:

- have EBT questions to the vendors' retailer Help Desks;
- need a manual voucher authorization to the Lone Star Retailer's Help Desk at 877-209-5339; or
- have questions about U.S. Department of Agriculture (USDA) FNS authorization to the USDA Dallas office at 877-823-4369 or to the USDA website at FNS.USDA.gov/snap/retailers/merchants.htm.

B—382 Client Inquiries

Revision 14-2; Effective April 1, 2014

TANF and SNAP

If an individual contacts the local office to question an account balance, the advisor resolves the question if it relates to eligibility. If the question does not relate to eligibility, refer the individual to the Lone Star Help Desk (1-800-777-7EBT). Individuals may also call the help desk for questions, such as expunged benefits and discrepancies with retailers.

A household has 90 calendar days from the date the error occurred in an EBT transaction to request an adjustment. The EBT vendor reviews the request and notifies the household of the vendor's determination. Within 10 business days the EBT vendor must:

- investigate the dispute;
- determine eligibility for an adjustment; and
- if applicable, deposit the adjustment into the household's account.

After receiving written notice of the EBT vendor's decision, if the individual disagrees with the decision, the individual may contact LSBS for a second review.

The household retains the right to a fair hearing.

See B-382.2, Balance Disputes, for the account balance dispute process, and B-1000, Fair Hearings.

B—382.1 Client Problems Accessing Benefits

Revision 18-1; Effective January 1, 2018

TANF and SNAP

Contact the local office site coordinator for situations such as:

- The benefits show in TIERS, but not on the ATA, and both the card and PIN appear to work.
- The benefits show in the ATA with no benefit number, but do not show in TIERS.

B—382.2 Balance Disputes

Revision 18-1; Effective January 1, 2018

TANF and SNAP

If the individual reports an account balance dispute to the local eligibility determination office, determine if the individual contacted the Lone Star Help Desk.

If ...	then ...
yes,	forward the complaint to Lone Star Business Services by email at EBT_Operations@hhsc.state.tx.us.
no,	refer the individual to the Lone Star Help Desk at 800-777-7EBT.

B—382.3 Client Problems with Retailers

Revision 18-1; Effective January 1, 2018

TANF and SNAP

When a person reports any problem with a retailer, other than an account balance dispute, forward it to the Lone Star Business Services by email at EBT_Operations@hhsc.state.tx.us.

B—382.4 Client Problems with an EBT Vendor

Revision 18-1; Effective January 1, 2018

TANF and SNAP

When a person reports a problem with an EBT vendor, forward it to the Lone Star Business Services by email at EBT_Operations@hhsc.state.tx.us.

B—390 Documentation Requirements

Revision 11-2; Effective April 1, 2011

TANF and SNAP

Document the reason for:

- cancelling benefits (see B-331, Cancelling Benefits in EBT Accounts); and
- replacing benefits (see B-341.1, Procedures for Replacing EBT Benefits).

Related Policy
Documentation, C-940
The Texas Works Documentation Guide

TWH, B-400, Special Households

Revision 18-1; Effective January 1, 2018

B—410 Students in Higher Education

Revision 13-4; Effective October 1, 2013

B—411 General Policy

Revision 15-4; Effective October 1, 2015

SNAP

A student in higher education is one who is enrolled at least half-time (as defined by the institution) in a college or university curriculum that offers degree programs, regardless of whether a high school diploma is required for admittance, or at a business, technical, trade or vocational school that normally requires a high school diploma or equivalent for admittance.

Student higher education policy does not apply to individuals:

- under age 18 (students are 18 the month after the student's 18th birthday);
- age 50 or older (students are 50 the month of the student's 50th birthday);
- enrolled in curricula (such as beauty school or auto mechanics) that do not require a diploma or the equivalent for entrance; or
- enrolled only in English as a second language curriculum.

Enrollment begins the first day of the first school term. For example, a high school senior might be accepted by a college and register for classes before graduation; however, the Texas Health and Human Services Commission (HHSC) does not consider the student enrolled until the first day of the college term.

Once enrolled, HHSC considers the student enrolled through vacation and recess, until the student graduates, is expelled, drops out, or does not intend to register for the next usual term, excluding summer school. A student remains enrolled between terms, breaks, and during summer vacations unless the student does not intend to return to school the next term.

B—412 Student Eligibility Requirements

Revision 15-4; Effective October 1, 2015

SNAP

A student qualifies for the Supplemental Nutrition Assistance Program (SNAP) if the student is:

1. Unfit for employment. If not evident, proof is required from a certified doctor or psychologist, or receipt of permanent or temporary disability benefits issued by government or private sources must be verified.

2. Employed for pay an average of 20 hours a week. If self-employed, the student must work an average of 20 hours a week and earn at least the federal minimum hourly wage.
3. Participating during the regular school year in a state or federally-funded work study program. The student must be actually working at a job for pay or for dollar credits against tuition charges. This does not include students who must work for academic requirements, such as interns and student teachers.The student exemption begins the month the school term begins or the work study is approved to begin, whichever is later. The student exemption stops:

- if the student quits working (unless it results solely from lack of work study funds), or
- when there is a break between terms of a full calendar month or longer unless the student continues work study during the break.

4. Enrolled in school through one of the following programs:
    - Workforce Innovation and Opportunity Act (WIOA),
    - Choices,
    - SNAP Employment and Training (E&T),
    - Trade Adjustment Assistance (a program administered by the Texas Workforce Commission), or
    - other state and local government training programs approved by state office as equivalent to E&T.
5. Participating in an on-the-job training program (classroom study is not considered on-the-job-training for this purpose).
6. Approved for Temporary Assistance for Needy Families (TANF).
7. Responsible for the care of a dependent child who is a household member and the child is:
    - under age 6;
    - at least age 6 but under age 12, and the student states there is no available child care to enable the student to attend class and comply with work requirements in Item B or C above.

      Note: If both parents/caretakers are students, both cannot obtain student eligibility by caring for the same child.

8. A single parent (natural, adoptive or stepparent in the home or other single adult with parental control) who is:
    - enrolled full-time (as determined by the school), and
    - responsible for the care of a child under age 12.

B—413 Ineligible Students

Revision 15-4; Effective October 1, 2015

SNAP

A student who does not meet the student eligibility requirements is not a member of the household. Do not count the student's income and resources for the remaining household members. If an ineligible student is also disqualified for another reason, the student is treated as a disqualified member.

If an ineligible student is also disqualified for another reason, the student is treated as a disqualified member. Advisors follow resource policy in A-1210, General Policy, and income policy in A-1362, Disqualified Members.

B—414 Work Registration

Revision 13-4; Effective October 1, 2013

SNAP

Eligible students are exempt from work registration during the regular school term. This exemption continues between terms, breaks and through scheduled school vacations for students who remain enrolled.

B—415 Verification Requirements

Revision 16-4; Effective October 1, 2016

SNAP

Staff must verify self-employment hours of students who work at least a weekly average of 20 hours and earn at least the federal minimum hourly wage. If the student does not provide verification by the due date, the student will be denied for failure to provide and is considered an ineligible student, unless they meet another student eligibility requirement as described in B-412, Student Eligibility Requirements.

B—416 Documentation Requirements

Revision 16-4; Effective October 1, 2016

SNAP

Advisors must document the student's eligibility, if questionable.

B—420 Other Special Situations

Revision 13-4; Effective October 1, 2013

B—421 Food Distribution Program on Indian Reservations (FDPIR)

Revision 13-4; Effective October 1, 2013

SNAP

FDPIR is a food distribution program that provides commodity foods to low-income households living on an Indian reservation, and to Native American families residing near reservations. The Indian tribe administers this program under approval from the Food and Nutrition Service (FNS). Households eligible for the FDPIR receive a monthly food package based on the number of household members. The only tribe approved in Texas is the Alabama-Coushatta Tribe of Texas in Polk County.

Individuals cannot participate simultaneously in SNAP and FDPIR. An Indian Tribal Household eligible for both programs may participate in only one of the programs of its choice for a given month. The household may switch from one program to the other, but benefits must be ended in one program before certifying the household for the other program. Benefits in the new program can be issued for the month after benefits end in the previous program.

B—421.1 Duplicate Participation

Revision 13-4; Effective October 1, 2013

HHSC staff must identify household members receiving duplicate benefits with SNAP and FDPIR. The household can be denied from either program. If duplicate participation occurs, a household overpayment occurs for the program that was certified for benefits last. HHSC staff must send an overpayment referral to the Office of Inspector General (OIG) if the overpayment occurred in SNAP.

The Livingston HHSC office receives a list of certified FDPIR households each month.

HHSC staff must:

- perform inquiry to identify any household members receiving benefits in both FDPIR and SNAP;
- notify FDPIR staff about any household member with duplicate participation;
- notify the corresponding HHSC office in another county, if the duplicate participant household moved to that county; and
- deny SNAP, if appropriate, and refer the household to OIG for a SNAP overpayment.

Related Policy
How to File an Overpayment Referral, B-730

B—421.2 Intentional Program Violation (IPV)

Revision 13-4; Effective October 1, 2013

Any member disqualified from SNAP for an IPV is also disqualified from participating in the FDPIR program. Likewise, any member disqualified from FDPIR for an IPV is also disqualified from participation in SNAP for the full length of the IPV disqualification period. Advisors follow policy in B-940, Texas Works (TW) Responsibilities.

B—421.3 Switching from FDPIR to SNAP

Revision 15-4; Effective October 1, 2015

SNAP

If an Indian Tribal Household chooses to receive SNAP, staff must contact the Alabama-Coushatta FDPIR staff to verify that the household does not receive FDPIR before determining SNAP eligibility.

Note: Alabama is the only other state that can be entered in the Out of State Benefit Logical Unit of Work in this situation, and advisors must document the facts in the Texas Integrated Eligibility Redesign System (TIERS) Case Comments.

B—421.4 Switching from SNAP to FDPIR

Revision 15-4; Effective October 1, 2015

SNAP

For Indian Tribal Households switching from SNAP to FDPIR, staff must:

- process the switch as a verbal request for voluntary withdrawal from SNAP;
- send Form TF0001, Notice of Case Action, allowing adequate notice;
- terminate SNAP benefits for the household as soon as possible so the household may be certified for FDPIR; and
- notify FDPIR staff of the SNAP denial effective date for the household.

Related Policy
Form TF0001 Required (Adequate Notice), A-2344.1

B—421.5 Verification Requirements

Revision 15-4; Effective October 1, 2015

SNAP

HHSC staff must contact Alabama-Coushatta FDPIR staff to verify that the household does not receive FDPIR and whether there is a current FDPIR IPV before determining SNAP eligibility for any Indian Tribal Household living in Polk County.

FDPIR staff must contact the Livingston HHSC office to verify the household does not receive SNAP and to verify any current SNAP IPV disqualification before certifying the household for FDPIR.

B—421.6 Documentation Requirements

Revision 15-4; Effective October 1, 2015

SNAP

Advisors must document the:

- name and telephone number of the FDPIR staff who provides verification; and
- name of the household member currently disqualified for an IPV in FDPIR.

Related Policy
Documentation, C-940

B—430 Households with Elderly Members or Members with a Disability

Revision 13-4; Effective October 1, 2013

B—431 Definition of Elderly

Revision 01-1; Effective January 1, 2001

SNAP

An elderly person is someone who is age 60 or older as of the last day of the month.

B—432 Definition of Disability

Revision 15-4; Effective October 1, 2015

SNAP

The following people are considered to have a disability:

- People approved for Supplemental Security Income (SSI), Social Security disability or blindness payments, or SSI Medicaid only.
- Veterans who receive Veterans Affairs (VA) benefits because they are rated a 100 percent service-connected disability or who, according to the VA, need regular aid and attendance or are permanently housebound.
- Surviving spouses of deceased veterans who meet one of the following criteria according to the VA:
  - need regular aid and attendance,
  - are permanently housebound, or
  - are approved for benefits from the VA because of the veteran's death and could be considered to have a permanent disability for Social Security purposes. (See B-432.1, Social Security's Criteria for Disability.)
- Surviving children (any age) of a deceased veteran who the VA:
  - determines are permanently incapable of self-support, or
  - approves for benefits because of the veteran's death and could be considered to have a permanent disability for Social Security purposes. (See B-432.1.)
- People receiving disability retirement benefits from any government agency for a disability that could be considered permanent for Social Security purposes.
- People receiving Railroad Retirement Disability who are also covered by Medicare.

B—432.1 Social Security's Criteria for Disability

Revision 15-4; Effective October 1, 2015

SNAP

The Social Security Administration (SSA) considers that any of the following 12 conditions result in permanent disability:

- Permanent loss of use of both hands, both feet, or one hand and one foot.
- Amputation of leg at hip.
- Amputation of leg or foot because of diabetes mellitus or peripheral vascular diseases.
- Total deafness, not correctable by surgery or hearing aid.
- Statutory blindness, unless caused by cataracts or detached retina.
- IQ of 59 or less, established after the person becomes age 16.
- Spinal cord or nerve root lesions resulting in paraplegia or quadriplegia.
- Multiple sclerosis in which there is damage to the nervous system caused by scattered areas of inflammation. The inflammation recurs and has progressed to varied interference with the function of the nervous system, including severe muscle weakness, paralysis, and vision and speech defects.
- Muscular dystrophy with irreversible wasting of the muscles, impairing the ability to use the arms or legs.
- Impaired renal function caused by chronic renal disease, resulting in severely reduced function which may require dialysis or kidney transplant.
- Amputation of a limb of a person at least age 55.
- AIDS progressed so that it results in extensive and/or recurring physical or mental impairment.

If the individual already receives SSI or Social Security blindness or disability payments, or the disability is obvious to the advisor (such as amputation of leg at hip), the advisor does not require additional verification. Other conditions may require the opinion of a physician. Advisors use Form H1836-A, Medical Release/Physician's Statement, in these instances.

B—433 Special Provisions for Households with Elderly Members or Members with a Disability

Revision 15-4; Effective October 1, 2015

SNAP

Households containing members who are elderly or who have a disability receive special treatment. The special provisions are:

- Exemption from the gross income test;
- Allowance of a deduction for medical expenses when the medical expenses exceed a total of $35 per month for all eligible members who are elderly or who have a disability; and
- Allowance of an uncapped excess shelter deduction for the full monthly amount that exceeds 50 percent of the household's monthly income after the allowable deductions.

B—434 Verification Requirements

Revision 15-4; Effective October 1, 2015

SNAP

Advisors must verify that a household member:

- is age 60 or older; and
- meets the disability criteria in B-432, Definition of Disability.

Related Policy
Questionable Information, C-920

Providing Verification, C-930

B—435 Documentation Requirements

Revision 15-4; Effective October 1, 2015

SNAP

Advisors must document:

- the reason the individual is considered to have a disability (see B-432, Definition of Disability);
- how age was verified (see B-431, Definition of Elderly); and
- how disability was verified (see B-432).

Related Policy
Documentation, C-940

B—440 Drug and Alcohol Treatment (D&A)/Group Living Arrangement (GLA) Facilities

Revision 05-1; Effective January 1, 2005

B—441 Residents of Drug and Alcohol Treatment (D&A) Facilities

Revision 16-3; Effective July 1, 2016

SNAP

Individuals receiving chemical dependency treatment and residing in a facility that conducts a chemical dependency program may be potentially eligible for SNAP, regardless of the number of meals the facility provides, if the treatment facility is an approved institution. A drug and alcohol treatment (D&A) facility is an approved institution if it is either:

- certified as a retailer by Food and Nutrition Service (FNS) to accept SNAP benefits; or
- a private, nonprofit organization or institution, or a publicly operated community mental health center. To qualify under this provision, the facility or organization must also meet one of the following two requirements:

    1. be licensed by the Texas Department of State Health Services (DSHS) to operate a chemical dependency treatment facility; or
    2. have written verification from DSHS that it is a registered faith-based exempt chemical dependency treatment program under Texas Health and Safety Code, Chapter 464, Subchapter C, and also is recognized by DSHS as operating a program that furthers the purposes of Part B of Title XIX of the Public Health Service Act, the rehabilitation of drug addicts and/or alcoholics. The facility does not have to actually receive funds from DSHS.

Individuals residing in D&A facilities that are not approved institutions are potentially eligible for SNAP only if the facility provides half of their meals or less as described in B-490, Determining Whether an Individual Who Resides in a Facility Is Institutionalized.

Note: See A-232.2, Disqualified Persons, for disqualification of individuals due to felony drug conviction.

Advisors must evaluate all other eligibility criteria to determine whether a resident of the treatment center is eligible for SNAP.

Advisors determine eligibility following the same income and resource policy as other households. Most time frames and procedures for certifying households apply to residents of treatment facilities. The exceptions are:

- Household size — advisors must certify:
    - single residents of the treatment facility as separate one-person households; and

    - adult residents and their children as one household.
- Authorized representative (AR) — The treatment facility must act as the AR for all residents of the facility.

Any facility that is disqualified by the U.S. Department of Agriculture (USDA) as a retailer or that loses its license from a state agency cannot serve as an AR. If this happens, the advisor must deny all existing SNAP Eligibility Determination Groups (EDGs) of residents in the facility. The facility may not debit residents' food accounts after the disqualification occurs.

- Expedited service — The advisor must provide benefits so the resident has an opportunity to participate by the seventh calendar day after the application date. The application date is day zero.
- Adverse action — When the facility loses its status as AR or loses its certification, the resident must be given adequate notice of adverse action.
- Work registration — The resident is exempt from work registration.

Note: If a treatment center inquires about obtaining a SNAP retailer license from FNS, advisors should refer the center to the USDA FNS at 1-877-823-4369 or www.fns.usda.gov/snap/retailers/application-process.htm.

Related Policy
Nonmembers, A-232.1
Determining Whether an Individual Who Resides in a Facility Is Institutionalized, B-490

B—442 Residents of Group Living Arrangement (GLA) Facilities

Revision 16-3; Effective July 1, 2016

SNAP

A group living arrangement (GLA) is a public or private nonprofit residential facility that serves no more than 16 residents. Individuals residing in a GLA facility may be potentially eligible for SNAP, regardless of the number of meals the facility provides, if the GLA facility is an approved institution. A GLA is an approved institution if it is either:

- a certified SNAP retailer; or
- a nonprofit, certified by a state agency as required by Section 1616(e) of the Social Security Act.

Individuals residing in GLA facilities that are not approved institutions are potentially eligible for SNAP only if the facility provides half of their meals or less as described in B-490, Determining Whether an Individual Who Resides in a Facility Is Institutionalized.

Residents who meet the criteria in B-432, Definition of Disability, may be certified under group living arrangements. Eligibility is determined by the same income and resource standards as other households.

The residents of group living arrangements may apply:

- for themselves,
- through an AR of their choosing, or
- through an AR employed by the facility.

If a member of the group wants to apply separately from other GLA residents, the facility makes the decision to let the resident apply separately based on the resident's physical and mental ability. Applications from any individual the facility allows to apply as a one-person household or for any group of residents applying as a household are accepted.

Most time frames and procedures for certifying households apply to group living arrangements. The exceptions are:

- Household size — If the resident applies using the facility as AR, the resident is treated as a one-person household. If the residents apply without using the facility as AR, 16 is the largest allowable household size.
- Expedited service — Benefits are provided so the resident has an opportunity to participate by the seventh calendar day after the application date. The application date is day zero.
- Adverse action — When the facility loses its status as AR or loses its certification, the resident is given adequate notice of adverse action.
- Work registration — Members must be registered unless exempt.

Related Policy
Nonmembers, A-232.1
Determining Whether an Individual Who Resides in a Facility Is Institutionalized, B-490

B—443 HHSC Responsibilities

Revision 13-4; Effective October 1, 2013

B—443.1 Advisor Responsibilities

Revision 15-4; Effective October 1, 2015

SNAP

For residents participating in D&A/GLA facilities, advisors must verify that the:

- D&A facility meets the eligibility criteria in B-441, Residents of Drug and Alcohol Treatment (D&A) Facilities; and
- GLA meets the eligibility criteria in B-442, Residents of Group Living Arrangement (GLA) Facilities.

Certification may be verified by contract documents or certificates of eligibility from the USDA, HHSC, DSHS, Texas Department of Aging and Disability Services (DADS), or Texas Department of Assistive and Rehabilitative Services (DARS). Verify nonprofit status by a current, valid Internal Revenue Service (IRS) exemption or a document from the Texas State Comptroller of Public Accounts. If the facility is a USDA-certified retailer, the facility's eligibility is verified.

- Ensure the AR has a copy of Form H1851, Reference Guide for Drug and Alcohol Treatment (D&A)/Group Living Arrangement (GLA) Facilities. Have the AR acknowledge receipt of Form H1851 by signing Form H1846, Facility Authorized Representative Interview. Ensure the AR understands each of the facility's responsibilities.
- Ensure the AR has a supply of Form H1852, List of Resident Participants in the Supplemental Nutrition Assistance Program (SNAP). The AR must return this form by the fifth of every month, or the following workday if the fifth is not a workday. Repeated failure to return this form is a program violation. Use Form H1852 to help monitor the facility's compliance with its responsibilities as AR. Complete and send Form H1847, Reminder to Submit Form H1852, when the facility report is three days past due.
- Ensure the AR has a supply of Form H1019/H1019-S, Report of Change, and postage-paid envelopes.
- Make on-site visits to the facility at least once every six months.

  During these visits, use Form H1845, Drug and Alcohol Treatment (D&A)/Group Living Arrangement (GLA) Facility Review, to document:
  - the date of the visit,
  - the number of residents, and
  - proof the facility continues to meet eligibility requirements.
- Report suspected misuse of SNAP by the facility to the supervisor or program manager. Use Form H1845 or Form H1853, Documentation of Findings for Form H1852, if staff discover the suspected misuse during the monthly evaluation of Form H1852 that the facility returned.
- Ensure the facility returns the correct amount of benefits to the individual's Electronic Benefit Transfer (EBT) card. If the facility is unable or unwilling to return the individual's benefits, send Form H1096, Notification Letter, to the facility advising them of the overpayment; email Form H1095, Treatment Facility Fraud Referral, to the OIG General Investigations Policy and Quality Control unit at oig_gi@hhsc.state.tx.us; and immediately restore improperly accessed benefits to the individual.

Note: If a Centralized Benefit Services (CBS) household moves into a D&A/GLA facility, the advisor must update the Living Arrangement record to convert the EDG back to SNAP and out of the CBS caseload.

Maintain a D&A/GLA facility case file in the local office for each facility. Keep copies of any forms, reports or supporting documentation in this file.

B—443.1.1 Monitoring Facilities

Revision 15-4; Effective October 1, 2015

SNAP

Advisors must monitor information provided each month by facilities on Form H1852, List of Resident Participants in the Supplemental Nutrition Assistance Program (SNAP), to ensure that certified residents receive the correct amount of SNAP benefits.

Facilities must return Form H1852 to the office by the fifth of every month, or the next workday if the fifth is not a workday. If the facility fails to provide the report, prompt the facility using Form H1847, Reminder to Submit Form H1852, when the report is three days past due.

Advisors must compare the information on the current month's Form H1852 to the information on the previous month's Form H1852 and clear any discrepancies. Consider the following questions in detail:

- Are the same residents certified?
- Did any of the residents move out during the month? If so:
  - Did the facility report the change and return the Lone Star Card and personal identification number (PIN) in the correct sleeve within three days?
  - Did the Lone Star account contain the correct amount of benefits?

If the facility fails to report residents who move out and/or fails to return the Lone Star Card and PIN, the advisor must take action to deny the EDGs following procedures in B-447, Resident Moves Out of a Drug and Alcohol Treatment (D&A)/Group Living Arrangement (GLA) Facility. Remind facilities of the responsibility as an AR to report moves and return the Lone Star Card and PIN within three days of the change. Complete Form H1853, Documentation of Findings for Form H1852, monthly to document findings. If no findings, document no findings. Provide a copy of negative findings to the program manager responsible for the facility case file, and file a copy in the facility case file.

B—443.2 Program Manager Responsibilities

Revision 17-3; Effective July 1, 2017

HHSC Benefit Office program managers report misuse of SNAP benefits in facilities certified as retailers by the USDA by sending Form H1853, Documentation of Findings for Form H1852, to:

Texas Health and Human Services Commission
Eligibility Operations - Field
Mail Code 992-6
909 W. 45th Street
Austin, TX 78751

State office makes referrals to the OIG and EBT. The USDA, if necessary, sends a copy to the program manager and subsequently, notification of any action taken.

Do not take any further adverse action on a facility certified by USDA before USDA's action. Compute overissuances for the individual residents as appropriate.

If the investigative unit confirms the report is valid, the investigative unit program manager refers the misuse to the USDA for its information and consideration for prosecution. The investigative unit sends a copy of the referral to the HHSC Benefit Office program manager responsible for the facility case file and notifies the program manager of any action taken by USDA.

B—444 Overview of Electronic Benefit Transfer (EBT) Processes for Residents of Drug and Alcohol Treatment/Group Living Arrangement (D&A/GLA) Facilities

Revision 15-4; Effective October 1, 2015

SNAP

Establish the AR as the primary cardholder (PCH) and issue a Lone Star Card to access a resident's benefits in the food account. Allow the AR to select a PIN through the Lone Star Help Desk Automated Voice Response (AVR) unit or receive a pre-assigned PIN.

Some D&A/GLA facilities are certified by the USDA as SNAP retailers and some are not. Either way, the facility serves as AR and is responsible for the use of SNAP benefits of all residents who participate in SNAP (except for some GLAs). Benefits issued via EBT for residents of these D&A/GLA facilities are handled according to one of the following three methods (1A, 1B, or 2):

1. An EBT vendor contracts with D&A/GLA facilities certified by USDA as SNAP retailers to process EBT transactions in two ways:
   1. If the D&A/GLA facility processes a minimum monthly value of SNAP transactions, an EBT vendor installs Point of Sale (POS) equipment there. The facility, as AR/PCH, debits the residents' SNAP benefits by swiping each resident's Lone Star Card

through their POS equipment and entering the associated PIN. An EBT vendor completes financial settlement to pay the retailer the day after SNAP transactions are completed.
   2. If the retailer processes less than the minimum monthly value of SNAP transactions to receive POS equipment, an EBT vendor contracts with the retailer to use a manual voucher system to process EBT SNAP transactions from each resident'saccount. An EBT vendor completes financial settlement to pay the retailer the day after SNAP transactions are completed.
2. D&A/GLA facilities that are not USDA-certified retailers do not contract with an EBT vendor to accept SNAP benefits. However, as long as the facility meets the eligibility criteria specified in B-441, Residents of Drug and Alcohol Treatment (D&A) Facilities, or B-442, Residents of Group Living Arrangement (GLA) Facilities, for non-USDA certified retailers, residents of those facilities can still participate in the SNAP program with the facility AR responsible for the residents' SNAP benefits. In this situation, the facility AR is established as the PCH; a Lone Star Card is issued; and the AR is allowed to select a PIN through the Lone Star Help Desk AVR unit or receive a pre-assigned PIN. The facility AR may use the food account Lone Star Card and PIN to purchase food for the resident at a retail food store/market.

   Note: GLAs do not always serve as AR for each resident. If the GLA employee is not listed as a GLA-AR on a resident's SNAP EDG:

1.
   - advisors must follow normal EBT issuance procedures rather than procedures in this section for issuing cards and self-selecting/issuing PINs; and
   - the resident uses the card/PIN to purchase food from a regular retailer, or purchase prepared meals from the GLA if the GLA is certified as a retailer by USDA.

B—445 D&A/GLA Facility Responsibilities as Authorized Representatives

Revision 15-4; Effective October 1, 2015

SNAP

The facility acting as AR must:

- apply for and provide accurate information on behalf of a resident;
- use the Lone Star Card to debit the resident's food account;
- buy and prepare food for eligible residents;
- buy meals delivered to the individual residents;
- report within 10 days to the SNAP office loss of USDA/DSHS certification or loss of nonprofit status;
- report any changes, losses, misuse and overissuances of SNAP benefits;
- give departing residents Form H1019/H1019-S, Report of Change, as appropriate, and advise the individual to report the new address within 10 days;
- report and return to HHSC the Lone Star Card (in the proper sleeve) issued for that resident within three days after the resident moves out, whether announced or not;
- ensure security of all Lone Star Cards and PINs issued to the facility AR;
- ensure that the departing resident's Lone Star Card contains all the SNAP benefits that are unspent when the resident moves out; and
- return Form H1852, List of Resident Participants in the Supplemental Nutrition Assistance Program (SNAP), by the fifth of every month, or the following workday if the fifth is not a workday.

The resident and AR both must sign the application form.

The facility, acting as an AR, is liable if it knowingly commits a program violation to obtain SNAP benefits for a resident.

B-445.1, Use of SNAP Benefits by Drug and Alcohol Treatment (D&A) /Group Living Arrangement (GLA) Facilities Which Serve as SNAP Authorized Representative (AR), explains facility responsibilities specific to EBT.

The facility must maintain a sufficient supply of required forms. Form H1852, Form H1019/H1019-S and HHSC return envelopes may be obtained from the local eligibility determination office and will be offered to the AR at each certification.

B—445.1 Use of SNAP Benefits by Drug and Alcohol Treatment (D&A)/Group Living Arrangement (GLA) Facilities Which Serve as SNAP Authorized Representative (AR)

Revision 15-4; Effective October 1, 2015

SNAP

HHSC restricts how the D&A/GLA facility may use the resident's benefits as explained in B-445.1.1, Account Access, through B-445.1.4, Residents Moving Out Before the 16th of a Month. The advisor must inform the facility AR of these rules during the interview and provide them with Form H1851, Reference Guide for Drug and Alcohol Treatment (D&A)/Group Living Arrangement (GLA) Facilities.

B—445.1.1 Account Access

Revision 15-4; Effective October 1, 2015

SNAP

HHSC issues a Lone Star Card to the facility AR and enables the AR to select a PIN through the Lone Star Help Desk AVR unit. HHSC allows the AR access **only** to benefits issued for a month the individual is a facility resident. The facility may have one person serve as AR to apply for the resident and another to serve as AR/PCH and use the Lone Star Card.

Note: When the D&A/GLA facility is the AR, it is responsible for all benefits in an account. Therefore, security of the card and PIN is as important to them as it is to an individual not in a facility.

A D&A/GLA facility AR may access benefits issued to a resident's food account only in the following situation. If HHSC is unable to issue benefits with the facility as AR for a month the resident is residing in the facility because that month's benefits were already issued to the resident's food account and the resident wants to allow the facility access to those previously issued benefits, the resident, not the facility AR, has the following options:

For facilities that are not USDA-certified retailers, the resident may:

- use the card to purchase groceries to give to the facility; or
- make the D&A/GLA facility AR a secondary cardholder on the existing account to access those benefits.

To establish the facility AR as secondary cardholder in this situation, the:

- advisor must ensure that the individual made this choice and then approve it; and
- local office EBT clerk must establish the secondary cardholder, issue the card, and enable PIN self-selection.

For facilities that are USDA-certified retailers, the resident can:

- use one of the options listed above for facilities that are not USDA-certified; or
- use the Lone Star Card and PIN to purchase meals via the facility POS device or via the EBT manual voucher process. The facility **is not** allowed possession of the card previously issued to the resident, nor knowledge of the resident's PIN. When using this option, the facility may only charge for prepared meals on a per day basis (not in advance).

B—445.1.2 Returning Lone Star Cards

Revision 13-4; Effective October 1, 201 3

SNAP

The D&A/GLA facility must return the facility AR's card for each resident who moves out within three days of the move.

B—445.1.3 Returning Unspent Benefits When a Resident Moves Out

Revision 15-4; Effective October 1, 2015

SNAP

When a resident moves out of the D&A/GLA facility, the facility must return all unspent benefits issued to the AR's account regardless of when the resident moves out, even if it means returning all of the resident's benefits. D&A/GLA facilities are not allowed to spend a resident's benefits after the resident moves out.

To return unspent benefits after a resident moves out, the facility returns the AR's card and ensures that the account contains all unspent benefits. For purposes of this policy, "spent" means the facility used the Lone Star Card to access the resident's benefits before the resident moved out.

If the facility accesses benefits that it is not allowed to use, the facility must return the benefits to the account. USDA-certified facilities can return benefits using the POS device to process a return on the account or via communication with an EBT vendor. Facilities not certified as retailers by USDA must return groceries to the store and get the store to process a return on the resident's account using the AR's card on the store's POS device.

If the retailer is unable to restore benefits to the EBT card, the advisor initiates a claim against the facility by sending Form H1096, Notification Letter, and sending Form H1095, Treatment Facility Fraud Referral, to the OIG General Investigations Policy and Quality Control Unit Outlook Mailbox. The advisor restores benefits to the individual as outlined in B-800, Restored Benefits.

B—445.1.4 Residents Moving Out Before the 16th of a Month

Revision 15-4; Effective October 1, 2015

SNAP

The D&A/GLA facility must return at least half of the monthly allotment for residents who move out before the 16th of a month. Therefore, even though the facility can access more than half of the monthly allotment before the 16th, it is not good practice to do so.

The D&A/GLA facility AR knows the full allotment amount from the individual notice. If the EDG has recoupment, the advisor must notify the facility AR so the AR can use the Lone Star Help Desk AVR system (1-800-777-7EBT) to verify monthly benefits.

When using a resident's benefits, D&A/GLA facilities without a POS device must be cautious to ensure they do not use more than half of a month's allotment before the 16th of the month, because they have no POS device to process a return if they spend more than half of a resident's allotment.

B—446 Application Processing for Drug and Alcohol Treatment (D&A)/Group Living Arrangement (GLA) Facilities

Revision 15-4; Effective October 1, 2015

SNAP

Advisors must process SNAP EDGs for residents in D&A/GLA facilities using one of the following three procedures, depending on the resident's situation at application.

B—446.1 New Resident (or Denied Resident with No Benefits in an Electronic Benefit Transfer [EBT] Account) Who Moves into a D&A/GLA Facility and Applies for SNAP

Revision 15-4; Effective October 1, 2015

SNAP

1. The advisor:

- interviews the AR;

- advises the AR about the limitations noted on Form H1851, Reference Guide for Drug and Alcohol Treatment (D&A)/Group Living Arrangement (GLA) Facilities;
- provides EBT training material if the AR has not already received it;
- sends the PCH record for the facility AR to the EBT system by indicating in the TIERS issuance pages that there is an alternate payee and by filling out Part I of Form H1175, Authorization for Administrative Terminal Application Action, which is sent to EBT staff to data enter into the Administrative Terminal Application (ATA);

Note: Because the PCH must use biographical data to access PIN selection through the Lone Star Help Desk AVR system, the EBT clerk must enter additional data to the PCH record using the Form H1175/ATA process. TIERS does not collect this data on D&A/GLA facility ARs; therefore, TIERS cannot send the information to the EBT system.

At the time of disposition, advisors must ensure that TIERS has successfully included the PCH record for the facility AR by reviewing the Issuance – Details page and the Alternate Payee – Summary page.

- disposes the SNAP EDG; and
- completes and submits Form H1172, EBT Card, PIN and Data Entry Request, to the EBT clerk.

2. The EBT clerk:
    - securely files the signed, original EBT forms;
    - issues a card to the AR and reports the personal account number (PAN);
    - prints the case/EDG name in the space under the signature field on the back of the Lone Star Card; and
    - enables the AR to select a PIN through the Lone Star Help Desk AVR system.
3. The facility AR uses the card and PIN to access benefits in the food account. **Note:** If the resident also receives TANF, the cash account is not available to the D&A/GLA facility AR. The resident has a separate card and PIN for the cash account.

B—446.2 Resident Has an Active SNAP EDG (or a Denied-Ongoing SNAP EDG), No Benefits in the Food Account, and All SNAP Household Members Move into the D&A/GLA Facility

Revision 15-4; Effective October 1, 2015

SNAP

Advisors follow policy in B-446.1, New Resident (or Denied Resident with No Benefits in an Electronic Benefit Transfer [EBT] Account) Who Moves into a D&A/GLA Facility and Applies for SNAP, except the D&A/GLA facility representative is added as AR for the existing SNAP EDG and the SNAP EDG is certified if it is currently denied.

B—446.3 All Other Situations

Revision 15-4; Effective October 1, 2015

SNAP

Advisors assign the resident a new SNAP EDG number and certify the resident using the new EDG number to establish a separate EBT food account as a resident of a D&A/GLA facility with a facility AR.

- If the resident is on an active SNAP EDG (and all members are not moving into the facility), the individual is removed from the existing EDG before being certified on a new case. This resident's application is processed using procedures in B-446.1, New Resident (or Denied Resident with No Benefits in an Electronic Benefit Transfer [EBT] Account) Who Moves into a D&A/GLA Facility and Applies for SNAP.
- If the resident is currently certified as a single person household on a previous case (but has a remaining benefit balance), the resident is certified for SNAP with a certification period for the remaining months using a different case number. A new Form H1010, Texas Works Application for Assistance — Your Texas Benefits, is not required. The file date is the first day of the first month of the remaining certification period. The other case is cross referenced in the TIERS Case Comments section of each case.

Advisors enter the facility AR's information in the Authorized Representative page and indicate in the Issuance – Details page that there is an alternate payee. Complete the subsequent Alternate Payee – Summary page.

Advisors complete and submit Form H1172, EBT Card, PIN and Data Entry Request, and Part I of Form H1175, Authorization for Administrative Terminal Application Action, to the EBT clerk. The EBT clerk enters additional data to the PCH record for the AR through the ATA for the new EDG number. Note: Because the PCH must use biographical data to access PIN selection through the Lone Star Help Desk AVR system, the EBT clerk must send the PCH record using the Form H1175/ATA process. TIERS does not collect this data on D&A/GLA facility ARs; therefore, TIERS cannot send the information to the EBT system.

At the time of disposition, advisors must ensure TIERS has successfully included the PCH record for the facility AR by reviewing the Issuance – Details page and the Alternate Payee – Summary page.

Advisors then follow policy in B-446.1, Numbers 2 and 3.

B—447 Resident Moves Out of a Drug and Alcohol Treatment (D&A)/Group Living Arrangement (GLA) Facility

Revision 15-4; Effective October 1, 2015

SNAP

Advisors follow these procedures when the resident moves out of the facility;

1. The facility AR:
   - notifies the advisor of the move, and
   - returns the Lone Star Card (in person) for this account to the local office within three days of the move.
2. The advisor checks the account balance to ensure the D&A/GLA facility returned the correct amount of benefits. The advisor must ensure that the facility returns to the resident's food account any amount of benefits spent after the resident moved out. Monthly benefits and account balance information are available on the ATA benefit history screen. The ATA transaction history screens provide information to verify the AR did not debit the account after the resident moved out. Transactions are listed by date and time.

Advisors must report violations as noted in B-443.1, Advisor Responsibilities.

3. After ensuring benefits are properly returned, staff destroy the card according to procedures for returned cards in B-237, Returned Lone Star Cards and PIN Packets.
4. The advisor follows procedure I or II below.
   1. **The facility reports the move and the former resident has not contacted HHSC:**
      - Send the EDG name to the EBT system as the new PCH. If necessary, complete Part I of Form H1175, Authorization for Administrative Terminal Application Action, and send to EBT staff, who will use the information to create the new PCH record through the ATA.
      - Immediately remove the AR entries in TIERS including any designations in the Issuance – Details and the Alternate Payee – Summary pages and update the address, if known.
      - Document in TIERS Case Comments the name of the facility and facility AR that are being removed and when. Do not issue a new card and PIN until the former resident requests it.
      - Follow normal adverse action procedures to deny the EDG.

Note: If the advisor fails to remove the AR before denying the EDG, establish a new PCH by updating the PCH record by completing Part III of Form H1175.

2. **Former resident reports the move:**
   1. If the former resident moves to another D&A/GLA facility, the advisor must follow the procedure below:
      - Do not deny the existing active case.
      - Remove the former facility AR.
      - Document in TIERS Case Comments the name of the facility and facility AR that are being removed and the name of the new facility and facility AR that are being added and when.
      - Enter the new facility AR's information in the Authorized Representative page and indicate in the Issuance – Details page that there is an alternate payee. Complete the subsequent Alternate Payee – Summary page.
      - Complete Form H1172, EBT Card, Pin and Data Entry Request, to issue a card and enable the new AR to select a PIN through the Lone Star Help Desk AVR system.
      - Complete Part I of Form H1175 and send to EBT staff, who will use the information to complete the new PCH record on the new AR via the ATA.

Note: Because the PCH must use biographical data to access PIN selection through the Lone Star Help Desk AVR system, the EBT clerk must enter additional data to the PCH record using the Form H1175/ATA process. TIERS does not collect this data on D&A/GLA facility ARs; therefore, TIERS cannot send the information to the EBT system.

At the time of disposition, advisors must ensure that TIERS has successfully included the PCH record for the new facility AR by reviewing the Issuance – Details page and the Alternate Payee – Summary page.

- The EBT clerk securely files the signed, original EBT forms; issues a card to the AR; reports the PAN; prints the case/EDG name in the space under the signature field on the back of the Lone Star Card; and enables the AR to select a PIN through the Lone Star Help Desk AVR system.

2. If the former resident moves in with another active SNAP household and the former resident will participate with that household, the advisor follows the procedure below:
    - Deny the active D&A/GLA case and send Form TF0001, Notice of Case Action, following regular adverse action procedures.
    - Send the case name to the EBT system to change the PCH on the case by removing all AR-related entries in TIERS including any designations in the Issuance – Details and the Alternate Payee – Summary pages.
    - Change the address to the resident's new address.
    - Document in TIERS Case Comments the name of the facility and facility AR that are being removed and when. Cross reference the other case in the TIERS Case Comments section of each case.
    - If there are still benefits in the account, process Form H1172 to give the former resident access to the account by issuing a card and enabling the individual to select a PIN through the Lone Star Help Desk AVR system.
    - If necessary, complete Part I of Form H1175 and send to EBT staff, who will use the information to create the new PCH record through the ATA.
    - Add the former resident to the other household's SNAP EDG effective for the month after any final benefits are received.
3. If the former resident moves and no longer lives in a D&A/GLA facility or does not participate with another active SNAP household, use the following special procedure to move the former resident's remaining months of SNAP certification to a different case (and thus a new food account):
    - Send the case name to the EBT system to change the new PCH on the currently active case by removing all AR-related entries in TIERS including any designations in the Issuance – Details and the Alternate Payee – Summary pages.
    - Change the address to the resident's new address.
    - Document in TIERS Case Comments the name of the facility and facility AR that are being removed and when.
    - Deny the former resident's active SNAP EDG. Do not send notice of adverse action since benefits are not actually being denied.
    - Certify the former resident for SNAP with a certification period for the remaining months using a different case number. (Use a previous, denied-ongoing case number and associate the case number during Application Registration, if the former resident has one.) Do not require a new Form H1010, Texas Works Application for Assistance — Your Texas Benefits. The file date is the first day of the first month of the remaining certification period. Cross reference the other case in the TIERS Case Comments section of each case.
    - Process Form H1172 to give the former resident access to the account(s) by issuing a new card and enabling the individual to select a new PIN through the Lone Star Help Desk AVR system.
    - If necessary, complete Part I of Form H1175 and send to EBT staff, who will use the information to create the new PCH record through the ATA.

B—448 Drug and Alcohol Treatment (D&A)/Group Living Arrangement (GLA) Facility Replaces the Authorized Representative (AR)

Revision 15-4; Effective October 1, 2015

SNAP

To replace an AR, the D&A/GLA facility must provide the advisor a written request.

If a D&A/GLA facility replaces the AR, the local office may avoid replacing cards for all the residents' accounts. Advisors must:

- change the name of the AR on all applicable TIERS cases by replacing the former facility AR with the new individual in the Authorized Representative page and the Alternate Payee Summary page. Advisors must document for each case the change and when the change occurred in TIERS Case Comments.
- complete Part III of Form H1175, Authorization for Administrative Terminal Application Action, to update the existing PCH record to reflect the new AR name and biographical information. The advisor must not create a new PCH record.

  Note: Because the PCH must use biographical data to access PIN selection through the AVR, the EBT clerk must send the PCH record using the Form H1175/ATA process. TIERS does not collect this data on D&A/GLA facility ARs; therefore, TIERS cannot send this information to the EBT system.

  At the time of disposition, advisors must ensure that TIERS has successfully included the PCH record for the new facility AR by reviewing the Issuance – Details page and the Alternate Payee – Summary page.

EBT staff securely file the original, signed Form H1175 with the daily paperwork and the associated Form H1172, EBT Card, PIN and Data Entry Request. The office must ensure that the new AR gets a new PIN for each account.

Note: Advisors must complete a new Form H1846, Facility Authorized Representative Interview, at the first certification interview following replacement of the AR.

B—449 Verification Requirements

Revision 15-4; Effective October 1, 2015

SNAP

Advisors must verify that the GLA meets the eligibility criteria in B-442, Residents of Group Living Arrangement (GLA) Facilities.

Related Policy
Questionable Information, C-920
Providing Verification, C-930

B—450 Residents in Family Violence Shelters

Revision 13-4; Effective October 1, 2013

B—451 Eligibility Requirements

Revision 16-3; Effective July 1, 2016

SNAP

Individuals residing in a family violence shelter may be potentially eligible for SNAP, regardless of the number of meals the shelter provides, if the family violence shelter is an approved institution. A family violence shelter is an approved institution if it is either:

- a certified SNAP retailer: or
- a public or private nonprofit facility.

Individuals residing in family violence shelters that are not approved institutions are potentially eligible for SNAP only if the facility provides half of their meals or less as described in B-490, Determining Whether an Individual Who Resides in a Facility Is Institutionalized.

Residents in eligible family violence shelters may receive SNAP benefits as individual household units or as part of a group of individuals like any other household.

Residents in family violence shelters may apply for SNAP and use SNAP benefits on their own behalf. They may also appoint a shelter representative or another person to act as AR and/or secondary cardholder.

Resident households must meet the same income and resource standards as other households. Resources held jointly with the person who abused the individual are considered as inaccessible. Room payments to the shelter are considered as shelter expenses. These households have the same rights to notices of adverse action, fair hearing, and lost benefits as other households. Residents should be registered for work unless otherwise exempt.

The usual processing standards for initial and later eligibility decisions, handling reported changes and other actions, and usual verification and documentation requirements apply to residents in shelters for battered persons.

Related Policy
Nonmembers, A-232.1
Determining Whether an Individual Who Resides in a Facility Is Institutionalized, B-490

B—452 Approved Centers That Provide Meals

Revision 15-4; Effective October 1, 2015

SNAP

Family violence shelters that provide meals must be public or private nonprofit residential facilities that serve victims of family violence. If a facility serves other people, part of the facility must be set aside on a long-term basis to serve only family violence victims.

Advisors must verify the shelter's status as a nonprofit organization by seeing a current certificate from the IRS or a document from the Texas State Comptroller of Public Accounts. If the shelter is a USDA-certified retailer, the shelter's eligibility is verified.

B—452.1 Buying Meals

Revision 13-4; Effective October 1, 2013

SNAP

Individual households may use their SNAP benefits to buy meals prepared for them at a shelter that is a USDA-certified retailer.

B—453 Authorized Representatives

Revision 01-3; Effective April 1, 2001

SNAP

Employees of facilities that are USDA-certified retailers may not be authorized to serve as AR/secondary cardholders unless HHSC decides that there are no other representatives available.

If the shelter is not a USDA-certified retailer, the household may authorize a shelter representative as secondary cardholder.

B—454 Participation Twice in Same Month

Revision 10-4; Effective October 1, 2010

SNAP

A shelter resident can qualify for a duplicate SNAP benefit in a single month if:

- the resident's former household already received benefits for the month; and
- the resident's former household was based on a household size that included the resident, any children, and the person who abused or threatened to abuse them.

B—454.1 Duplicate Participation Procedures

Revision 15-4; Effective October 1, 2015

SNAP

Advisors must take action to remove the resident from the former household's case.

Special certification procedures based on entries made on the Living Arrangements screen allow duplicate participation until the resident is removed from the former household. The advisor must establish a new SNAP case and food account for the individual whether or not the individual is the case name or has a Lone Star Card on the previous case. The individual must complete a new Form H1010, Texas Works Application for Assistance — Your Texas Benefits.

If the individual has not been removed from the former case, the advisor must:

- complete the certification process;
- issue the individual a new Lone Star Card and PIN following procedures in B-233, Issuing a Lone Star Card;
- enable the individual to select a PIN through the Lone Star Help Desk AVR unit following the procedures in B-234, Personal Identification Number (PIN) Selection and Issuance; and
- issue benefits according to procedures in B-252, Benefit Issuance on Applications.

B—460 Prepared Meal Services

Revision 13-4; Effective October 1, 2013

B—461 Communal Dining or Meal Delivery Services

Revision 15-4; Effective October 1, 2015

SNAP

Eligible individuals and their spouses may use SNAP benefits to purchase prepared meals through communal dining or meal delivery services authorized by FNS.

To be eligible, a household member must:

- be age 60 or older;
- be housebound;
- have a physical disability;
- have a disability to the extent the member is unable to adequately prepare all meals; or
- be receiving SSI.

B—462 Prepared Meals for Homeless

Revision 12-2; Effective April 1, 2012

SNAP

Homeless individuals may use SNAP benefits to purchase prepared meals from meal providers authorized by FNS.

B—463 Advisor Responsibilities

Revision 15-4; Effective October 1, 2015

SNAP

The Lone Star Card does not identify individuals qualifying for communal dining, meal delivery, or homeless individuals eligible for prepared meals. If the individual requests verification of his/her qualification for prepared meal services, the advisor must:

- issue Form H1803, Food Stamp Identification Card; and
- enter the appropriate code as follows:
  - C – Communal dining
  - M – Meal delivery
  - H – Homeless
  - E – Every service

When using Form H1175, Authorization for Administrative Terminal Application Action, to send the PCH record, the advisor must indicate in the endorsement box of Form H1175 either:

- Communal dining
- Meal delivery
- Homeless
- Every service

B—464 EBT Coordinator Responsibilities

Revision 15-4; Effective October 1, 2015

SNAP

If a meal-provider representative contacts HHSC about certification procedures, the advisor should refer the meal-provider representative to the EBT coordinator to approve these providers.

The EBT coordinator must ensure through discussion with the meal provider that the establishment:

- provides meals to homeless people, and
- is a public or private nonprofit organization as defined by IRS. HHSC may require the provider to present documentation from IRS to verify nonprofit status under §501(c)(3) of IRS regulations.

If the meal provider meets these requirements, the EBT coordinator will:

- obtain the meal-provider representative's signature on Form H1832, Affidavit for Meal Providers to the Homeless; and
- refer the provider to USDA, with the original, signed Form H1832, to apply for authorization as a retailer.

B—465 Matrix of Prepared Meals, Services, Households and Codes

Revision 15-4; Effective October 1, 2015

SNAP

	Prepared Meals		
SNAP Recipient	**Communal Dining (Public or Nonprofit Private)**	**Meal Delivery**	**Homeless Meal Provider (Public or Nonprofit Private)**
Age 60 or older, not homeless	XX	XX	
SSI recipient who is under age 60, not homeless	XX	XX	
Under age 60, not an SSI recipient, housebound, a person with physical disabilities, or has disabilities to the extent they are unable to adequately prepare own meals		XX	
Homeless only			XX
Homeless age 60 or older	XX	XX	XX

SNAP Recipient	Communal Dining (Public or Nonprofit Private)	Meal Delivery	Homeless Meal Provider (Public or Nonprofit Private)
Homeless SSI recipient who is under age 60	XX	XX	XX
Endorsement status allowed to purchase from meal provider	Codes C,E	Codes C,M,E	Codes H,E

Codes:

C – SSI/elderly member authorized to purchase prepared meals from communal dining facilities or meal delivery services.

E – Homeless and either elderly or SSI household authorized to purchase from every service (communal dining, meal delivery services or homeless meal providers).

H – Homeless household authorized to purchase from homeless meal provider.

M – Housebound or a member with a disability authorized to purchase from meal delivery service.

B—466 Loss of SNAP Identification (ID) Card (Form H1803)

Revision 15-4; Effective October 1, 2015

SNAP

When replacing a lost or damaged ID card, the advisor must:

- verify the identity of the person requesting the replacement,
- ensure the person is authorized to act for the household, and
- issue a new SNAP ID card.

B—470 Categorically Eligible Households

Revision 05-5; Effective October 1, 2005

SNAP

Categorically eligible households are subject to fewer eligibility requirements than other SNAP households. HHSC uses special procedures to process applications from persons who potentially meet the categorical eligibility criteria. Categorical eligibility does not mean the applicants automatically receive SNAP.

B—471 Eligibility Criteria

Revision 15-4; Effective October 1, 2015

SNAP

SNAP households meet categorical eligibility criteria if:

- all members are approved for TANF cash assistance or SSI; or
- the household:
  - meets the resource criteria to be authorized to receive TANF Non-cash (TANF-NC) services (see A-1210, General Policy); and

- has gross income less than or equal to 165 percent of the Federal Poverty Income Limit (FPIL) for its size.

This also includes households that have:

- active EDGs but whose benefits are being recouped; or
- a disqualified alien member or student who does not get TANF/SSI.

The household is not categorically eligible if:

- one or more members are disqualified from TANF or SNAP for an IPV; or
- the entire household is ineligible because the primary wage earner (PWE) failed to comply with E&T or voluntary quit requirements; or
- if the household is otherwise ineligible due to one or more members' disqualification for any reason.

For TANF-NC, a household is not categorically eligible if one or more members has a current SNAP IPV disqualification. If the household meets the combined resource limit of $5,000 for liquid assets and excess vehicle value, the household is still authorized to receive TANF-NC, and their remaining resources are exempt. The household is not exempt from the gross/net income limits.

B—472 Special Treatment for Households Meeting Categorical Eligibility Criteria

Revision 15-4; Effective October 1, 2015

SNAP

Categorically Eligible TANF/SSI Households

Categorically eligible households are not subject to the resource or gross/net income limits. These households are exempt from verification requirements regarding:

- Social Security numbers (SSNs),
- resources,
- residence, and
- sponsored alien information.

Categorically Eligible TANF-NC Households

TANF-NC categorically eligible households are not subject to the gross/net income limits. Once the household passes the resource criteria for TANF-NC, the remaining non-liquid resources are exempt. TANF-NC categorically eligible households must comply with all other eligibility criteria.

Related Policy
General Policy, A-1210
Limits, A-1220
Prepaid Burial Insurance, A-1233.2
Vehicles, A-1238
How to Determine Fair Market Value of Vehicles, A-1238.5
General Policy, A-1310
Special Provisions for Households with Elderly Members or Members with a Disability, B-433

B—473 Application Processing

Revision 15-4; Effective October 1, 2015

SNAP

Advisors must follow these procedures when processing a joint application for TANF and/or SSI and SNAP:

If the TANF/SSI application is pending and the household...	then ...

is eligible for SNAP without meeting categorical eligibility criteria,	certify the SNAP application as soon as possible. Follow normal SNAP time frames.
will not be eligible for SNAP unless the TANF or SSI application is granted,	delay denial of the SNAP EDG. Pend the SNAP application for up to 30 days awaiting the TANF/SSI decision. If the TANF/SSI application is denied on or before the 30th day, deny the SNAP application immediately. If the TANF/SSI application is granted by the 30th day, certify for SNAP as soon as possible. Prorate from the SNAP application date. If the TANF/SSI application is still pending by the 30th day: • deny the SNAP application; and • notify the individual on the denial notice to contact the certification office if the TANF/SSI is later granted. If the TANF/SSI application is granted after the 30th day: • copy Form H1010, Texas Works Application for Assistance — Your Texas Benefits, and return the original to the applicant (the applicant must initial any changes, re-sign Form H1010, and return it to the local eligibility determination office); • reopen the SNAP application when Form H1010 is returned; • verify and document any changes since the initial interview; and • prorate benefits from the original SNAP file date or the effective date of TANF/SSI benefits, whichever is later.*

* When prorating from the effective date of TANF/SSI benefits, use this date as the new SNAP file date. The effective date of benefits for TANF is the earlier of the certification date or 30 days after the file date. The effective date of benefits for SSI applicants is the:

- SSI file date; or
- date the individual met all eligibility criteria, if later than the file date.

Advisors must verify the SSI benefit effective date by viewing the award letter or by running Wire Third-Party Query (WTPY) or the State Online Query (SOLQ).

B—474 Centralized Benefit Services (CBS) Section

Revision 13-4; Effective October 1, 2013

SNAP and Medical Programs

CBS is a centralized section that processes certain types of cases statewide.

Related Policy
Specialized and Centralized Casework Units, C-1471

B—474.1 Programs Administered by CBS

Revision 13-4; Effective October 1, 2013

SNAP and Medical Programs

CBS administers SNAP and Medical Programs for several individual groups. For information concerning the SNAP Combined Application Project (SNAP-CAP), which is one of the programs that CBS administers, see B-475, Supplemental Nutrition Assistance Program Combined Application Project (SNAP-CAP).

B—474.1.1 SNAP Programs

Revision 18-1; Effective January 1, 2018

SNAP

CBS administers SNAP for:

- pure categorically eligible SSI households:
  - either through the SNAP-SSI caseload; or
  - as part of SNAP-CAP.

B—474.1.1.1 SNAP-Supplemental Security Income (SSI) Caseload

Revision 15-4; Effective October 1, 2015

For the SNAP-SSI caseload, Texas is operating under a waiver that allows the state to process both timely and untimely redeterminations without an interview.

CBS staff may complete a redetermination for SNAP-SSI EDGs without an interview except in the following situations:

- the household requests an interview,
- the case contains earned income, or
- it appears the household is going to be denied.

Advisors cannot deny redetermination households for a missed appointment, except for a case with earned income. For the other two situations, staff must schedule an appointment and attempt to conduct an interview but continue to process the redetermination application if the household misses the appointment. If the household is ineligible, the EDG must be denied for the appropriate reason rather than a missed appointment.

If the household submits a redetermination application by the last day of the last benefit month, no interview is required. If the file date falls after the last day of the last benefit month, an interview is required. These households may be denied for a missed appointment.

For untimely submitted redetermination applications, the initial application processing time frames are used, as stated in B-124, Processing Untimely Redeterminations.

B—474.1.1.2 Pending SNAP-SSI Redeterminations for Missing Information/Verification

Revision 15-4; Effective October 1, 2015

If more information is needed from the household to complete the redetermination, the advisor must attempt to contact the household immediately by telephone to obtain the information. If unable to reach the household by telephone, the advisor must mail Form H1830, Application/Review/Expiration/Appointment Notice, with the advisor's telephone number, advising the household to call the advisor on a specific date and time, along with Form H1020, Request for Information or Action, clearly explaining the information/verification that is required.

Combining the pending information notice and the appointment notice in one envelope will help staff complete the redetermination timely, rather than waiting to schedule the appointment later if the household fails to provide requested information. The advisor should mail Form H1830-I, Interview Notice (Applications or Reviews), the same day the EDG is identified as one that must be scheduled for an interview, or no later than the next workday.

Households must be allowed the usual 10 days to provide the missing information/verification.

If the household member misses the scheduled appointment, a missed appointment notice is not required. The advisor should continue to attempt to process the EDG without an interview.

B—474.1.1.3 SNAP-SSI Redeterminations– Inconsistent or Discrepant Information

Revision 15-4; Effective October 1, 2015

While processing SNAP-SSI redeterminations, advisors may notice inconsistent or discrepant information (including management problems). If this occurs, the advisor must contact the household (and pend the EDG if necessary) to resolve the inconsistency. If unable to reach the household by telephone, the advisor must mail Form H1830, Application/Review/Expiration/Appointment Notice, with the advisor's telephone number, advising the household to call the advisor on a specific date and time, along with Form H1020, Request for Information or Action, clearly explaining the information/verification that is required.

For the SNAP-SSI population, advisors should pay careful attention to shelter costs since this area historically is the most prone to quality control errors. Advisors should establish the actual costs the individual pays, review the current application's reported expenses compared to the previous entries, and resolve any inconsistencies or discrepant information.

B—474.1.1.4 SNAP-SSI Redetermination Denials

Revision 15-4; Effective October 1, 2015

With the exception of cases with earned income, the policy on scheduling an interview before denying a household's request to recertify SNAP benefits is a federal condition of HHSC's waiver approval. The policy is intended to ensure the household has an opportunity to explore continued eligibility before being denied. Additionally, advisors must review facts about the EDG, the household's income and all possible deductions for which the household may be eligible, especially ones that are not as commonly claimed, such as medical transportation costs or adult dependent care costs.

If the advisor determines the household appears ineligible while processing the SNAP-SSI redetermination, the advisor must attempt to conduct an interview before the EDG can be denied. The advisor must telephone the household to conduct the interview if a telephone number is available. If unable to reach the household by telephone, the advisor must mail Form H1830, Application/Review/Expiration/Appointment Notice, which contains the advisor's telephone number, notifying the household to call the advisor to complete the redetermination. Form H1830 must be mailed the same day, or no later than the next workday, when the EDG is identified as one that must be scheduled with an interview. Advisors should continue to attempt to process the redetermination, and deny if ineligible using normal processing time frames.

B—474.1.2 Medical Programs

Revision 17-2; Effective April 1, 2017

CBS administers medical programs for:

- children placed in or released from a Texas Juvenile Justice Department (TJJD) or Juvenile Probation Department (JPD) facility;
- former foster care children;
- women diagnosed with breast or cervical cancer;
- refugees; and
- individuals incarcerated in the Texas Department of Criminal Justice (TDCJ) who receive inpatient services.

B—474.1.2.1 Child Placed in a Juvenile Facility

Revision 17-2; Effective April 1, 2017

The TJJD or JPD notifies HHSC within 30 days of a child's placement in a juvenile facility. Upon notification of the placement, TIERS automatically:

- suspends the child's Medicaid eligibility effective the day after HHSC receives the notification if the child is certified for TP 44;
- terminates the child's Children's Health Insurance Program (CHIP) eligibility effective the day after HHSC receives the notification if the child is certified for CHIP;
- terminates the child's Medicaid eligibility allowing adequate notice according to policy in A-2344.1, Form TF0001 Required, Adequate Notice, if the child is certified on a Medicaid type other than TP 44; and
- removes the child from other Eligibility Determination Groups (EDGs) in which the child is included.

Exceptions:

- Children certified on a Supplemental Security Income (SSI) or Department of Family and Protective Services (DFPS) type of Medicaid are not terminated by HHSC.
- Children placed in a non-secure facility may receive TP 44 as an independent child. Therefore these EDGs are not suspended or denied when a notification of placement is received for one of these children.

When an exception to the automated process occurs, CBS must manually process the suspension, termination, or removal of the child from associated EDGs.

Related Policy
Medicaid Suspension, A-825.2

B—474.1.2.1.1 Child Placed in a Non-Secure Facility

Revision 18-1; Effective January 1, 2018

Children placed in a non-secure juvenile facility with 16 or fewer beds are considered independent children and are potentially eligible for Medicaid. When reporting that a child has been placed in a juvenile facility, TJJD or JPD notifies HHSC if the facility is a secure or non-secure facility.

In general, children placed in a public, non-secure facility with more than 16 beds are not eligible for Medicaid, but children placed in a TJJD or JPD halfway house are not subject to this restriction. Children residing in a TJJD or JPD halfway house with more than 16 beds may be eligible for Medicaid if the halfway house meets the federally required criteria listed in A-241.3.1, Children's Living Arrangements, and if the children meet all other eligibility criteria.

To determine the correct medical effective date (MED) for children in a non-secure facility, advisors may follow the chart below:

If the child is ...	**then ...**
not active on Medicaid/Children's Health Insurance Program (CHIP) and the file date is within the same month as the placement date of the child,	the MED is the placement date of the child.
not active on Medicaid/CHIP and the file date is not within the same month as the placement date of the child (that is, the application is filed the month after the placement date),	the MED is the first day of the application month. **Note:** For unpaid medical bills prior to the file date, follow policy in A-831.1, How to Apply for Three Months Prior Coverage.
active on CHIP,	test for Medicaid eligibility following procedures in A-126.3, Advisor Action for Determining Eligibility for Children.
Exception: If the child is receiving SSI or Foster Care Title IV-E, deny the application.	

Related Policy
Children's Living Arrangement, A-241.3.1

B-474.1.2.2 Child Released from a Juvenile Facility

Revision 17-2; Effective April 1, 2017

Upon release from a juvenile facility, HHSC automatically reinstates the TP 44 eligibility for a child whose eligibility was suspended and there are months remaining on the child's original certification period. The effective date of the reinstatement is the date of the child's release from the juvenile facility. The child's eligibility is reinstated even if the case in which the child was originally certified is denied, or if the child is released to a different household than the one in which they were living at the time they were placed.

If the child is not eligible for reinstatement, but is released to a home in which a sibling is receiving Medicaid or CHIP, the child is automatically added to the case.

If the child is not eligible for reinstatement and cannot be added to an existing case, staff must send the household an application packet.

Related Policy
Regular Medicaid Coverage, A-820
Medicaid Reinstatement, A-826
Additions to the Household, B-641

B-474.1.2.2.1 Notification of Anticipated Release

Revision 17-2; Effective April 1, 2017

Within 30 days prior to a child's release, TJJD or JPD notifies HHSC of the child's anticipated release date. Upon receipt of the information, HHSC determines if the child:

- is eligible for reinstatement of TP 44 eligibility;
- can be added to an existing case if not eligible for reinstatement; or
- must reapply.

If the child cannot be reinstated because their original certification period has ended or their TP 44 was not suspended or cannot be added to an existing case, CBS staff are notified in the HHSC Action Status field located under the TIERS TJJD/JPD Release page to send the household an application packet, which includes the following:

- Form H1205, Texas Streamlined Application;
- postage paid envelope addressed to CBS;
- cover letter which provides information and instructions for submitting the application and information on how to obtain help in completing the application; and
- list of Community Partners in the family's area that provide application assistance upon the household's request of assistance.

Related Policy
Medicaid Reinstatement, A-826

B-474.1.2.2.2 Notification of Actual Release

Revision 17-2; Effective April 1, 2017

Upon notification from TJJD or JPD of the child's actual release, HHSC automatically reinstates the TP 44 eligibility for a child whose eligibility was suspended and there are months remaining on the child's original certification period. The child's TP 44 eligibility is effective the date of their release and they receive the remaining months of their original certification period.

Examples:

Child is certified	HHSC receives notification from TJJD	then the child's TP 44 is…

for TP 44 from…	or JPD of the child's release from placement on…	
April 1, 2017 - March 31, 2018. The TP 44 is suspended on June 3, 2017*	December 2, 2017,	reinstated effective December 2, 2017 - March 31, 2018. The child's MED is 12/02/2017.
June 1, 2017 - May 31, 2018. The TP 44 is suspended on August 19, 2017.*	March 31, 2018,	reinstated effective March 31, 2018 - May 31, 2018. The child's MED is 03/31/2018.
February 1, 2017 - January 31, 2018. The TP 44 is suspended on July 17, 2017.*	December 19, 2017,	reinstated effective December 19, 2017 - January 31, 2018. The child's MED is 12/19/2017.
December 1, 2016 - November 30, 2017. The TP 44 is suspended on April 1, 2017.*	December 15, 2017,	not reinstated, as the child does not have any months remaining on their original certification period. The child is added to an existing case or, if the child cannot be added to an existing case, the household is sent an application packet.

*The TP 44 suspension date is based on the date that TJJD or JPD notifies HHSC of the placement. See A-825.2, Medicaid Suspension.

The child is automatically added to an existing case if the child is not eligible for reinstatement, but has a sibling receiving Medicaid or CHIP. The child is also added to any other EDGs on the case of which the child is required member.

When an exception to the automated process occurs, CBS must manually process the reinstatement or add the child to an existing case.

Within two business days of notification of the child's release, CBS staff must process and dispose any pending applications.

CBS accepts applications up to and including the 14th calendar day after the confirmed date of release. Any applications received after the 14th day are routed to the local office for processing.

CBS reports to TJJD via the Juvenile Medicaid Tracker one of the following:

- the child has Medicaid or CHIP;
- the child was denied;
- the CBS unit never received the application; or
- the application was sent to the local office.

If the child is eligible for Medicaid, the MED cannot be any earlier than the release date.

Related Policy
Adverse Actions Not Requiring Advance Notice, A-2344
Enrollment, D-1700
Regular Medicaid Coverage, A-820
Medicaid Reinstatement, A-826
Additions to Household, B-641

B-474.1.2.3 Medicaid for Transitioning Foster Care Youth

Revision 17-2; Effective April 1, 2017

Policy for TP 70 — Medicaid for Transitioning Foster Care Youth (MTFCY), is explained in Part M, Medicaid for Transitioning Foster Care Youth (MTFCY).

B-474.1.2.4 Former Foster Care in Higher Education

Revision 17-2; Effective April 1, 2017

Policy for type Assistance (TA) 77 — Former Foster Care in Higher Education (FFCHE), is explained in Part F, Former Foster Care in Higher Education (FFCHE).

B-474.1.2.5 Medicaid for Breast and Cervical Cancer

Revision 17-2; Effective April 1, 2017

Policy for TA 66 — Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive, and TA 67 — MBCC, is explained in Part X, Medicaid for Breast and Cervical Cancer (MBCC).

B-474.1.2.6 Former Foster Care Children

Revision 18-1; Effective January 1, 2018

Policy for TA 82 — Medicaid for Former Foster Care Children (FFCC), is explained in Part E, Former Foster Care Children (FFCC).

B-474.1.2.7 Medicaid Coverage for Inmates of a Public Institution

Revision 18-1; Effective January 1, 2018

The policy and processes stated in this section only apply to inmates of the Texas Department of Criminal Justice (TDCJ) and do not apply to any other state, county, or city jails. Applications are submitted to HHSC only by The University of Texas Medicaid Branch at Galveston.

An inmate of a public institution is eligible for Medicaid coverage if the following conditions are met:

- The inmate meets Medicaid eligibility requirements. Inmates who are pregnant and children through age 18 could meet current Medicaid eligibility requirements.
- The inmate receives inpatient services.
- The inpatient services are provided by a hospital that is not on the premises of a prison, jail, detention center, or other penal setting, including a facility run by a private health care entity.

The Medicaid coverage is limited to the specific days the inmate is admitted as a patient receiving inpatient services as verified by the medical provider using Form H1046, Inpatient Medical Services Certification. Inpatient services are those provided on the recommendation of a physician or dentist and received in a medical institution. The individual must receive or expect to receive room, board, and professional services in the institution for a 24-hour period or longer.

If the inmate is ineligible due to U.S. citizenship or alien status, the medical provider must also complete Form H3038, Emergency Medical Services Certification. The ineligible inmate is eligible only for those dates verified as an emergency, even if the inpatient treatment continues after the verified emergency dates.

The incarcerated individual is only eligible for prior coverage.

The TDCJ or its designee submits the following documents to HHSC via fax:

- Form H1205, Texas Streamlined Application, on behalf of the inmate the month following the month the eligible hospital bill was incurred;
- Form H1046;
- Form H3038, if applicable; and
- all required verification, such as verification of citizenship, alien status, etc.

Note: If the required information or verification is not received, staff must call or send secure email to the designated TDCJ contact.

Upon disposition of the application, staff must send Form TF0001, Notice of Case Action, to the address of the representative provided on Form H1205.

B—474.2 Conversion of EDGs

Revision 13-4; Effective October 1, 2013

SNAP

EDGs are converted to CBS when all members meet all SNAP eligibility requirements that pertain to categorically eligible households, receive SSI, and no individual is disqualified for:

- able-bodied adults without dependents (ABAWD) time limits,
- fleeing as a felon,
- an IPV,
- refusal to cooperate with a Quality Control review,
- E&T noncooperation,
- SSN noncooperation,
- student status, or
- felony drug conviction.

Note: Additionally, in order to be eligible for conversion to the SNAP-SSI caseload, no individual can reside in a group living arrangement, drug/alcohol treatment center or boarding house, or have earned income, including self-employment income.

After the local office completes an initial certification, an automated process converts EDGs that meet the criteria to CBS. The automated process occurs monthly at cutoff. The individual is mailed a notice to inform the individual:

- that the EDG is handled by CBS, and
- to report household changes by:
  - telephoning 2-1-1, or
  - entering the change in the Self-Service Portal, or
  - mail.

The notice includes contact information. Field staff continue to accept changes and complete case actions until the EDG converts to CBS.

B—474.3 Methods of Reporting Changes

Revision 15-4; Effective October 1, 2015

SNAP and Medical Programs

Local office staff may fax changes to CBS. The vendor will create a task for online or mailed changes.

Related Policy
Reporting Requirements, B-620

B—474.4 Reserved

Revision 15-4; Effective October 1, 2015

B—474.5 Replacement of Lone Star Cards/PINs/Medical Care IDs

Revision 15-4; Effective October 1, 2015

SNAP

See procedures in B-243, Centralized Benefit Services (CBS) Cases, for CBS individuals who request card or PIN replacements.

Medical Programs

Replacement or temporary medical care ID cards (Form H1027-A, Medicaid Eligibility Verification; Form H1027-B, Medicaid Eligibility Verification - MQMB; and Form H1027-C, Medicaid Eligibility Verification - QMB) must be issued by local eligibility determination offices. The individual can print an image of the medical care identification card and request a replacement online through YourTexasBenefits.com, or call 1-855-827-3748 to request a replacement.

B—474.6 Moving Cases Out of CBS

Revision 15-4; Effective October 1, 2015

SNAP

The CBS section:

- moves cases out of the CBS caseload if:
  - the household no longer meets the criteria to be a CBS case (earnings, loss of SSI);
  - household composition changes; or
  - because regional staff request the transfer under special circumstances;
- shortens the certification period as specified in B-474.6.1, Special Procedures for Shortening Certification Periods for Centralized Benefit Services (CBS) Eligibility Determination Groups (EDGs); and
- documents in TIERS Case Comments the reason for return.

The CBS section also returns untimely redetermination EDGs received in the month after the last benefit month to the task queue and documents in TIERS Case Comments the reason for return.

Medical Programs

Children's MedicaiD – CBS moves completed Medicaid determinations, both active and denied, out of the CBS section.

B—474.6.1 Special Procedures for Shortening Certification Periods for Centralized Benefit Services (CBS) Eligibility Determination Groups (EDGs)

Revision 15-4; Effective October 1, 2015

SNAP

If the household reports a change that results in the household no longer meeting CBS caseload criteria, such as the loss of SSI benefits, an addition to the household, or moving into a GLA, then CBS staff move the EDG out of the CBS caseload.

Before moving the EDG out of the CBS caseload, CBS must take appropriate action based on the following criteria:

If the household's certification period is in ...	then ...
month 1-11,	if benefits: • will increase or decrease, send the household Form TF0001, Notice of Case Action, informing the individual that the last benefit month is month 12; and • shorten the certification period to a 12-month total by processing a change action with the new benefit amount and change the last benefit month to month 12.
month 12-36,	if benefits: • are being increased or decreased, send the household Form TF0001, Notice of Case Action, informing the household that the certification period is being shortened because it no longer meets the criteria specified in B-474, Centralized Benefit Services (CBS) Section; and • shorten the certification period to end on the last day of the month after the month Form TF0001 was sent. **Note:** CBS staff also must include Form H1830, Application/Review/Expiration/Appointment Notice, and Form H1010, Texas Works Application for Assistance — Your Texas Benefits, advising the individual how to file future applications.

B—474.7 Denied EDGs

Revision 15-4; Effective October 1, 2015

SNAP

The local office must perform an inquiry on denied EDGs to ensure the CBS section is not in the process of certifying the EDG.

Note: Advisors must accept Form H1840, SNAP Food Benefits Renewal Form, if received at the local office and the CBS SNAP EDG certification period has expired.

Medical Programs

The local office must coordinate with CBS to determine the effective date of certification when a youth certified for TP 70, TA 82, or TP 44 (Medicaid coverage to eligible youths in the custody of or released from the Texas Juvenile Justice Department), or an adult certified for TA 67, applies for Medicaid.

B—474.8 Opportunity to Register to Vote

Revision 15-4; Effective October 1, 2015

All Programs

Advisors must mail Form H0025, HHSC Application for Voter Registration, to households who do not have a face-to-face interview, unless Form H0025 is requested through the Voter Registration Information Individual Demographic screen.

If the individual contacts the local office to decline the opportunity to register to vote after receipt of Form H0025, the advisor should mail Form H1350, Opportunity to Register to Vote, to the individual for a signature. The advisor sends the completed Form H1350 for imaging and retains the form for 22 months.

Related Policy
Registering to Vote, A-1521

B—475 Supplemental Nutrition Assistance Program Combined Application Project (SNAP-CAP)

Revision 13-4; Effective October 1, 2013

B—475.1 Overview

Revision 16-3; Effective July 1, 2016

SNAP-CAP

SNAP-CAP is a demonstration project to outreach older SSI recipients not currently certified for SNAP. Single SNAP-CAP households are certified for either a $65 or $95 standard SNAP-CAP allotment based on their reported monthly shelter expense.

If the household reports that the monthly shelter expense is less than $ 400 per month, the monthly SNAP-CAP allotment is $65. If the household reports that the monthly shelter expense is more than or equal to $ 400 per month, the monthly SNAP-CAP allotment is $95.

To be eligible for SNAP-CAP, an individual must:

- be an SSI recipient,
- be age 50 or older,
- reside in Texas,
- not reside in an institution that causes ineligibility, and
- not receive regular SNAP benefits.

Additionally, an individual is not eligible to participate in SNAP-CAP if the person:

- is a fleeing felon,
- is disqualified for an IPV, or
- is disqualified due to a felony drug conviction that occurred on or after September 1, 2015 as described in A-232.2, Disqualified Persons.

No other regular SNAP eligibility criteria apply to SNAP-CAP. **Note:** Individuals may switch from SNAP to SNAP-CAP as described in B-475.2.2, Switching from the Regular SNAP Program to SNAP-Combined Application Project (CAP).

B—475.2 Application Processing

Revision 15-4; Effective October 1, 2015

SNAP-CAP

State office identifies potential SNAP-CAP recipients via the Texas State Data Exchange (SDX) match process. State office automatically mails a form to individuals potentially eligible for SNAP-CAP. For individuals who previously received SNAP benefits in Texas, the mail out occurs two months after the last month individuals last received benefits in Texas. CBS certifies the SNAP-CAP EDG for 36 months, provides notice of eligibility, and authorizes an EBT account without a face-to-face or telephone interview.

If an individual receives a SNAP-CAP application and also applies for SNAP at the local office, advisors coordinate the application process with CBS staff before making an eligibility decision in the local office to ensure that the individual can make an informed choice about which program the individual prefers. The individual may voluntarily withdraw the other application.

If the spouse of an active SNAP-CAP participant submits an application at the local office, advisors certify the spouse separately from the active SNAP-CAP participant. If the spouse appears potentially eligible for SNAP-CAP, the advisor explains the program and requirements outlined in B-475, Supplemental Nutrition Assistance Program Combined Application Project (SNAP-CAP). The SNAP application may be withdrawn if the individual wants to participate in SNAP-CAP. Refer the individual to 2-1-1. Advisors must document that the individual was informed of the program, but that the individual withdrew the SNAP application.

A SNAP-CAP application returned to a local eligibility determination office must be faxed to the non-expedited fax line at 1-877-447-2839 the same day it is received.

Expedited processing and benefit proration do not apply to the SNAP-CAP program. A standard allotment is issued for the month the application is returned.

B—475.2.1 Identifying Intentional Program Violations (IPVs) and Felony Drug Convictions

Revision 15-4; Effective October 1, 2015

SNAP-CAP

The Data Broker vendor will receive the monthly SNAP-CAP application file and will notify state office Eligibility Operations of any clients with active out-of-state SNAP IPV disqualifications and felony drug convictions.

State office staff will forward any IPV matches to the Customer Care Center-Electronic Disqualified Recipient System (CCC-eDRS) staff using secure Voltage email at HHSC Office of Eligibility Services CCC Open Investigation (HHSC OES CCC IC) who will complete a secondary verification and then forward a completed Form H1856, SNAP Out-of-State Intentional Program Violations, to OIG at CDU@hhsc.state.tx.us, and document this action in TIERS Case Comments.

OIG Centralized Disqualification Unit (CDU) staff will enter the IPV disqualification data from Form H1856 into TIERS and create a reported change task to notify the advisor of the disqualification. The CBS advisor then takes appropriate action to deny the application/EDG. **Note:** If CBS staff has not yet processed the application, TIERS will ensure it is denied if the application is subsequently filed and/or processed.

State office also shares any felony drug conviction data matches with CBS. CBS staff must follow policy in A-232.2, Disqualified Persons, to take adverse action.

B—475.2.2 Switching from the Regular SNAP Program to SNAP-Combined Application Project (CAP)

Revision 15-4; Effective October 1, 2015

SNAP-CAP

If an SSI recipient receiving regular SNAP benefits wants to switch to SNAP-CAP, the individual must contact CBS staff and request to withdraw from the regular program and apply for SNAP-CAP.

Within 10 days of receipt of the request and determination that the individual meets SNAP-CAP eligibility requirements, CBS staff:

- send the individual a notice of denial for the regular SNAP, using adequate notice procedures;
- terminate the person's participation in the regular SNAP as soon as possible (that is, the end of the month the individual made the request if the 10th day falls before the monthly computer cutoff, and no later than the end of the next month); and
- send the individual a SNAP-CAP application if the individual has not already filed one with CBS.

If HHSC fails to take action within 10 days to authorize denial of the regular SNAP EDG for the applicable month, HHSC restores any lost benefits as a result of untimely agency action.

HHSC does not provide a SNAP-CAP application to anyone who does not meet the SNAP-CAP eligibility criteria. CBS also certifies eligible individuals for SNAP-CAP if the individuals submit applications they obtained on their own. CBS will coordinate termination of the individual's participation in regular SNAP, if not already terminated. To avoid duplication of SNAP benefits when an eligible individual requests to switch from the regular SNAP to SNAP-CAP, CBS staff use a file date equal to the first day of the first month the individual qualifies for SNAP-CAP, if that date is later than the date the application form is actually received. CBS staff must document in TIERS Case Comments the reason for the modified file date as compared to the date on the application form.

Note: CBS staff may also cancel a month's regular SNAP issuance in order to expedite the recipient's switch to SNAP-CAP, if it is not too late to cancel that issuance. Refer to B-331, Cancelling Benefits in EBT Accounts.

B—475.3 Household Composition

Revision 15-4; Effective October 1, 2015

SNAP-CAP

A SNAP-CAP food unit consists of one person. Married individuals who are both receiving SSI are considered separate households and certified on individual SNAP-CAP EDGs. (See A-231, Who Is Included.)

A SNAP-CAP participant who resides in a household in which other members receive SNAP through the regular program is considered a separate household, regardless of how they purchase and prepare their meals. (See A-232.1, Nonmembers.)

Do not include a SNAP-CAP participant when determining regular SNAP eligibility for other household members. Follow policy in A-1326.1.1, Contributions from Noncertified Household Members.

A minor child residing with a SNAP-CAP participant may be certified as SNAP head of household. The SNAP-CAP participant must be listed as the AR on the minor child's EDG. (See A-231.)

B—475.4 Income

Revision 13-4; Effective October 1, 2013

SNAP-CAP

SSI eligibility is verified weekly via the SNAP-CAP participant's SDX record.

B—475.5 Shelter and Utility Expenses

Revision 15-4; Effective October 1, 2015

SNAP-CAP

Advisors follow policy in A-1429, Shelter Costs, for separate households sharing shelter expenses, including standard utility allowance (SUA)/basic utility allowance (BUA), if applicable.

B—475.6 Changes

Revision 15-4; Effective October 1, 2015

SNAP-CAP

SNAP-CAP participants are not required to report changes. CBS processes shelter and address changes reported by SNAP-CAP participants.

CBS will mail Form H0025, HHSC Application for Voter Registration, to the individual when the individual reports a change of address. If the individual contacts CBS to decline the opportunity to register to vote after receipt of Form H0025, CBS will mail Form H1350, Opportunity to Register to Vote, to the individual for a signature. After the household returns Form H1350, the advisor sends the form for imaging and retains the image for 22 months.

State office uses SDX records to automatically update individual information on a weekly basis. The weekly SDX update results in a SNAP-CAP EDG denial if the individual no longer receives SSI, dies or moves to a nursing home.

Related Policy
Registering to Vote, A-1521

B—475.7 Issuing Benefits

Revision 15-4; Effective October 1, 2015

SNAP-CAP

CBS authorizes a SNAP-CAP participant's EBT account. Replacement EBT cards may be obtained from local eligibility determination offices if the local office replacement criteria are met. Advisors follow policy in B-235.1, Lone Star Card Replacement Procedures, to determine whether the SNAP-CAP participant can get a replacement card locally or must obtain it from the Lone Star Help Desk.

Follow policy in B-362, Advisor Action on Dormant Accounts, when a SNAP-CAP EDG is dormant.

B—475.8 Fair Hearings

Revision 13-4; Effective October 1, 2013

SNAP-CAP

Follow policy in B-1000, Fair Hearings.

B—475.9 Claims

Revision 15-4; Effective October 1, 2015

SNAP-CAP

Advisors file an overpayment referral when a household receives benefits it is not entitled to receive. This may occur based on agency error, individual error/misunderstanding, or through fraud or an IPV. OIG receives the overpayment referral and establishes a claim if the referral is valid.

SNAP-CAP households are subject to overpayment referrals and claims. Households may repay benefits through recoupment or through restitution. Recoupment is a method of recovering an overpayment claim by withholding a portion of the household's benefits. Restitution is a method of recovering an overpayment claim by the receipt of payments from the household paid to HHSC.

For additional information, follow policy in B-700, Claims.

B—475.10 Redeterminations

Revision 15-4; Effective October 1, 2015

SNAP-CAP

State office automatically mails Form H1842, SNAP-CAP Renewal Application, two months before the last benefit month. To reapply in a timely manner, the individual must submit the completed Form H1842 by the 15th day of the last benefit month.

CBS staff must process timely redeterminations by the last workday of the certification period. CBS staff certify the SNAP-CAP EDG for 36 months and provide a notice of eligibility without a face-to-face or telephone interview. Advisors must ensure that the individual's normal issuance cycle is not interrupted.

If CBS receives Form H1842 after the 15th day of the last benefit month, advisors certify or deny the application by the 30th day after the file date. Expedited processing and benefit proration do not apply to SNAP-CAP.

A Form H1842 returned to a local eligibility determination office must be faxed to CBS the same day it is received. The fax number is 1-877-447-2839.

B—475.10.1 Opting Out of SNAP-CAP

Revision 15-4; Effective October 1, 2015

SNAP-CAP

Individuals currently receiving SNAP-CAP may choose to apply for traditional SNAP because they may be eligible for a higher allotment. If an individual returns Form H1010, Texas Works Application for Assistance — Your Texas Benefits, and chooses to opt out of SNAP-CAP, the local office must:

- contact and confirm the applicant wants to apply for benefits under regular SNAP;
- schedule an appointment for an interview;
- perform Application Registration using a different SNAP EDG number than the SNAP-CAP EDG number;
- determine if the individual would receive a higher allotment under regular SNAP;
- notify the individual of the allotment amount under regular SNAP and confirm if the individual wishes to withdraw from SNAP-CAP;
- contact 2-1-1 to request EDG closure because the individual wishes to withdraw from SNAP-CAP;
- confirm the SNAP-CAP EDG has been denied; and
- certify the individual for regular SNAP effective the first month the individual qualifies for benefits without duplicating benefits.

B—476 Joint Supplemental Security Income (SSI)-SNAP Applications

Revision 15-4; Effective October 1, 2015

B—476.1 Applications Filed in the Social Security Office

Revision 15-4; Effective October 1, 2015

SNAP

Households whose members are all applying for or receiving SSI may apply for SNAP at the SSA office unless the households already have a SNAP application pending. These individuals are not required to come to the SNAP office to complete the application or redetermination process. If more information is needed from the household, the advisor must contact the household by home visit, telephone, or mail.

SSA:

- accepts and completes the SNAP application during the SSI interview; and
- forwards the following items to the Document Processing Center within one workday after receiving the application:
  - the application;
  - Form SSA-4233, Social Security Administration Transmittal for Food Stamp Applications; and
  - any verification SSA has received.

The file date for the application is the date SSA receives the application. SSA notes this date on Form SSA-4233. When SSA receives additional verification after forwarding the application to the Document Processing Center, SSA sends the additional verification with Form SSA-4233.

B—476.1.1 Expedited Service

Revision 15-4; Effective October 1, 2015

SNAP

Advisors determine expedited services eligibility for SSI households the same as other households, except expedited time limits begin with the date the correct SNAP office receives the application.

SSA staff:

- screen the application for expedited services on the day they receive it;
- note "Expedited Processing" on the first page of Form H1010, Texas Works Application for Assistance — Your Texas Benefits, if the household appears to be eligible; and
- fax the application within one workday to the Document Processing Center's expedited fax number.

The individual may also take the application to the SNAP office.

B—476.1.2 Work Registration

Revision 16-2; Effective April 1, 2016

SNAP

SSI household members who apply for SSI and SNAP at the Social Security office are exempt from work registration until the SSA determines their eligibility for SSI.

Related Policy
E&T Exemptions, A-1822.1

B—476.1.3 Special Review

Revision 15-4; Effective October 1, 2015

SNAP

For households applying at SSA, advisors process a special review during the third month of the certification period to determine whether the individual received a decision on the SSI claim.

B—476.1.4 Notice of Expiration

Revision 13-4; Effective October 1, 2013

SNAP

TIERS sends Form H1830-R, Texas Works Renewal Notice, to the SSI household:

- no earlier than the month before the last month of the certification period, and
- no later than the first day of the last month of the certification period.

The notice of expiration informs the individual:

- what programs are due for redetermination,
- verifications needed for the redetermination,
- when the redetermination application and verifications are due, and
- the individual's rights and responsibilities.

B—476.1.5 Reporting Changes

Revision 15-4; Effective October 1, 2015

SNAP

These households are subject to the same change reporting requirements as other SNAP households.

HHSC receives information on whether the SSI was granted or denied through an interface with SSA. Advisors must take action on information from this or any other source.

Related Policy
Reporting Requirements, B-620

B—476.1.6 Redetermination

Revision 13-4; Effective October 1, 2013

SNAP

Households in which all members are applying for or receiving SSI may file a redetermination for SNAP at the SSA.

The SSA office sends:

- the application,
- transmittal sheet (Form SSA-4233), and
- any available verification to the Document Processing Center.

B—476.2 Applications Filed in Public Institutions

Revision 15-1; Effective January 1, 2015

SNAP

A resident of a public institution may jointly apply for SSI and SNAP while in the institution if scheduled for release within 30 days.

SSA:

- within one business day, sends non-expedited applications to:
  - HHSC
    P.O. Box 149024
    Austin, TX 78714-9024

    or
  - faxes them to 1-877-447-2839;
- within one business day, faxes expedited applications to 1-866-559-9628;
- notes "PRERELEASE" in red ink across the top of Form H1010, Texas Works Application for Assistance — Your Texas Benefits;
- sends Form SSA-4233 to HHSC; and
- gives HHSC the name, address and telephone number of a staff contact at the institution.

When the individual does not have a post-release address, SSA holds the application for 30 days and documents its actions. SSA sends these applications and Form SSA-4233 to HHSC within one business day when:

- SSA receives a post-release residence address;
- release has occurred, but SSA has not received a post-release address;
- SSA denies SSI prior to release; or
- release from the institution is canceled.

HHSC staff:

- register the application, and
- pend the application until SSA notifies HHSC that the applicant has been released.

If the applicant is:

- not released, HHSC denies the application.
- released, HHSC determines eligibility for benefits, including expedited services. HHSC offers benefits to allow the individual a chance to participate per the time frames in A-100, Application Processing.

Note: The file date is the date the applicant is released from the institution. The file date is day zero.

Certification Period/Special Review — The advisor must process a special review during the third month of the certification period to determine whether the individual receives SSI.

B—480 A Household with Members on TANF, TANF-State Program (SP), TP 07, TP 08 and TP 20

Revision 15-4; Effective October 1, 2015

TANF

When household members on a TANF EDG that includes other-related children become ineligible, and the other-related children remain eligible for TANF, advisors must ensure the other-related children continue to receive TANF.

Advisors must:

- deny the TANF or TANF-SP EDG; and
- continue the TANF for the other-related children.

TP 08

If a caretaker relative who receives TP 08 based on caring for (an) other-related child(ren) receiving Medicaid becomes ineligible for TP 08 due to new or increased earnings or spousal support and begins receiving TP 07 or TP 20, the other-related child(ren) will also transition from their TP 43, TP 44, or TP 48 EDG to a TP 07 or TP 20 EDG.

B—481 EDGs That Include an Other-Related Child

Revision 15-4; Effective October 1, 2015

B—481.1 At Initial Certification

Revision 15-4; Effective October 1, 2015

TANF or TANF-SP

When a TANF EDG includes an other-related child, advisors must:

- explain to the household that the other-related child, if eligible alone, can continue receiving TANF even if the TANF for the other members of the household is denied. Denials include, but are not limited to, those because of:
  - resources,
  - earnings, or
  - child support.
- advise households that have an other-related child included in the TANF EDG to contact HHSC immediately if they receive a notice in the mail stating that their TANF or TANF-SP will be denied because they are no longer eligible for the 90 percent earned income deduction.
- set a special review to contact the household and continue TANF for an eligible other-related child when the EDG is expected to be denied because the 90 percent earned income deduction will be removed.

B—481.2 Before a TANF or TANF-SP EDG Is Denied

Revision 15-4; Effective October 1, 2015

TANF

Advisors determine whether an other-related child is eligible for TANF on a separate EDG before the household's TANF is denied. Advisors must contact the household to ensure that the household wants the child's TANF to continue.

Advisors provide TANF to the other-related child without a break in benefits, if the other-related child is eligible alone and the household:

- wants the other-related child's TANF to continue, or
- cannot be contacted.

If more than one other-related child is in the household, other-related children who are not siblings are certified on separate EDGs.
Exception: The individual may choose to combine EDGs if one EDG is ineligible separately but would be eligible if the members were combined.

The other-related child is kept in the original household group if the:

- child is not eligible alone, or
- the household does not want the child to receive TANF.

B—482 Separating Household Members

Revision 15-4; Effective October 1, 2015

TANF

The eligibility system creates an EDG for the other-related child's TANF. Advisors must verify that each certified group contains the correct members. Advisors also must ensure that a new Lone Star Card is issued for the other-related child's new EDG. A new application is not required.

Note: These procedures ensure that TANF-SP EDG numbers follow the SP members.

B—490 Determining Whether an Individual Who Resides in a Facility Is Institutionalized

Revision 16-3; Effective July 1, 2016

SNAP

Individuals residing in institutions that are not approved may be potentially eligible for SNAP only if the individual is not considered institutionalized. Approved institutions are defined in A-116.2, Applications from Residents of a Homeless Shelter; B-440, Drug and Alcohol Treatment (D&A)/Group Living Arrangement (GLA) Facilities; and B-450, Residents in Family Violence Shelters.

Additionally, individuals who reside together and receive residential services from nonprofit organizations or for-profit providers who contract with DADS or HHSC to provide residential services may participate in SNAP only if the individual is not considered institutionalized.

Provider staff may:

- manage an individual's personal funds at the request of the individual; or
- be the payee on the resident's SSI benefit check.

If the individual requests the provider staff to manage the individual's personal account, the staff must maintain a financial account for the individual and a separate detailed record of all deposits and expenditures for each individual.

Provider staff may not commingle the individual's personal funds with the provider's funds.

For individuals residing in a facility or receiving residential services, staff must determine whether an individual is institutionalized for SNAP eligibility following the steps below:

Step	Yes	No
1. Does the individual do their own shopping and meal preparation for more than 50 percent of their meals, **or** do the facility staff manage the individual's personal account (which can include SNAP benefits) and use those funds to purchase a majority of the individual's meals and prepare them for the individual?	The individual is **not** considered institutionalized. The individual is eligible for SNAP if all other SNAP eligibility requirements are met. Go to Step 3.	Go to Step 2.

Step	Yes	No
2. Does the facility : • contract with DADS or HHSC to furnish a majority of the individual's meals along with other services; • provide a majority of the individual's meals from food purchased with money other than the individual's funds; or • charge the individual a standard fee for a majority of the individual's meals?	The individual is considered "institutionalized" for purposes of SNAP eligibility since the contractor is providing a majority of meals for the individual. The individual can only qualify if the individual meets the requirements for a resident of a nonprofit GLA in B-442, Residents of Group Living Arrangement (GLA) Facilities.	The individual is **not** considered institutionalized. The individual is eligible for SNAP if all other SNAP eligibility requirements are met. Go to Step 3.
3. Does the individual purchase **and** prepare their meals separately from others (including situations in which an attendant purchases food for the individual with the individual's money and prepares the individual's meals separately from other individuals), **or** does the individual intend to purchase and prepare separately after certification for SNAP?	The individual can apply as a one-person household following regular policy.	Individuals who purchase **or** prepare their food together must be included together on the SNAP application. HHSC determines eligibility for all those purchasing or preparing together following policy in A-210, General Policy. **Example:** The facility uses each individual's personal funds to purchase groceries and then prepare meals for all individuals together. In this example, those individuals must be included together for SNAP.

Verify and document the answers to the questions in the chart. If the individual designates provider staff as the AR and the AR states the attendant purchases meals/food using the individual's funds, the AR must provide a copy of the detailed record of deposits and expenditures for those individuals.

B—491 Documentation Requirements

Revision 15-4; Effective October 1, 2015

SNAP

For households receiving residential assistance, responses to the questions in B-490, Determining Whether an Individual Who Receives Residential Assistance Is Institutionalized, must be documented.

TWH, B-500, Reserved for Future Use

Reserved for future use.

TWH, B-600, Changes

Revision 17-3; Effective July 1, 2017

B—610 General Policy

Revision 15-4; Effective October 1, 2015

All Programs

Changes are situations that occur in a household that may affect eligibility or the amount of benefits. The advisor must take action on reported changes to ensure that:

- individual benefits are issued timely and accurately;
- the Texas Health and Human Services Commission (HHSC) is not sanctioned for failure to provide correct benefits for the correct month; and
- Quality Control (QC) initiatives are met.

B—620 Reporting Requirements

Revision 05-4; Effective August 1, 2005

B—621 What to Report

Revision 17-3; Effective July 1, 2017

All Programs

The advisor must inform all households of their responsibility to report changes in residence.

TANF and SNAP except SNAP Streamlined Reporting (SR) Households

The advisor must inform all households of their responsibility to report the following changes:

- source of income;*
- household composition;
- ownership of a licensed vehicle; and
- wage rate or status (full-time to part-time or vice versa as defined by the employer) for employed household members.*

* SR households must report any change that causes the ongoing income to exceed the 130 percent federal poverty income limit (FPIL) including a new household member.

TANF

The advisor must inform all households of their responsibility to report the following changes:

- the amount of non-exempt unearned income of any household member;
- circumstances other than employment that affect an individual's amount of benefits or employment services exemption status;
- address, job, or other information related to the absent parent; and
- available cash, stocks, bonds, or money in a bank or savings account if the total is over $1,000.

SNAP

Streamlined Reporting 1 households meet the SR criteria described in A-2350, Streamlined Reporting Households, and have income below 130 percent FPIL. These households are required to report:

- residence and associated changes in shelter cost such as rent/mortgage and utilities; and
- when the ongoing gross monthly income exceeds 130 percent FPIL for the household's size. Consider the income ongoing if it exceeds 130 percent FPIL for two consecutive months. **Example:** A new household member who is required to be included in the SNAP Eligibility Determination Group (EDG) moves into an SR household and the new member has income that causes the household's income to exceed the current 130 percent FPIL. The household must report the change. The advisor must issue a new Form TF0001, Notice of Case Action, notifying the household of the requirement to report changes in residence and associated changes in shelter costs.

Streamlined Reporting 2 households meet the SR criteria described in A-2350 and have income above 130 percent FPIL. These households are required to report changes in residence and associated changes in shelter costs such as rent/mortgage and utilities only.

Streamlined Reporting 3 households do not meet the SR criteria in A-2350. These households are required to report:

- gross monthly household unearned income if the amount changes by more than $50 during the certification period;
- residence and associated changes in shelter costs such as rent/mortgage and utilities;
- legal obligation of child support paid to or for nonmembers; and
- available cash, stocks, bonds or money in a bank or savings account if the combined resources total is $5,000 or more.

When an SR 1 household reports a change that occurs after certification and the change causes their ongoing income to exceed their gross monthly income limit (130 percent FPIL) for two consecutive months, the household has met the SR reporting requirement. If the household remains eligible for an allotment, the household is not required to report additional income changes during the certification period, and is only required to report changes in residence. However, if the advisor later processes a reported change and income is again below 130 percent FPIL (due to decreased income or fewer household members), Form TF0001 should be issued advising the household they are again responsible for reporting if their income exceeds 130 percent FPIL.

SR 1 and SR 2 households:

- must respond as directed to all notices and letters from the employment program;
- are not required to report any other changes. If the household reports a change, the advisor takes the appropriate action and continues to act on all agency-generated changes; and
- are not required to report when a child turns age 18 during the certification period. If an SR household contains a child who will turn age 18 during the certification period, time limits do not apply to anyone until the next redetermination.

Advisors must inform SR 1 and SR 2 households with associated TANF or Medical Program (MP) EDGs of the TANF/MP reporting requirements. A status of SR 1 or SR 2 on a SNAP EDG does not alter the change reporting requirements for associated TANF or MP EDGs.

If the SR 1 or SR 2 household reports that a minor child is no longer in the home and the only person age 18 up to age 50 is now an Able Bodied Adult without Dependents (ABAWD) who:

- does not meet the SNAP ABAWD work requirement, the advisor processes the household composition change and registers the individual for SNAP Employment and Training (E&T). The advisor must send the ABAWD a new notice informing the individual of the time limit and set a special review for the month before the end of the ABAWD's time limit to disqualify the ABAWD or deny the EDG.
- meets the SNAP ABAWD work requirement, the ABAWD's months do not count and a special review is not required.

Medical Programs except TP 45

Advisors must inform all households of their responsibility to report the following changes:

- address;
- intent to reside in Texas;
- the individuals living in the home;
- income, including sources of income, regular hours worked and pay rate;
- Modified Adjusted Gross Income (MAGI) expenses;
- a child being institutionalized or dying; and
- medical insurance coverage.

TP 08 and TA 31

Advisors must inform all households of their responsibility to report changes in the address, job, or other information related to the absent parent.

TP 40

Households must report the termination of a pregnancy.

TP 45

Households must report if the child no longer resides in Texas.

Related Policy
General Reminders, A-1510
Monitoring Questionable Management, A-1731
Length of Certification, A-2324
Streamlined Reporting Households, A-2350

B—622 When to Report

Revision 05-4; Effective August 1, 2005

All Programs

During the interview or application processing, households must report changes that occurred since the application was filed. See B-116, Information Reported During Application Processing.

After the interview, the household must report changes listed in B-621, What to Report, within 10 days after the household knows about the change.

For special reviews, see the requirements in B-125, Processing Special Reviews.

B—623 How to Report

Revision 15-4; Effective October 1, 2015

All Programs

Household members or someone acting on the household's behalf may report changes:

- online through YourTexasBenefits.com;
- in person;
- by telephone;
- by fax;
- by mail; or
- on Form H1019, Report of Change, submitted in person, by fax or by mail.

Notes:

- When a change is reported by telephone, the advisor must verify that the person speaking has the authority to report a change.
- When a signed Form H1019 is not on file, the individual's signature on Form H1028, Employment Verification, is acceptable as a written, signed report of income change for adequate notice purposes.
- When a change is reported on an application form, staff do not have to act on the change within 10 days. The file date is considered the report date for purposes of determining the effective date of the change. The date the advisor begins working the EDG and becomes aware of the change is day zero for purposes of taking action on the change for the associated EDGs. The individual must provide any requested verification by the Form H1020, Request for Information or Action, due date to be considered timely verification.
- If the household reports a change of address in person, the advisor must provide the individual with the opportunity to complete Form H0025, HHSC Application for Voter Registration, to register to vote based on their new address. If the individual declines to register to vote, the advisor should ask the individual to sign Form H1350, Opportunity to Register to Vote. The advisor must send Form H1350 for imaging when the individual returns the form and retain the form for 22 months.
- If the household reports a change of address online through YourTexasBenfits.com, or via mail, fax, telephone, or through an authorized representative, the advisor must mail the individual Form H0025 to register to vote based on the new address. If the individual contacts the local office to decline the opportunity to register to vote after receipt of Form H0025, the advisor must mail Form H1350 to the individual for a signature. The advisor must send Form H1350 for imaging when the individual returns the form and retain the form for 22 months.
- When a household requests to make a new person or organization their authorized representative, the advisor must verify the change using the client's signature or documentation explained in A-170, Authorized Representatives (AR).

Related Policy
Form TF0001 Required (Adequate Notice), A-2344.1
Receipt of Duplicate Application, A-121.2
Receipt of Identical Application, A-121.3
Registering to Vote, A-1521

B—623.1 Determining Whether New Income Information Is a Reported Change

Revision 15-4; Effective October 1, 2015

TANF, TP 08 and SNAP

When an advisor works a Children's Medicaid application/redetermination during a TANF/Medicaid/SNAP certification period, and a household member's source of income currently budgeted on the other active EDG has not changed, the advisor must determine whether the member is reporting a change in income. To do this, the advisor must determine whether the income verification the household provided with the Children's Medicaid application/redetermination is:

- a more recent payment than previously verified; and
- within the range of payments previously verified that are currently used in the budget for the associated active EDG(s), whether the individual provides only one or more than one. "Range of payment" is the highest to the lowest representative pay amounts used to determine the current ongoing budget.

Advisors may follow the guidelines below:

If ...	then ...
any of the payment amounts provided as verification for the Children's Medicaid application/redetermination are: • more recent; and • at least $25 outside the range of payment currently used as "representative income" in the budget for the active EDG,	treat this as a reported change for the active EDG and take action following B-631, Actions on Changes (including additional verification of income, if necessary). If the individual fails to provide timely verification, follow policy in B-642, Changes Increasing Benefits (Other than Additions to the Household), and B-643, Changes Decreasing Benefits.
all of the payment amounts provided as verification for the Children's Medicaid application/redetermination are: • older than those currently used, or • less than $25 outside the range of payment currently used as "representative income" in the budget for the active EDG,	do not treat this as a reported change for the active EDG (unless the individual reports that the source of income or amount of income has changed).

Example: The lowest representative check used for the current certification period is $175 and the highest representative check used is $200. The individual provides a check stub for the Children's Medicaid EDG in the amount of $210. This check is less than $25 outside the range of payments and is not considered a change.

If a change is reported during the Children's Medicaid application/redetermination, the advisor processing the Medicaid EDG must either take action on the associated TANF/Medicaid/SNAP EDG or notify the local office of the reported change. The file date is considered the report date for purposes of determining the effective date of the change. The date the advisor works the Children's Medicaid EDG and becomes aware of the change is day zero for purposes of taking action on the change for the associated EDG. The individual must provide any requested verification by the due date on Form H1020, Request for Information or Action, to be considered timely verification.

B—624 Receipts for Reported Changes

Revision 15-4; Effective October 1, 2015

All Programs

Households may request a receipt to acknowledge the change report. The receipt includes the type of change(s) and the date reported. If an individual requests a receipt, the advisor must issue:

- a copy of the individual's completed Form H1019, Report of Change; or
- Form H1800, Receipt for Application/Medicaid Report/Verification/Report of Change.

B—630 Processing Requirements

Revision 05-5; Effective October 1, 2005

B—631 Actions on Changes

Revision 17-2; Effective April 1, 2017

All Programs

Customer Care Center (CCC) staff is responsible for processing most client-reported changes.

Upon receipt of a change report in the local office, staff must:

- Accept the change.
- Date stamp the written change report.
- Enter the change into the State Portal — Report a TIERS Change portlet if the change is received without verification and verification is required.
- Complete an MI/Change Routing Cover Sheet and fax the change to the vendor at 1-877-236-4123 if the change is received with verification. The advisor must not enter the information in the State Portal — Report a TIERS Change portlet.

Note: Advisors provide Form H1800, Receipt for Application/Medicaid Report/Verification/Report of Change, upon request.

- To reduce the potential for quality control (QC) errors when the household reports a change in person or by phone, staff taking the change report must attempt to collect enough information to determine whether the change will decrease benefits. For new or increased income, this includes the following information:
  - date of the change;
  - date of the first payment;
  - source of the income;
  - expected pay amounts (or weekly hours and rate of pay for earnings); and
  - pay frequency.

Note: Advisors do not verify income if the amount reported makes the household ineligible.

- Advisors provide the household with Form H1020, Request for Information or Action, and Form H1020-A, Sources of Proof, on the day of the report (no later than the next workday) if more information or verification is required to complete the change action. The household is allowed 10 full days to provide the requested information or verification.

Note: When a SNAP household reports a change during the last certification month, staff are not required to give the household Form H1020/Form H1020-A, if the effective date of the change is after the certification period expires. Staff may send the change for imaging and address it with the individual at the redetermination interview.

Advisors must:

- Document the:
  - reported change;
  - date the change occurred; and
  - date the change was reported.
- Calculate the budget (if applicable).

Exception: Advisors must take the following steps when an individual reports a change in annual or seasonal self-employment income or expenses during their certification period:

Step	Yes	No
1. Does the current budget already include fluctuations as significant as the change reported?	**Stop** — the change is part of the normal fluctuation of the business; do not rebudget.	Re-evaluate, go to Step 2.
2. Does the re-evaluation result in a change of more than $25 to the average monthly net self-employment income?	Rebudget the EDG(s) using new average monthly net self-employment income.	**Stop** — do not rebudget.

- Send the individual Form TF0001, Notice of Case Action:
  - Following policy in B-642, Changes Increasing Benefits (Other than Additions to the Household); B-642.1, Verification Provided Timely; and B-642.2, Verification Not Provided Timely, if benefits increase or remain the same.
  - Following policy in B-643, Changes Decreasing Benefits, if benefits decrease. See A-2343.1, How to Take Adverse Action if Advance Notice Is Required.
- Provide the household with a new Form H1019, Report of Change, and a prepaid envelope to report future changes.

Related Policy
The Texas Department of Family and Protective Services (DFPS) notifies HHSC via an interface when a child receiving TANF, Medicaid or SNAP has been placed in foster care. Mass Update is triggered, and the child is automatically removed from the EDG(s). If Mass Update fails because the case is not in ongoing mode, HHSC staff must take action to remove the child from the EDG(s).

For this type of change, advance notice of adverse action is required for SNAP, but not for TANF or Medicaid.

The Texas Juvenile Justice Department (TJJD) or Juvenile Probation Department (JPD) notifies HHSC via the TJJD/JPD Placement Logical Unit of Work in the Texas Integrated Eligibility Redesign System (TIERS) when a child certified for Medicaid has been placed in a juvenile facility and when a child has been released. Please see policy in A-825, Medicaid Suspension, and in A-826, Medicaid Reinstatement regarding action taken on a case containing a child placed in or released from a juvenile facility.

Related Policy
Change in Medical Expenses During Certification, A-1428.4
Adverse Actions Not Requiring Advance Notice, A-2344
Form TF0001 Required (Adequate Notice), A-2344.1
Information Received During Expedited Application Processing, B-116.1

SNAP

When SR and non-SR households report a change in residence address, staff must request information on the associated changes in shelter costs. The advisor contacts the household by phone or using Form H1020, Request for Information or Action, to request the amount of the new shelter cost and utilities at the new residence. If the household fails to provide this information, the advisor must rebudget eligibility without the shelter expense and notify the household.

Medical Programs

Advisors are required to update the case information for all reported changes regardless of whether the recipient is in a continuous or non-continuous eligibility period.

During a non-continuous eligibility period, when a client reports any financial or non-financial change, advisors must attempt to verify client-reported income and expenses by determining if the reported income is reasonably compatible with electronic data sources, as explained in A-1370, Verification Requirements, Medical Programs.

If the applicant's or client's statement of income is not determined to be reasonably compatible with electronic data, income must be verified using other acceptable income verification sources, explained in A-1371, Verification Sources.

When processing a change during a non-continuous eligibility period, the system automatically sends individuals determined ineligible for Medicaid and the Children's Health Insurance Program (CHIP) to the Marketplace for an eligibility determination for federal health care coverage programs.

To qualify for the federal health care coverage programs, all individuals must first be determined ineligible for Medicaid and CHIP. Advisors must test whether an individual is eligible for all Medical Programs. The Texas Works Medical Programs Hierarchy, explained in A-132.1, Medical Programs Hierarchy, does this automatically for most programs.

Related Policy
Verification Requirements, A-1370

For non-financial changes reported during a period of continuous eligibility, advisors must set a special review in the first week of the sixth month before cutoff. Advisors must process the change following the process explained in B-125, Processing Special Reviews, before cutoff, as long as nothing else is needed to process the change. This will ensure that the change is effective in the seventh month, which is when the non-continuous eligibility period begins. A special review is not needed for financial changes, as these will be processed during a periodic income check (PIC), as explained in B-637, Periodic Income Checks.

TP 40, TP 43, TP 44, TP 48

When processing a change, a household may be eligible for expedited CHIP enrollment if the household:

- is determined ineligible for Medicaid during the eligibility period but before the end of the certification period;
- is determined eligible for Children's Health Insurance Program (CHIP); and
- owes a CHIP enrollment fee.

As explained in D-1711, Expedited CHIP Enrollment, an appeal and reactivation due to a change or PIC is an eligible case action for expedited CHIP enrollment.

Related Policy
Medicaid Termination, A-825
Expedited CHIP Enrollment, D-1711

B—631.1 Multiple Changes

Revision 15-4; Effective October 1, 2015

All Programs

Multiple changes reported on the same day must be processed as one occurrence. If required, the advisor must send Form H1020, Request for Information or Action, with the corresponding pending period and list the verifications needed for all changes.

Multiple changes reported on different days must be processed as separate occurrences. If required, the advisor sends Form H1020 for each reported change with the corresponding pending period and lists only the verification needed for that change.

Each change could affect the benefits for different months. Advisors refer to B-640, Changes Affecting Benefits, to determine the correct month for each change.

Exception: All changes associated with an individual at the time the individual joins a household affects the benefits for the same month, even if the report of change is on a different day.

Example A – A household consists of a mother and son who receive SNAP, TANF and Medicaid (TP 08 for the mother and Children's Medicaid for the son). On January 10, the mother reports the birth of her daughter on January 4 and that she and the newborn went home from the hospital on January 6. The EDGs are pended for more information with a due date of January 20. The mother provides the requested information on January 20, reports she has gone to work, and provides verification of her new employer. She reports her first day of work was January 16 and that she is paid semimonthly. She will receive her first check January 30, and it is not a partial payment. The advisor must:

- Add the newborn to the SNAP and TANF certified group effective February and request supplements for both programs;
- Adjust the TANF benefit amount, counting the income effective for March benefits, since adverse action must first expire — apply the 90 percent earned income deduction if the mother is eligible; and
- Adjust the SNAP budget to include the new TANF grant amount and the new earned income effective for March, since adverse action must first expire.

Example B – A household consists of a father, mother, and three children who receive SNAP and Children's Medicaid. The father is employed, and the mother receives Unemployment Insurance Benefits (UIB). On January 5, the mother reports that the father left the household on October 31 and that she received her last UIB check November 16. She also reports she started working December 3 and provides verification.

- Remove the father from the household and terminate his income effective for February SNAP benefits.

- Terminate the mother's UIB using either the Texas Workforce Commission inquiry system or the verification provided, effective for February SNAP benefits.
- Add the mother's new income effective for February.
- Children's Medicaid is continuously eligible for the first six months. The income change will be processed during a PIC, as explained in B-637, Periodic Income Checks.
- There is no overissuance because this is a streamlined reporting household.

Example C – On March 7, the household in Example B reports that the mother's sister has moved in, and the sister wants to be added to the SNAP EDG. The EDG is pended for the sister's Social Security number (SSN) with a due date of March 17. The sister provides a current pay stub from her employer that includes her SSN on March 17. On the same day, the SNAP EDG is pended again for verification of income that was not previously reported, with a new due date of March 27. On March 25, the sister provides Form H1028, Employment Verification, that states she has worked for her employer for one year and includes all other needed information.

- The sister is not added to the certified group for April SNAP benefits. Advance notice of adverse action for the addition of the sister's income will not expire in March.
- The sister is added to the certified group and her income counts, effective for May benefits.

B—631.2 Actions on Office of Inspector General (OIG) Match Action Alert Changes

Revision 16-3; Effective July 1, 2016

All Programs

OIG staff help with computer matching for the following reports:

- Interstate Match Report;
- Texas Department of Criminal Justice State Prison Match;
- Social Security Administration Deceased Individual Report;
- Social Security Administration Prisoner Verification System; and
- Bureau of Vital Statistics Deceased Individual Report.

Interstate Matches and Prisoner Matches

When OIG finds a match on an active Texas Integrated Eligibility Redesign System (TIERS) EDG, OIG investigates those cases. If HHSC needs to take action on the TIERS EDG, OIG lets HHSC staff know using Form H1186, OIG Match Action Alert.

OIG staff send Form H1186 without a cover sheet by mail or fax to the Document Processing Center (DPC) in Austin, Texas. The DPC images Form H1186, and once the form has been imaged, creates a task and routes it to the Customer Care Center (CCC). The CCC must send Form TF0001, Notice of Case Action, to the household within 10 days of receiving Form H1186. The advisor takes required action as necessary. The advisor must document in TIERS Case Comments if no action is required for any reason.

The appointed CCC contact is responsible for monitoring Form H1186 to make sure the advisor takes timely action.

When staff request Data Broker, the Texas Department of Criminal Justice (TDCJ) information is displayed on the combined report for an incarcerated individual. See C-825.17, Inmate/Parolee Match, for staff instructions for processing Prisoner Matches viewed in Data Broker.

Note: When clearing Form H1186 for a Children's Medicaid household, follow policy in B-631, Actions on Changes.

Deceased Individual Matches

HHSC matches recipients on active TIERS EDGs with records from the Social Security Administration and Texas Bureau of Vital Statistics to find deceased individuals and remove them from active EDGs, or tasks eligibility staff to perform additional research to determine the validity of the computer match. TIERS updates the date of death information for all active and inactive individuals and either:

- denies single household member cases if all data elements match; or
- creates and routes a Date of Death Action Alert Task List Manager (TLM) task with one of the following alerts:
  - Alert 810 — Process a Date of Death with a Perfect Match (created when the record exactly matches a TIERS individual and the case is in a mode other than Ongoing, or the deceased individual is the head of household);
  - Alert 811 — Process a Date of Death with a Non-Perfect Match (created when the record closely matches a TIERS individual, but is not an exact match); or
  - Alert 812 — Verify Discrepancy in Date of Death for Individual (created when the record exactly matches a TIERS individual, but the date of death does not match the date of death already in TIERS).

For detailed processing instructions, advisors may review the Eligibility Services State Processes document.

B—632 Mass Changes

Revision 15-4; Effective October 1, 2015

All Programs

The state or federal government initiates changes that can affect all individuals or large numbers of individuals. Individuals are not required to report mass changes. These changes occur in the:

- income eligibility standards;
- shelter and dependent care maximum deductions;
- Thrifty Food Plan and standard deductions;
- utility standard;
- cost-of-living adjustments for Social Security, Supplemental Security Income (SSI) and other federal benefits;
- TANF grants; and
- other eligibility criteria based on legislative or regulatory actions.

When these changes occur, HHSC automatically adjusts eligibility or benefits for most individuals and notifies the households via Form TF0001, Notice of Case Action. The adjustments are effective the date of the change. Advisors do not send Form TF0001.

HHSC generates an exception report for EDGs that are not adjusted during the state office conversion. Advisors must review the EDGs, adjust benefits if necessary, and send the individual Form TF0001, allowing advance notice of adverse action if required.

B—633 Changes in Eligibility Test

Revision 15-4; Effective October 1, 2015

All Programs except TP 45

If a household's circumstances change and the household is subject to a new income/resource test, the advisor must determine eligibility by applying the new test when the change is reported.

B—634 Changes in SNAP EDGs Jointly Processed with Supplemental Security Income (SSI)

Revision 15-4; Effective October 1, 2015

SNAP

Individuals whose SNAP and SSI applications have been jointly processed must report changes like other SNAP individuals.

B—635 Shortening Certification Periods as a Result of a Change

Revision 15-4; Effective October 1, 2015

SNAP

In the following situations, the advisor may shorten a non-public assistance (NPA) SNAP certification period:

- A change occurs that makes the case circumstances unstable, and the advisor cannot readily determine the effect of the change on the household's eligibility or benefits. This includes:
  - receipt of the discrepancy report Alert 254, Employer New Hire Data;
  - new listings of information on Data Broker that are inconsistent with information previously reported by the household; and
  - situations in which a public assistance household's TANF is denied for some administrative reason, such as missed appointment, voluntary withdrawal, or failure to provide information requested to redetermine TANF eligibility, and the individual's SNAP EDG becomes questionable.
- The household's eligibility becomes questionable as described in special reviews for known changes. See B-125.1, Due Dates.

Exception: Do not shorten the certification period if the household is designated SR. The advisor must send Form H1020, Request for Information or Action, requesting specific verification. If the SR household does not provide the verification, the EDG is denied and the advisor sends Form TF0001, Notice of Case Action. See A-2330, Setting Special Reviews, to determine when to set a special review on SR EDGs.

Centralized Benefit Services (CBS) staff shorten certification periods when a household reports a change that results in the household being transferred out of CBS. See B-474.6.1, Special Procedures for Shortening Certification Periods for Centralized Benefit Services (CBS) Eligibility Determination Groups (EDGs).

In all of the situations where advisors may shorten an NPA SNAP certification period, the advisor must use the following procedures before shortening the certification period:

- Send the household Form H1020 and list the specific verification needed to process the case. If the household responds, take appropriate action.
- If the household fails to provide verification, deny the EDG using denial reason failure to provide information and send Form TF0001.
- Send Form H1830, Application/Review/Expiration/Appointment Notice, and Form H1010, Texas Works Application for Assistance – Your Texas Benefits, to the household along with Form TF0001. Mark the first box on Form H1830 that begins, "Attached is an application for ..." and mark "SNAP." When the individual returns Form H1010, follow normal application time frames.

Related Policy
Data Broker, C-820
Questionable Information, C-920

B—636 Change in Head of Household

Revision 15-4; Effective October 1, 2015

All Programs

When the current head of household dies or leaves the home, the advisor must change the head of household to another responsible household member without requiring the remaining household members to reapply for benefits.

If the head of household who left the home was the Electronic Benefit Transfer (EBT) primary cardholder, the advisor must update the primary cardholder information to allow the household access to SNAP and TANF benefits and issue the individual a new Lone Star Card if one is needed.

Related Policy
When to Send a PCH Record, B-231.1
Issuing a Lone Star Card, B-233

B—637 Periodic Income Checks

Revision 17-2; Effective April 1, 2017

TP 08, TP 43, TP 44 and TP 48

Initiating a PIC requires no advisor action and uses the automated income check process to determine whether there has been a change in the client’s income that makes the client potentially ineligible for Medical Programs.

As part of the automated income check process, the client's income information in the eligibility system is compared with income data available through electronic data sources to determine whether it is reasonably compatible, as explained in A-1370, Verification Requirements, Medical Programs.

Electronic income data is requested one month before it is used by the eligibility system. If the client's income is not determined to be reasonably compatible with electronic data, the client must provide other acceptable verifications explained in A-1371, Verification Sources. When there are no earned income electronic data sources (TWC or TALX) available for the client, the eligibility system checks to see whether there is a New Hire Report. When a New Hire Report exists with an employer's name and hire date that is not currently included in the client's income, the client must provide verification of the information on the New Hire Report.

Advisors must process verifications returned as the result of a PIC following the process explained in B-631, Actions on Changes. If the client does not provide the requested verification by the 10th day, the eligibility system will automatically deny the individual on the 11th day.

The eligibility system may be able to complete the entire PIC process without any advisor action or correspondence sent to the client if the PIC does not find an indication that there has been a change in the client's income that makes them potentially ineligible for Medical Programs. If the result of the reasonable compatibility calculation is "Process Failure," the PIC is attempted again at the next scheduled PIC.

Note: Verification is required for SNAP and TANF during the automated income check process when:

- The reasonable compatibility calculation result is "Need Info because ELDS above limit" or the client is required to provide verification of information found on a New Hire Report for a Medical Program.
- An individual in the MAGI household is included in a SNAP or TANF budget group.

The client has 10 days to provide the verification for SNAP and TANF. If the client does not provide verification by the 10th day, the eligibility system will automatically take the following action on the 11th day based on the income type and electronic data source used during the automated income verification process:

- **Deny** SNAP and TANF benefits for the following data sources:
  - quarterly wage data from the Texas Workforce Commission (TWC); or
  - new Hire Report data from the Office of the Attorney General (OAG).
- **Notify the advisor to adjust** SNAP and TANF benefits for the following data sources:
  - earned income data from TALX;
  - unearned Retirement, Survivors, and Disability Insurance (RSDI) income data from the Social Security Administration (SSA); or
  - unearned unemployment data from TWC.

Note: Earned income data from TALX, unearned RSDI data from SSA, or unearned unemployment data from TWC are valid forms of verifications for SNAP and TANF. Since quarterly wage data from TWC and New Hire Report data from OAG are not valid forms of verifications for SNAP and TANF, the client must provide verification of the income.

TP 08

A PIC is initiated in months three through eight of the certification period when the following conditions are met:

- Any of the following is true for at least one individual in the MAGI household for at least one countable income or expense source:
  - an income or expense is not verified;
  - one of the following income types uses "Verified by Reasonable Compatibility" as the verification source:
    - employment income;
    - unemployment compensation income; or
    - RSDI income; or
  - The verification source is anything other than "Verified by Reasonable Compatibility" and the verification received date is more than 60 days old.
- The case is in Approved Ongoing mode.
- There are no pending TLM tasks for the case.

TP 43, TP 44 and TP 48

A PIC is initiated in months five through eight of the certification period when the following conditions are met:

- The individual will not age out before or during the PIC review month;
- Any of the following is true for at least one individual in the MAGI household for at least one countable income or expense source:
  - an income or expense is not verified;
  - one of the following income types uses " Verified by Reasonable Compatibility" as the verification source:

        - employment income;
        - unemployment compensation income; or
        - RSDI Income; or
    - The verification source is anything other than “Verified by Reasonable Compatibility” and the verification received date is over 60 days old.
- The case is in Approved Ongoing mode.
- There are no pending TLM tasks for the case.

The first time the result of a PIC could impact eligibility is the seventh month of the 12-month certification period because the first six months are continuous.

Exception: A PIC is not initiated when a TP 44 child released from placement in a juvenile facility is reinstated to a different household than the one in which they were residing at the time of their placement, or is reinstated as an independent child.

When taking action on the result of a PIC due to excess income, a household may be eligible for expedited CHIP enrollment if the household:

- is determined to be ineligible for Medicaid during the eligibility period but before the end of their certification period;
- is determined eligible for Children's Health Insurance Program (CHIP); and
- owes a CHIP enrollment fee.

An appeal and reactivation due to a change or PIC is an eligible case action for expedited CHIP enrollment.

Related Policy
Medicaid Termination, A-825
Expedited CHIP Enrollment, D-1711

B—638 Returned Mail

Revision 16-4; Effective October 1, 2016

All Programs

Advisors must take the following action when returned mail is received:

If the case includes an active SNAP EDG:

1. Review the address indicated on the returned mail, the case record, and the State Portal to determine whether the household has reported a new address. If a new address was reported, process the address change and any related changes in shelter expenses. Otherwise, go to Step 2.
2. If the new address was not reported and a forwarding address was not provided, make one attempt to contact the household via telephone to confirm the address and document the attempt. If able to contact the household and the household provides a new address, process the change and any related changes in shelter expenses. Otherwise, go to Step 3.
3. If the returned mail is a SNAP redetermination packet and there are no other active EDGs, document these facts in Texas Integrated Eligibility Redesign System (TIERS) Case Comments and take no further action. Otherwise, go to Step 4.
4. For households with:
    - no individuals receiving Retirement, Survivors, and Disability Insurance (RSDI) or Supplemental Security Insurance (SSI), go to Step 5; or
    - individuals receiving RSDI or SSI, use the State Online Query (SOLQ) to verify the household's address. If the address in SOLQ:
        - is different from the address in the TIERS case record, use the information in SOLQ to update the address and explore shelter expenses as necessary; and
        - matches the address in the TIERS record, document in TIERS Case Comments that the SOLQ inquiry address matches the TIERS address and take no further action. Otherwise, go to Step 5.
5. If unable to contact the household via telephone to obtain an update on their address and no household member receives RSDI or SSI, send Form H1020, Request for Information or Action, to the TIERS address to request verification of address and any change in shelter expenses. To pend for address information:
    - in Change Action mode, go to "Individual Demographics";
    - edit the head of household's record;
    - change the effective begin date appropriately;
    - on the "Residency" page, select "not verified" from the residency verification drop down menu;
    - complete the Logical Unit of Work (LUW);
    - document all attempts to contact the household by telephone; and
    - run eligibility.

6. If the household fails to provide information as requested on Form H1020, deny the household for failure to provide information. Send Form TF0001, Notice of Case Action, to deny the case using the denial reason "Failed to Provide Information."
7. If the household is denied for failure to provide information and provides a correct address within the advance notice of adverse action period, reopen the EDG using the original certification period and process any related changes in shelter expenses. Please refer to the TIERS Advance Notice of Adverse Action Reference Guide in the ASK iT Knowledge Base for instructions.

If the case does not include an active SNAP EDG:

1. Review the address on the returned mail, the case record, and the State Portal to determine whether the household has reported a new address. If a new address has been reported, process the address change. Otherwise, go to Step 2.
2. If a new address has not been reported and a forwarding address was not provided, make one attempt to contact the household via telephone to obtain an update on their address and document the attempt. If the household provides a new address, process the change. Otherwise, go to Step 3.
3. For households with individuals receiving RSDI or SSI, use SOLQ to verify the household's address. If the address in SOLQ is different from the address on file, use the address in SOLQ to update the address. If the address in SOLQ matches the address in the TIERS record, document in TIERS Case Comments that the SOLQ inquiry address matches the TIERS address and take no further action. Otherwise, go to Step 4.
4. If unable to contact the household by telephone to obtain an updated address and no household member receives RSDI or SSI, use the following steps to deny the EDG using the denial reason "**Unable to Locate"** as stated in TWH A-2344.1, Form TF0001 Required (Adequate Notice):
    - in Change Action Mode, go to "Household Information" and select "Yes" for the question "Is the worker unable to locate the household?";
    - document all attempts to contact the household by telephone; and
    - run eligibility.

Related Policy
Actions on Changes, B-631
Returned Mail, E-2221
Returned Mail, M-2221

B—640 Changes Affecting Benefits

Revision 09-3; Effective July 1, 2009

B—641 Additions to the Household

Revision 17-2; Effective April 1, 2017

TANF and SNAP

Advisors determine household eligibility when a member must be added. If the addition to the household causes benefits to increase or remain the same, the advisor must send Form TF0001, Notice of Case Action, by the 10th day after the change is reported. If additional information or verification is required, the advisor sends Form TF0001 the next workday, but no later than the workday after the Form H1020, Request for Information or Action, due date. The advisor must request supplemental benefits, if required, no later than the last day of the month in which the verification is received.

If the household addition is a member of another active EDG, the individual is removed from the other EDG before the individual is added to the new EDG. Benefits are restored if the addition of the individual increases benefits and HHSC failed to remove the individual from the active EDG in a timely manner. The advisor should take overpayment action on the old EDG.

Medical Programs except TP 45

Under MAGI household composition rules, explained in A-240, Medical Programs, an individual joining or leaving the home may or may not affect eligibility depending on that person's tax status, tax relationships, and family relationships.

TP 08

If the household requests Medicaid for an additional legal parent or caretaker relative, the new individual is given a separate EDG and the system aligns the certification period of the newly created EDG with the existing TP 08 certification period.

Exception: Advisors assign a Medicaid eligibility date as early as three months before the month the individual reports the change for applicants who have unpaid medical bills and meet the criteria described in A-830, Medicaid Coverage for the Months Prior to the Month of Application. When applying the criteria in A-830, the application month is the month the individual reports the change.

TP 43, TP 44 and TP 48

If the household requests Medicaid for a new child who is the sibling of a child receiving TP 43, TP 44 or TP 48, a separate application is not needed. If the new child is not a sibling, a new application is required. The new child is given a separate EDG and the system aligns the certification period of the newly created EDG with the existing child's Medicaid certification period.

Exception: Staff must not add additional children/siblings to a case where a denied EDG was reinstated due to the release from a juvenile facility. The household must submit an application for the additional children/siblings.

If there is not an existing TP 43, TP 44, TP 48 or CHIP EDG, a separate application is required to initiate benefits for a new child being added to the case, as explained in A-121, Receipt of Application.

Related Policy
Regular Medicaid Coverage, A-820

B—641.1 Adding Newborns to the Case

Revision 15-4; Effective October 1, 2015

TANF and Medical Programs

Before adding a newborn child, advisors use inquiry to determine whether a TP 45 EDG has been opened. This helps prevent the assignment of duplicate coverage and individual numbers.

To locate the TP 45 EDG, the advisor must perform inquiry using the newborn's mother's individual number or demographic information.

Newborns are added to the household even if they are still hospitalized as long as the parent(s) exercises care and control and intends to bring the newborn home.

SNAP

The TP 45 certification date is considered the change report date for the birth of the child. This is considered a reported change whether the case is SR or non-SR, and the agency is required to take action on this reported change.

Before adding the newborn to the EDG, the agency must confirm that the child was released from the hospital to the individual's home. The advisor must attempt to contact the household by phone to confirm whether the newborn child has moved into the home (and the date that occurred) and to obtain any information not already available on the TP 45 EDG that is needed to add the child. If the advisor is not able to reach the individual by phone, the advisor must send Form H1020, Request for Information or Action, requesting the necessary information. The advisor must not pend for verification of an SSN application at change action to add a child age six months or younger. Advisors follow policy in B-641.2, Steps for Adding New Members, to determine the effective date of the change. If the individual does not respond by the Form H1020 due date:

- the child is not added to the SNAP EDG; and
- the advisor must document that the individual failed to provide required information to add the child.

If the household later provides information and verification related to the newborn, the child is added, effective the month after verification is received.

Related Policy
General Policy, A-410

B—641.2 Steps for Adding New Members

Revision 15-4; Effective October 1, 2015

All Programs

When the household reports a new member, the advisor sends Form H1020, Request for Information or Action, and Form H1020-A, Sources of Proof, the day of the report or no later than the next workday to request any necessary additional information or verification.

If the change is:

- **Timely reported and verified,** the advisor adds the new member to the case the month after the change occurred, unless benefits decrease. If benefits decrease, the advisor sends Form TF0001, Notice of Case Action, and decreases or denies benefits effective the month after notice of adverse action expires, as explained in B-643, Changes Decreasing Benefits.
- **Untimely reported with timely verification,** the advisor adds the new member effective the month after the change is reported. If the change decreases benefits, the advisor sends Form TF0001 and decreases or denies benefits effective the month after notice of adverse action expires, as explained in B-643.
- **Timely or untimely reported with a delay in verification of eligibility points that results in individual disqualification (for example, SSN or alien status)** and verification is not provided by the Form H1020 due date, advisors must take the following actions:
  - For TANF, if the new member is a required member of the certified group, disqualify the new member following applicable policy. Notify the household on Form TF0001 as appropriate. **Exception:** See TANF policy for household members who are not required members of the certified group.
  - For SNAP, disqualify the new member following applicable policy. Notify the household of the disqualification on Form TF0001 as appropriate.
  - For Medical Programs, see reasonable opportunity policy explained in A-351.1, Reasonable Opportunity.
- **Timely or untimely reported with enough information to determine benefits will decrease, but verification is delayed,** the advisor sends Form TF0001 and decreases or denies benefits based on the individual's unverified statement effective the month after notice of adverse action expires, as explained in B-643.
- **Timely or untimely reported lacking enough information regarding income, resources, or other factors necessary to determine eligibility and/or benefits,** the advisor sends Form H1020 and Form H1020-A to request verification the same day the change was reported or no later than the next workday and attempts to contact the household by phone within 10 days after the change is reported to obtain enough information to determine the effect of the change.
  - If information is obtained, policies for changes apply as described in this section.
  - If information is not obtained, the impacted EDGs are kept pending until the Form H1020 due date.
  - If verification is not received by the Form H1020 due date, the advisor sends Form TF0001 the next workday to deny the EDG for failure to furnish information.

Notes:

- There may be situations in which verification is provided to establish eligibility for one program and not the other.
- When the household reports a new member using an application or redetermination form, the file date is considered the report of change date. The individual must provide the verification by the Form H1020 due date to be considered timely verification.

TANF

Delays in verification of other legal requirements for required members: If the new member is a required member of the certified group and the household does not provide proof of age, relationship, or domicile by the Form H1020 due date:

- because it is not available, the advisor sends Form TF0001 to notify the household that the person cannot be added without required verification.
- but it is available, the advisor sends Form TF0001 to deny the EDG for failure to furnish information.

Delays in verification for persons who are not required members of the certified group: If the new member is not a required member of the certified group and the individual fails to provide requested proof by the Form H1020 due date, the advisor sends Form TF0001 to notify the household that the new person cannot be added without required verification. If the household later provides verification, the member is added the month after the verification is received.

SNAP

Request a combined Data Broker report for a new adult member.

B—641.3 Adding Disqualified Members

Revision 15-4; Effective October 1, 2015

TANF and SNAP

If the member being added was disqualified, the new member is added effective the month after the disqualification ends. See A-1800, Employment Services, for adding household members disqualified for noncompliance with employment services requirements.

SNAP

See A-1362, Disqualified Members, for special budgeting of TANF benefits.

B—642 Changes Increasing Benefits (Other than Additions to the Household)

Revision 15-4; Effective October 1, 2015

All Programs

Advisors determine the effective dates of a change based on the date the change is reported and the date the verification is provided, as explained in B-642.1, Verification Provided Timely, and B-642.2, Verification Not Provided Timely. If supplemental benefits are necessary, the advisor must request the issuance no later than the last day of the month in which the verification is received.

Note: If verification is not required, the change is treated the same as if verification was received timely (see B-642.1).

B—642.1 Verification Provided Timely

Revision 15-4; Effective October 1, 2015

All Programs

If the household provides verification of a reported change by the Form H1020, Request for Information or Action, due date, benefits are increased, effective the month after the change is reported, regardless of whether the change was reported timely. The advisor sends Form TF0001, Notice of Case Action, the next workday, but no later than the workday after the Form H1020 due date.

If the household reports a change on an application form, the file date is considered the report of change date. The individual must provide the verification by the Form H1020 due date to be considered timely verification.

B—642.2 Verification Not Provided Timely

Revision 15-4; Effective October 1, 2015

All Programs

If the household fails to provide timely verification, benefits are not increased until verification is received. The advisor sends Form TF0001, Notice of Case Action, by the next workday after the Form H1020, Request for Information or Action, due date to explain that benefits remain the same. If the household later provides verification untimely, benefits are increased, effective the month after verification is received.

If the household fails to provide verification before the next SNAP, TANF, or TP 08 redetermination, request it again during the interview process and deny the EDG if verification is not received.

SNAP

If decreased or denied TANF or Refugee Cash Assistance (RCA) benefits result in an increase in SNAP benefits, benefits are increased the same month the TANF or RCA is decreased, with some exceptions (see A-1324.18, Temporary Assistance for Needy Families [TANF]).

If the household appeals the TANF or RCA decision and receives continued TANF or RCA benefits, the advisor continues to budget the TANF or RCA grant in the SNAP EDG.

B—643 Changes Decreasing Benefits

Revision 16-; Effective October 1, 2016

TANF and SNAP

Advisors must act on changes as indicated below. Benefits are decreased or denied, effective the month after the notice of adverse action expires. If applicable, an overpayment claim is processed as specified in B-700, Claims. To determine the first month of an overpayment, advisors may refer to C-1140, TANF and SNAP Overpayment Determination Chart.

If a household reports a change ...	then ...
and provides all verification,	send Form TF0001, Notice of Case Action, by the 10th day after the change was reported* to decrease or deny benefits.
with enough information to determine eligibility/benefits but does not provide verification,	send Form H1020, Request for Information or Action, and Form H1020-A, Sources of Proof, the same day the change was reported or no later than the next workday to request verification.** Send Form TF0001 to decrease or deny benefits based on the individual's unverified statement at the time the change was reported: • by the 10th day after the change was reported;* or • with Forms H1020 and H1020-A if the change was reported untimely. Require verification of the change at the next TANF or SNAP redetermination. **Note:** Do not verify income if the amount reported makes the household ineligible.
without enough information to determine eligibility/benefits,	send Form H1020 and Form H1020-A the same day the change was reported or no later than the next workday to request verification.** Attempt to contact the household by phone to obtain enough information to send Form TF0001 by the 10th day after the change was reported.* **Note:** The regional director may opt out of the requirement to make a phone contact. If information **is not** obtained to redetermine eligibility, keep the EDG pending until the Form H1020 due date. If verification is not received by the Form H1020 due date, send Form TF0001 the next workday to deny the EDG for failure to furnish information. **Exception:** If the household fails to provide verification of a deductible expense that requires verification, do not deny the EDG; instead, disallow the deduction. Follow policy in A-1440, Verification Requirements, to determine if any deduction is allowable for the expense.

* If the due date for sending Form TF0001 falls on a non-workday, send it the preceding workday to meet the 10-day requirement.

** Allow the individual 10 days to provide the verification requested on Form H1020. If the 10th day falls on a non-workday, use the following workday as the due date.

Note: See B-631, Actions on Changes, for situations where the Texas Department of Family and Protective Services (DFPS) places a TANF or Medicaid child in foster care.

TP 08

If an individual reports or electronic data sources indicate new or increased earned income or alimony/spousal support that makes the individual ineligible for TP 08, the advisor must request verification of the income. If the individual fails to provide verification of the earned income or alimony/spousal support, the advisor must deny the TP 08 EDG and open the appropriate Transitional Medicaid EDG if:

- the information is not questionable; and

- they meet the eligibility requirements for the applicable Transitional Medicaid program as explained in A-842, TP 07 Transitional Medicaid and A-850, TP 20 Alimony/Spousal Support Transitional Medicaid Coverage.

In addition, the advisor must deny the Medicaid EDG and open the appropriate Transitional Medicaid EDG for each associated parent or caretaker and dependent child.

If the EDG is denied for failure to provide verification that does not cause Medicaid ineligibility, the advisor must determine the household's eligibility for other medical programs. See A-2342, Denial at Redetermination.

Related Policy
General Eligibility Information, A-841
General Eligibility Information, A-851

B—650 Correcting Incorrect Information

Revision 15-4; Effective October 1, 2015

All Programs

Individuals have a right to correct any information that HHSC has about the individual and any other individual on the individual's case.

Advisors follow policies in A-2300, Case Disposition; B-100, Processes and Processing Time Frames; and B-600, Changes, for the time frames and procedures to correct or update information when processing:

- applications,
- redeterminations, and
- other actions on active cases.

B—651 Correction Request

Revision 15-4; Effective October 1, 2015

All Programs

A request for correction must be in writing and:

- identify the individual asking for the correction;
- identify the disputed information about the individual;
- state why the information is wrong;
- include any proof that shows the information is wrong;
- state what correction is requested; and
- include a return address, telephone number, or email address at which HHSC can contact the individual.

During application, redetermination, and other actions on active EDGs, individuals are not required to request correction of incorrect information in writing. (Refer to B-116, Information Reported During Application Processing; B-124, Processing Untimely Redeterminations; and B-623, How to Report.)

B—652 Action on Denied EDGs or During the Last Month of Certification and the Client Has Not Reapplied

Revision 15-4; Effective October 1, 2015

All Programs

Advisors must respond according to the following chart:

When an individual requests that the agency correct their information ...	then ...
at application, redetermination, or anytime when an EDG is active,	follow policies in A-2300, Case Disposition; B-100, Processes and Processing Time Frames; and B-600, Changes.
on a denied EDG or during the last month of certification, and the individual has not reapplied,	• review the request, • contact third parties if necessary, and • send the correct information for imaging.

The advisor notifies the individual in writing within 60 days (using current HHSC letterhead without the board members' names) that the information is corrected or will not be corrected and the reason. The advisor informs the individual if HHSC needs to extend the 60-day period by an additional 30 days to complete the correction process or obtain additional information.

If HHSC makes a correction to individually identifiable health information, the advisor must ask the individual for permission before sharing with third parties. HHSC will make a reasonable effort to share the correct information with persons who received the incorrect information from HHSC if they may have relied or could rely on it to the disadvantage of the individual. Advisors follow regional procedures to contact the HHSC privacy officer for a record of disclosures.

Note: Advisors follow procedures to establish a claim or restore benefits if an overissuance or underissuance occurred. Advisors make a referral to the Office of Inspector General for intentional program violation occurrences.

B—653 Different Review Process

Revision 15-4; Effective October 1, 2015

All Programs

Advisors must not follow procedures in B-600, Changes, when the accuracy of information provided by an individual is determined by another review process such as a:

- fair hearing,
- civil rights hearing, or
- other appeal process.

The decision in that review process is the decision on the request to correct information.

B—660 Documentation Requirements

Revision 15-4; Effective October 1, 2015

All Programs

According to B-631, Actions on Changes, advisors must document the:

- reported change,
- date the change occurred,
- date the change was reported, and
- date the verification is provided.

For new income changes, advisors document the date of the first payment.

For address changes, advisors document the actions taken to provide the individual with Form H0025, HHSC Application for Voter Registration, and Form H1350, Opportunity to Register to Vote.

Refer to A-1380, Documentation Requirements, for further requirements related to income.

SNAP

Advisors must document:

- the reason for shortening certification as a result of a change. See B-635, Shortening Certification Periods as a Result of a Change.
- that the individual failed to provide required information to add a newborn when based on the TP 45 certification according to B-641.1, Adding Newborns to the Case.

Medical Programs

Clients are not required to report a change in tax status or tax relationship during the certification period because tax status and tax relationships are self-declared based on what the client expects to happen on their federal income taxes. If a change is reported, advisors should document the change in case comments and it will be addressed at the time of redetermination.

However, if multiple individuals self-declare to claiming the same person as a tax dependent, the advisor must clear the discrepancy with all individuals attempting to claim the same person as a tax dependent and update the tax statuses as a change in the eligibility system if necessary. For example, a change is reported that a child certified on Children's Medicaid will no longer be claimed as a tax dependent. This change will be addressed at redetermination.

TP 08

Advisors must document the reason for denying a TP 08 EDG and opening a TP 07 EDG when new or increased income makes the household ineligible.

Related Policy
Documentation Requirements, A-1380
Documentation, C-940
Registering to Vote, A-1521
The Texas Works Documentation Guide

TWH, B-700, Claims

Revision 15-4; Effective October 1, 2015

B—710 General Policy

Revision 11-1; Effective January 1, 2011

All Programs

An overpayment is the amount of benefits issued in excess of what should have been issued.

A claim is an amount owed by an individual for an overpayment of benefits or owed by an individual for benefits that are trafficked.

The date of discovery is the date the Office of Inspector General (OIG) substantiates that an overpayment occurred.

B—711 Types of Overpayment Claims

Revision 15-4; Effective October 1, 2015

All Programs

There are three types of overpayment claims:

- agency error,
- inadvertent household error/misunderstanding, or
- fraud or intentional program violation (IPV).

OIG staff process overpayment referrals, determine the overpayment amount, and submit as a claim to the Texas Health and Human Services Commission (HHSC) Fiscal Management Services (FMS) to collect.

Related Policy
Referrals for Intentional Program Violation (IPV), B-900

B—720 When to File an Overpayment Referral

Revision 15-4; Effective October 1, 2015

All Programs

Advisors must file an overpayment referral when a household receives benefits the household is not entitled to receive. When an overpayment occurs, OIG establishes a claim. The individual must repay any type of claim. The following situations do not cause an overpayment:

- changes a household is not required to report;
- overpayments that occurred more than six years before the date of discovery;
- an unsigned Form H1010, Texas Works Application for Assistance — Your Texas Benefits;
- expired or missing employment services registration forms; or
- households certified in the wrong county.

SNAP

Changes for categorically eligible households, except for changes in net income and/or household size, do not cause an overpayment. **Exception:** This does not apply to households that are categorically eligible based on receipt of Temporary Assistance for Needy Families - Non-Cash (TANF-NC).

OIG files a claim when an IPV is established against an individual for trafficking in Supplemental Nutrition Assistance Program (SNAP) benefits or access devices such as Electronic Benefit Transfer (EBT) cards.

B—730 How to File an Overpayment Referral

Revision 15-4; Effective October 1, 2015

All Programs

When an overpayment occurs, advisors determine the type of overpayment and enter an overpayment referral using the Automated System for Office of Inspector General (ASOIG) or the Texas Integrated Eligibility Redesign System (TIERS) referral interface. See B-770, Filing an Overpayment Referral, for overpayment referral instructions.

B—740 Texas Works Responsibilities

Revision 13-3; Effective July 1, 2013

All Programs

Texas Works staff:

- identify overpayments;

- enter all agency error, inadvertent household error/misunderstanding and fraud overpayment referrals using ASOIG or the TIERS referral interface, within 30 days of the date a potential overpayment is identified;
- process fair hearing requests related to claims establishment or collection using the TIERS interface; and
- forward any payments or warrants received at the local office, along with a copy of Form H4100, Money Receipt, within 24 hours of receipt to:

  Texas Health and Human Services Commission
  Fiscal Management Services
  ARTS Billing
  P.O. Box 149055
  Austin, TX 78714-9055

The Accounts Receivable Tracking System (ARTS) is administered by FMS staff who monitor and process payments from individuals who receive HHSC services. The ARTS Hotline number is 1-800-666-8531.

B—741 Texas Works Action on Agency Errors

Revision 11-1; Effective January 1, 2011

TANF and SNAP

When an agency error overpayment occurs, Texas Works staff:

- correct the ongoing benefits, as needed, using adverse action procedures; and
- enter an electronic overpayment referral using ASOIG or the TIERS referral interface within 30 days of the date a claim is identified.

Note: See B-770, Filing an Overpayment Referral, for instructions about how to complete and send an overpayment referral.

B—742 Texas Works Action on an Inadvertent Household Error/Misunderstanding or Intentional Program Violation (IPV)

Revision 15-4; Effective October 1, 2015

All Programs

When an overpayment is due to an inadvertent household error/misunderstanding or a potential IPV, Texas Works staff:

- correct the ongoing benefits, as needed, using adverse action procedures; and
- enter an overpayment referral using ASOIG or the TIERS interface within 30 days of the date a claim is identified.

Note: See B-770, Filing an Overpayment Referral, for instructions about how to complete and send an overpayment referral.

When an alien and the alien's sponsor are liable for an overpayment, both individuals are referred to the OIG.

The alien and the alien's sponsor are not referred for an overpayment claim if the sponsor also receives benefits in the same program in which the alien’s overpayment occurred.

B—750 Office of Inspector General (OIG) Responsibilities

Revision 11-1; Effective January 1, 2011

All Programs

The OIG General Investigations Division investigates allegations of recipient non-fraud overpayment and/or fraud. The General Investigations Division consists of the State Operations Unit with both Claims Investigation and Field Investigation units located throughout the state.

B—751 Office of Inspector General (OIG) Investigation Staff

Revision 15-4; Effective October 1, 2015

All Programs

OIG staff:

- screen all types of referrals and investigate valid agency error, inadvertent household error/misunderstanding, fraud or IPV, individual and/or retailer EBT trafficking, and employee fraud;
- process referrals including initiation of demand letters and establishment of claims;
- negotiate methods of repayment;
- set for active Eligibility Determination Groups (EDGs) a minimum amount of restitution at 10 percent of the monthly benefit or $25, whichever is greater;
- respond to follow-up questions from individuals and staff about the validity of claims;
- coordinate with Texas Works staff to process fair hearing requests related to claims establishment or collection; and
- initiate the process to debit an EBT food account to repay a SNAP claim when the request is made prior to claim establishment.

B—752 Determining Claim Amounts

Revision 15-4; Effective October 1, 2015

All Programs

OIG staff take the following steps when determining claim accounts:

- determine the first month of overpayment (see B-752.1, Determining the First Month of Overpayment);
- exclude any months in which the household did not receive benefits or benefits were expunged;
- follow applicable policy in A-1300, Income, to budget the overpayment months;
- budget each month of an overpayment by using actual income amounts received for the month (the income is not converted);

  Exceptions: OIG staff:
  - budget the income originally projected at certification/redetermination when the income does not involve a required change; and
  - budget earned income as reported quarterly to the Texas Workforce Commission (TWC) to determine the overpayment amount when all efforts to verify earned income amounts have been exhausted; allow the household the opportunity to provide verification of actual gross pay per pay period; and recompute the overpayment if the individual provides the verification. **Note:** For cases sent to an administrative disqualification hearing, staff must verify the employment hire date when computing an overpayment based on TWC wage information.
- do not allow earned income deductions for any earned income that the household failed to report timely as required and this failure caused an overpayment (deductions for overpayment months caused by an agency error are allowed);
- for excess resource overpayment EDGs, compute earned interest income to estimate an account balance for the tax year, as reported annually by the Internal Revenue Service (IRS) through the Income and Eligibility Verification System (IEVS), to determine the overpayment amount when all efforts to verify an unreported financial institution account have been exhausted; allow the household the opportunity to provide verification of the interest income and the resource; and recompute the overpayment if the individual provides the verification;
- subtract the amount the household was entitled to receive from the amount the household actually received before recoupment;

  Exception: There is no recoupment for Medical Programs.
- total all the monthly amounts of overpayment; and
- when the household is due unpaid restored benefits, offset the amount to be restored against the overpayment amount and document the offset according to B-831, Procedures for Counting Restored Benefits Toward a Claim.

Related Policy
Computing Benefits by EDG Action Type, A-1357
Reporting Requirements, B-620

TANF

When a child support payment was made during the overpayment month, the total income, less the $75 disregard, is counted to determine the overpayment amount.

B—752.1 Determining the First Month of Overpayment

Revision 11-1; Effective January 1, 2011

B—752.1.1 Errors at Certification

Revision 11-1; Effective January 1, 2011

All Programs

The first month of overpayment is the first month the household received more benefits than it was entitled to receive.

B—752.1.2 Errors After Certification

Revision 15-4; Effective October 1, 2015

All Programs

The first month of overpayment for non-streamlined reporting (SR) households is the month in which the change would have been effective had it been reported and acted on in a timely manner. However, the first month of overpayment can be no later than two months from the month the change occurred. Staff may use the following chart to determine the first month of overpayment.

If a change was...	then the first month of overpayment is the month that begins more than...
reported timely,	23 days after the date the change was reported. (Example: Change occurred January 5 and was reported January 10. Count 23 days to February 2. March is the first month of overpayment.)
not reported timely,	33 days after the date the change occurred. (Example: Change occurred January 5. Count 33 days to February 7. March is the first month of overpayment.)

Exception: The first month of overpayment may be earlier for errors caused by moves out of state. The first month of overpayment may be as early as the month after all members of the household leave the state and there is duplicate participation in that month.

Charts in C-1140, TANF and SNAP Overpayment Determination Chart, provide help for determining the first month of overpayment for both timely and untimely change reports.

SNAP

An overpayment does not exist on a streamlined reporting EDG unless:

- the household fails to timely report a required change, or
- the agency fails to timely act on a reported change.

Note: The 10-day reporting requirement for SR EDGs is from the first payment that exceeds the 130 percent Federal Poverty Income Limit (FPIL) threshold. For example, an individual receives a pay raise effective May 15. The individual's gross monthly income exceeds the 130 percent FPIL with the June 27 paycheck. The household must report the change within 10 days of June 27 to be timely.

The first month of overpayment is the month after the second month the income exceeds the 130 percent FPIL for the household size. For example, income exceeds the 130 percent FPIL on June 27 and for the month of July. August is the first month of overpayment.

Related Policy
Reporting Requirements, B-620

B—753 Establishing Claims

Revision 13-3; Effective July 1, 2013

B—753.1 Identifying Liable Members

Revision 15-4; Effective October 1, 2015

TANF

The liable household members responsible for repayment of a claim are determined in the following order:

1. The household that contains the caretaker or payee. **Note:** The caretaker may be an emancipated minor or minor parent who was certified separately.
2. Any household that includes a household member who was an adult member at the time of the overpayment.

SNAP

The liable household members responsible for repayment of a claim are determined in the following order:

1. The household that contains the head of household.
2. Any household that includes a majority of adult members from the overpayment household.
3. Any household that includes a household member who was an adult in the household at the time of overpayment.

TANF and SNAP

An authorized representative (AR) is liable for paying a claim when the AR causes an overpayment or traffics in SNAP benefits.

Sponsors and eligible aliens are jointly liable for overpayments resulting from incorrect information provided by the sponsor unless the sponsor:

- can show good cause,
- can show the eligible alien or sponsor was not at fault for the error, or
- receives benefits in the same program in which the overpayment occurred.

The sponsor, alien, or both may appeal the amount or fault of an overpayment.

B—753.2 Demand Letters

Revision 15-4; Effective October 1, 2015

TANF and SNAP

OIG staff send Form OIG 5034, Notice of Food Stamp Overpayment Claim, and/or Form OIG 5039, Notice of TANF Overpayment Claim, along with Form OIG 5027, Repayment Agreement, to the individual. To be timely, OIG staff must send the letters no later than 180 calendar days from the date of discovery of the overpayment.

OIG staff send separate demand letters to the alien and the alien's sponsor. The demand letter informs the sponsor that the sponsor is not responsible for the individual when the sponsor has good cause for the error, is not at fault, or receives benefits in the same program in which the alien's overpayment occurred.

Note: Calls about demand letters for overpayments are referred to the local OIG unit for clearance.

B—753.3 Claim Disposition

Revision 15-4; Effective October 1, 2015

TANF and SNAP

OIG staff allow the individual 20 calendar days to respond to the demand letter. If the individual responds to the demand letter, the individual may agree to repay the overpayment by:

- restitution, or
- recoupment.

When the individual does not respond within 20 calendar days and the EDG is:

- active, OIG staff initiate recoupment.
- denied, OIG staff initiate restitution.

OIG staff establish the claim in ARTS using ASOIG within 10 calendar days of the individual's response, the response due date, or by cutoff of that month, whichever is earliest. Establishing the claim is delayed when the individual requests a fair hearing.

B—760 Fiscal Management Services (FMS) Responsibilities

Revision 13-3; Effective July 1, 2013

All Programs

FMS staff:

- maintain ARTS;
- manage the billing and collection process;
- manage delinquent claims;
- renegotiate methods of collection;
- modify existing claims;
- respond to inquiries from individuals or staff from the date the claim is established, including:
    - delinquent notices,
    - collection efforts,
    - federal payment intercepts through the Treasury Offset Program,
    - Unemployment Insurance Benefits intercepts; or
    - license suspensions;
- process fair hearing requests related to claims establishment or collection;
- initiate the process to debit an EBT food account to repay a SNAP claim when the request is made after the claim is established; and
- provide claims data (via an interface) to the Office of the Attorney General to offset TANF and child support payments.

B—761 Claims Collection

Revision 11-1; Effective January 1, 2011

B—761.1 Recoupment

Revision 11-1; Effective January 1, 2011

TANF and SNAP

Recoupment is a method of recovering an overpayment claim by withholding a portion of the household's benefits.

B—761.1.1 Action on Recoupment Cases

Revision 13-3; Effective July 1, 2013

TANF and SNAP

Recoupment is initiated when OIG staff enters a claim against a household into ARTS. ARTS interfaces with TIERS to automatically reduce the household's ongoing benefits.

When an EDG is denied or the certification expires and the recoupment is incomplete, ARTS performs an automatic search to find another household member who is liable for the overpayment on an active EDG of the same program type. When ARTS:

- finds no liable member, it sends a bill to the individual to request payment of the remaining balance and transfers the claim to restitution. See B-753.1, Identifying Liable Members, and B-761.2, Restitution.
- finds a liable member, it transfers the recoupment to the active EDG.

A denied EDG is never purged from TIERS or ARTS when there is a recoupment record or a claim with a remaining balance. If the EDG is recertified, ARTS automatically resumes recoupment.

Notes:

- FMS staff may negotiate a repayment agreement with the individual.
- FMS staff are authorized to make corrections to the recoupment records in ARTS.

Recoupment information is available through TIERS inquiry, ARTS inquiry, or by calling the ARTS Hotline at 1-800-666-8531.

B—761.1.2 Recoupment Hierarchy

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Claims are recouped by error type in the following order.

1. Type A — IPVs (fraud)
2. Type J — inadvertent household error/misunderstanding
3. Type L — agency error

All three claim types can be simultaneously stored on ARTS. Recoupment of a Type A claim places Type J and L claims on hold status until the Type A recoupment is completed. ARTS automatically resumes recoupment of the Type J or L claim when all of the individual's Type A claims have been paid in full.

B—761.1.3 Recoupment Amount

Revision 15-4; Effective October 1, 2015

TANF

HHSC recoups Type A, J, and L claims at 10 percent of the household's maximum grant, rounded down to the nearest dollar.

Once a TANF claim is recouped in full, TIERS will automatically rebudget any active SNAP EDG to include the appropriate ongoing TANF grant amount. See A-1324.18, Temporary Assistance for Needy Families (TANF).

SNAP

For Type A claims, HHSC recoups at 20 percent of the household allotment or $20, whichever is greater. When calculating a dollar amount using the percentage, TIERS rounds 49 cents down and 50 cents up to the next whole dollar.

For Types J and L claims, HHSC recoups at 10 percent of the household allotment or $10, whichever is greater. When calculating a dollar amount using the percentage, TIERS rounds 49 cents down and 50 cents up to the next whole dollar.

Notes:

- When benefits are $10 or less, no benefits are issued.
- When a current household member is disqualified for an IPV, recoupment is computed using the allotment the household would receive if the disqualified member was included in the household size.

B—761.2 Restitution

Revision 11-1; Effective January 1, 2011

TANF and SNAP

Restitution is a method of recovering an overpayment claim by the receipt of payments in the form of a cashier's check, certified or personal check, and/or money orders made payable to the Texas Health and Human Services Commission.

B—761.2.1 Action on Restitution Cases

Revision 13-3; Effective July 1, 2013

TANF and SNAP

When the EDG is active and the individual misses a payment or makes a partial payment, ARTS sends a delinquency notice and initiates recoupment on the EDG after expiration of the advance notice period.

SNAP

ARTS initiates recoupment on the active EDG to repay the claim when the EDG is denied, and:

- the individual fails to respond to the ARTS notice within 10 days; and
- ARTS finds an adult household member who is liable for the overpayment on an active EDG of the same program.

When ARTS finds no liable adult household member on an active EDG, the claim is eligible for referral to:

- the Federal Treasury Offset Program for an intercept of federal payments;
- TWC for voluntary garnishment of Unemployment Insurance Benefits;
- the Texas Lottery Commission for an intercept of lottery winnings;
- applicable agencies to request suspension of licenses; or
- a private collection agency.

Restitution information is available through the ARTS inquiry or by calling the ARTS Hotline at 1-800-666-8531.

B—761.2.2 Restitution Amount

Revision 15-4; Effective October 1, 2015

TANF and SNAP

When an EDG is active, OIG staff are responsible for setting the amount of restitution at 10 percent of the monthly benefit or $25, whichever is greater.

When an EDG with a recoupment claim is denied, ARTS transfers the claim to restitution. ARTS sends a monthly billing statement to the individual for a minimum collection of $25.

B—762 Action on Receipt of Payments

Revision 15-4; Effective October 1, 2015

TANF and SNAP

When staff receive restitution payments from individuals, staff:

- complete Form H4100, Money Receipt; and
- submit the payment or warrants with a copy of Form H4100 within 24 hours of receipt to:

  Texas Health and Human Services Commission
  Fiscal Management Services
  P.O. Box 149055
  Austin, TX 78714-9055

Note: When staff receive TANF warrants, each warrant is marked void.

B—763 Debit of SNAP EBT Accounts

Revision 13-3; Effective July 1, 2013

SNAP

Debit of an EBT food account is a method of recovering an overpayment claim by electronically removing benefits from the household's EBT account. The value of the debit is applied to the SNAP claim.

B—763.1 One-Time Debit of an Active EBT Account

Revision 15-4; Effective October 1, 2015

SNAP

When an individual (primarily liable or authorized representative) requests a one-time debit of the EBT food account to pay a SNAP claim and the EBT account is active, OIG or FMS staff:

- use the Administrative Terminal Application (ATA) to verify the:
  - status of the individual's EBT food account; and
  - balance of the account;
- complete Form H1021, Payment Agreement — Verbal Authorization for One-Time Debit of an Active Lone Star Food Account (this form documents the individual's verbal authorization to repay the overissuance by removing benefits from the active EBT food account);

- inform the individual that:
    -
        - the amount of the one-time payment must be maintained in the individual's account until the debit is completed;
        - it takes approximately 14 days for the debit transaction to be completed; and
        - the individual will receive a receipt of the debit within 10 days of the debit transaction; and
- submit the original of Form H1021 to:

  HHSC Lone Star Business Services
  State Office
  Mail Code 2033

  Maintain a copy of Form H1021 in the OIG or ARTS file.

Lone Star Business Services staff remove the SNAP benefits from the food account and submit Form H1021 to ARTS in FMS to repay the claim. ARTS staff send a receipt to the individual for the amount listed on Form H1021 within 10 days of the debit transaction.

Note: When the individual contacts HHSC and disagrees with the debit transaction, the individual may request a fair hearing to request the return of the benefits to the individual's account.

B—763.2 Debit of a Dormant EBT Account

Revision 15-4; Effective October 1, 2015

SNAP

When the individual requests a debit of the EBT food account to pay a SNAP claim and the EBT account is dormant, then OIG or ARTS staff:

- use the ATA to verify the:
    - status of the individual's EBT food account; and
    - balance of the account;
- complete and send the original Form H1022, Notice to Apply Benefits in a Dormant Lone Star Food Account to a Food Stamp Claim, to the individual (this form notifies the individual that benefits will be removed from the EBT food account to pay a SNAP claim); and
- allow the individual (prior to processing the debit) 10 days from the date of the request to notify OIG or ARTS staff that the individual does not want HHSC to use the benefits in the EBT food account to pay a SNAP claim.

If the individual does not contact OIG or ARTS staff by the 10th day after the individual requested the debit, Claims Investigations or ARTS staff submit a copy of Form H1022 to:

HHSC Lone Star Business Services
State Office
Mail Code 2033

A copy of Form H1022 must be maintained in the OIG or ARTS file.

Lone Star Business Services staff remove the SNAP benefits from the food account and submit Form H1022 to ARTS in FMS to repay the claim.

B—763.3 Monthly Debit of an Active EBT Account

Revision 15-4; Effective October 1, 2015

SNAP

When the individual requests a monthly debit of an active EBT food account to pay a SNAP claim, OIG or ARTS staff:

- use the ATA to verify the:
    - status of the individual's EBT food account; and
    - balance of the account;

- complete and send Form H1023, Installment Payment Agreement — Debit of a Lone Star Food Account, to the individual (obtain the individual's signature and amount of monthly debit on Form H1023 — this form indicates that the individual agrees to repay a SNAP claim by a monthly debit of the EBT food account);
- inform the household that they must maintain the agreement amount in the account each month until the debit is completed, and that the agreement may be revoked at any time; and
- submit the original Form H1023 to:

  HHSC Lone Star Business Services
  State Office
  Mail Code 2033

  A copy of Form H1023 must be maintained in the OIG or ARTS file.

Lone Star Business Services staff remove the SNAP benefits from the food account each month and send a copy of Form H1023 to ARTS in FMS to repay the claim.

B—763.4 Offset Expunged Benefits

Revision 11-1; Effective January 1, 2011

SNAP

When staff become aware that a household has expunged SNAP benefits, OIG or ARTS staff must offset the balance of a SNAP claim by the amount of the expungement.

B—764 Fair Hearings

Revision 15-4; Effective October 1, 2015

TANF and SNAP

When it is unclear whether the household wishes to appeal a Texas Works advisor's EDG action or an action taken by OIG staff, local eligibility office staff and OIG review the request for an appeal to determine what action the household is truly appealing. If a household disputes the establishment of a claim or collection action and requests an appeal, OIG will take the lead and begin processing the appeal.

The following procedures are used to submit an appeal request. Form H4800, Fair Hearing Request Summary, is not used, but Form H4800, sent directly to the hearings division, will be returned to staff with instructions to correctly submit the information.

OIG Staff

OIG staff use the TIERS Hearings and Appeal functional area located in the left navigation menu to submit appeal requests on claims or on collection actions.

OIG staff use the State Portal Appeals tab and then the Hearing Evidence Packets Upload tab to transmit evidence documents related to an appeal request.

Texas Works Staff Working in TIERS

Eligibility staff process fair hearing requests using the State Portal Appeals tab when an individual verbally requests an appeal.

If the fair hearing request is received in writing (by fax or mail, for example), eligibility staff fax the appeal request, using the fair hearing cover sheet, through the expedited fax line (1-866-559-9628) for processing. The fair hearing request is not entered in the State Portal.

Whether the TIERS appeal request is received verbally or in writing, the Centralized Representation Unit continues to process the appeal, including creating and submitting the evidence packet. Copies of the evidence packet are mailed to the appellant and any authorized or legal representative.

B—770 Filing an Overpayment Referral

B—771 Filing an Overpayment Referral Using Automated System for the Office of Inspector General (ASOIG)

Revision 15-4; Effective October 1, 2015

All Programs

Staff create referrals for overpayments caused by agency error, individual error/misunderstanding, or suspected IPV or fraud in ASOIG.

ASOIG is accessed at the following website: https://hhsportal.hhs.state.tx.us/asoig.

Users log in using a unique sign on. A disclaimer page explaining IRS Federal Tax Information requirements must be agreed to before proceeding with the referral. Agreement takes the user to the ASOIG home page.

Investigation is selected from the left navigation menu to proceed to the Referral and Investigation search page. Users must enter identifying information and select Create Referral.

Identifying information may consist of one or more of the following:

- Suspect name,
- Individual (client) number,
- Social Security number, or
- EDG or case number.

The Create Referral tab takes the user to the Create Referral screen group. This consists of the **Referral, Suspects, Reasons, Contacts, Comments** and **Assignment** tabs. The user must go through all tabs, enter information as appropriate, and save the referral.

The **Referral** tab is the first tab in creating a referral. The tab has two areas. The top part, Alleged Information, is for entering biographical information. The bottom portion, EDG Types, is used to enter whatever program type information is known.

The New button at the bottom of the tab is used when adding types to the EDG Types portion of the tab. If the referral is associated with more than one EDG, users must click the New button to add additional types. The user must continue to click the New button until all EDGs associated with the referral are added. Once all types have been entered, the user must click the Next button to proceed to the next tab, **Suspects**.

The **Suspects** tab is used to enter information on suspects as well as household members associated with the referral. The top portion of the screen, Suspect, allows for the entry of any known biographical information. The bottom portion, Address, is for entering any known address(es).

At least one suspect screen with a name and type of suspect is required for a referral. Although children are not "suspects," entering all household members is recommended as that information will be required if an investigation is merited.

If an automated interface finds information in TIERS, users may select from a list of names. If a name is chosen from the list in this field, the ASOIG populates applicable biographical and EDG information such as date of birth, Social Security number and address. If TIERS information is not found, users must enter all known information.

The New button on the tab is to allow the user to include all household members in the referral. Once all members are entered, the user must click the Next button to advance to the next tab, **Reasons**.

The **Reasons** tab is used to establish the basis for the referral. The screen is divided into three sections, Reason, Source Information and Source Detail. One reason type and name is required for each referral.

Multiple reasons may be entered on a single referral. If there are multiple reasons, users enter the information for the first reason and then click the New button to enter information for the next reason. Once all applicable reasons are entered, the user must click the Next button to move to the next tab, **Contacts**.

The **Contacts** tab is used to enter sources of information such as another employee, agency or other person with information about the referral. The screen is divided into two sections. The Contact portion is for information on the source of information while the Address portion is for documenting any address information for the contact.

A **Contacts** entry is not required for a referral, but multiple entries may be made by clicking the New button. Clicking on the Next button takes the user to the next tab, **Comments**.

The **Comments** tab is used to enter information on the referral. It is used to document information not otherwise captured by ASOIG. At least one comment is required and multiple comments may be entered. Comments are listed by subject, and users should enter a concise statement in the subject to describe the contents of the comment.

Comments may be linked to a **Contact** by clicking the Related Contact checkbox.

Once a comment is saved by clicking the New or Next button, it cannot be modified. Care must be exercised in completing this tab. Clicking the Next button takes the user to the final tab, **Assignment**.

The **Assignment** tab allows the assignment of the referral based on predefined rules. Once the Save Referral button is clicked, the referral is saved and all information is locked, except for the ability of the user to include additional comments.

Saving the referral takes the user back to the **Referral** tab; however, it is only for viewing, and the user now has the ability to attach any electronic documents saved on the user's computer to the referral. Attach documents by clicking the paper clip icon next to the tabs, browse to select the document, give a name to the document, describe the contents of the document and click Save. Multiple documents may be attached using the New button.

Note: Logging out of the referral before it is saved on the **Assignment** tab will result in loss of information entered, requiring the user to start over.

B—772 Filing an Overpayment Referral Using TIERS

Revision 15-4; Effective October 1, 2015

SNAP and TANF

When eligibility staff discover that an overpayment exists, either by advisor knowledge or because it is identified in the TIERS Eligibility Summary, the following steps must be taken to enter the referral in TIERS:

- From the left navigation menu, the user must go to Data Collection > Initiate Interview and enter the case number and case mode. If a case is already in ongoing mode, the user may enter the referral.
- From the left navigation menu, the user must select Data Collection > Miscellaneous > Referral. The TIERS referral summary page will display. If an overpayment claim exists for the EDG, there will be an entry for the advisor to review on this page. To review the claim, the user must click on the edit icon.
- To enter a new referral, the user must click the red Add button.
- On the Details page, the user must enter the following information:
    - Name – From the drop-down menu, select the name of the individual causing the overpayment.
    - Effective Begin Date – Enter the date the overpayment began.
    - Discovery Code – From the drop-down menu, select the most appropriate entry to describe how the overpayment was discovered. If no entry is appropriate, select "other."
    - Error Referral Type – From the drop-down menu, select an entry based on the entity causing the error. For errors caused by the agency's error or failure to take action in a timely manner, select "agency." For errors caused by individuals without the intent to commit fraud, select "client." For errors where eligibility staff believe the individual intentionally committed fraud to receive additional benefits, select "fraud."
    - Overpayment Reason – From the drop-down menu, select the most appropriate reason for the overpayment. If no entry is appropriate, select "other."
    - Overpayment Discovery Date – Enter the date HHSC discovered the overpayment.
    - Benefit Type – From the drop-down menu, make the appropriate selection based on the type of benefit overpaid.
    - Financial Penalty Code – For overpayments caused by TANF Personal Responsibility Agreement (PRA) noncompliance, select the area with which the individual noncomplied.
    - Destination Unit – Select the appropriate unit by region and by the type of referral (CI – Claims Investigation/FI – Fraud Investigation).
    - Referral Benefit Restored Amount – If the overpayment was caused by the issuance of restored benefits, enter the overpayment amount in this field. If the overpayment was not caused by the issuance of restored benefits, a zero entry remains in this field.
    - Form 1898 Completion Date – This field is used for overpayment claims caused by the issuance of restored benefits only. Enter the date Form 1898, Restored Benefits Documentation, was completed at the time the restored benefits were authorized.
    - First Month and Year of Overpayment – Enter the month and year the overpayment began. Estimate only.
    - Last Month and Year of Overpayment – Enter the month and year the overpayment ended. Estimate only.
    - Overpayment Amount – Enter the dollar amount of the overpayment for all referrals except referrals based on restored benefits. If the overpayment was caused by the issuance of restored benefits, this field should contain a zero entry. Estimate only.

    - EDG Participation – For the individual causing the overpayment, select whether or not the individual was a member of the certified group.
    - Participation Change Date – For claims based on household changes, enter the date the participation status changed for the individual causing the overpayment.
    - Participation Change Report Date – For claims based on household changes, enter the date HHSC learned of the household change.
    - Enter comments you wish OIG to receive by entering page-level comments on this page – Click on the center icon next to the **Referral – Details** title to enter page-level comments.
- On the Income page (for overpayments caused by income only), if known, the user enters the following information:
    - Source Type – From the drop-down menu, select "earned income" or "unearned income" depending on the type of income causing the overpayment.
    - Source Name – Enter the name of the entity that provided the income that caused the overpayment. This may be the name of an individual, company or government agency.
    - Verification Source – From the drop-down menu, make the appropriate verification source selection. If the source used to verify the income is not available on the menu, select "none" and document the source in page-level comments on the details tab.
    - Source Hire Date – For earned income overpayments, enter the hire date for the individual.
    - First Check Date – Enter the date the individual received the first payment that caused the overpayment. **Note:** This could be a check or cash payment, and the payment could be for earned and unearned income.
    - Source Report Date – Enter the date the individual informed HHSC of the income change.
    - Source Amount – Type the monthly amount of the income received from the source.
    - Income Source Address – If known, enter the address of the income source.
- On the Resources page (for overpayments caused by resources only), if known, the user enters the following information:
    - Resource Type – From the drop-down menu, select the most appropriate entry for the type of resource causing the overpayment. If no selection is appropriate, select "other."
    - Resource Change Date – Enter the date the individual obtained possession of the resource.
    - Resource Report Date – Enter the date HHSC learned of the resource change.
    - Resource Amount – Enter the countable value of the resource.
- The user must document the overpayment referral and reason in TIERS Case Comments.

B—780 Documentation Requirements

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Advisors must document in TIERS Case Comments:

- that an overpayment referral was made via ASOIG or through the TIERS interface, according to B-730, How to File an Overpayment Referral; and
- a brief description of the overpayment, and how and when the overpayment was discovered, according to B-711, Types of Overpayment Claims.

Related Policy
Documentation, C-940
The Texas Works Documentation Guide

TWH, B-800, Restored Benefits

Revision 13-3; Effective July 1, 2013

B—810 Entitlement to Restored Benefits

Revision 10-2; Effective April 1, 2010

TANF and SNAP

Households are entitled to restored benefits when:

- legislation, federal regulations or court actions require restoration;
- the Health and Human Services Commission (HHSC) makes an error in the household's amount of benefits and the household was not at fault;
- an individual is disqualified for an intentional program violation, which is later reversed by a court; or
- the Supplemental Nutrition Assistance Program (SNAP) or an authorized representative of a drug and alcohol facility improperly accesses and fails to return the benefits to the individual's EBT account.

Households are **not** entitled to restored benefits for unreported changes or household errors.

Households are entitled to restored benefits regardless of whether they are currently eligible for or receiving benefits.

B—820 Time Frames for Qualifying for Restored Benefits

Revision 10-2; Effective April 1, 2010

TANF and SNAP

Restore benefits as directed by a court or if the loss occurred within 12 months of the date:

- the household:
  - contests an adverse decision,
  - attends a disqualification hearing, or
  - notifies HHSC that it believes it has lost benefits.
- HHSC discovers that the household may be entitled to a restoration.

The month the agency discovers the household is entitled to a restoration is counted as month zero.

B—830 How to Determine the Amount of Restored Benefits

Revision 13-3; Effective July 1, 2013

TANF and SNAP

Texas Integrated Eligibility Redesign System (TIERS) Eligibility performs the steps to calculate restored benefits in most instances. The advisor may be required to manually calculate the restored benefit, record the restored benefit and offset information, and issue benefits using the Benefit Issuance – Manual Issuance functional area in TIERS.

1. Determine the month the loss began.
2. Exclude months before the 12-month time limit.
3. Determine if the household was eligible for each month the houshold lost benefits.
4. Obtain needed information to determine eligibility for any restored benefit month in question.
5. For each month, compute the amount of benefits the household should have received.
6. Determine the restored benefit amount by subtracting the correct benefits from the amount of benefits actually issued. If there is a claim, subtract the restored benefit amount from the amount due on the claim. Issue any remainder to the household.

Note: When initial benefits are paid retroactively, do not reduce the retroactive payment to offset previous claims.

Issue restored benefit(s) within 30 days of the date the agency discovers the underpayment.

B—831 Procedures for Counting Restored Benefits Toward a Claim

Revision 13-3; Effective July 1, 2013

TANF and SNAP

1. Document the amount of restored benefits owed on the Restored Benefits Details page or Request Manual Issuance page.
2. Determine if there is a claim, as noted in A-832, How to Verify a Claim Amount. Refer to B-761.1.1, Action on Recoupment Cases.
3. The nightly interface between TIERS and the Accounts Receivable Tracking System (ARTS) will report the offset.
4. Notify the individual on Form H1825, Entitlement to Restored Benefits.

B—832 How to Verify a Claim Amount

Revision 13-3; Effective July 1, 2013

TANF and SNAP

Advisors must go to Benefits Issuance on the left navigation bar and click on View Overpayments to verify a claim amount. TIERS users can search for overpayment information by entering a Social Security number, an Eligibility Determination Group (EDG) number or claim number. The Search Results display columns are: Social Security number, EDG number, EDG Name, Claim number and Individual number. Clicking on the Social Security number hyperlink will display overpayment information, which includes the remaining overpayment balance.

B—840 Notice to the Household

Revision 01-3; Effective April 1, 2001

TANF and SNAP

Notify the household by Form H1825, Entitlement to Restored Benefits, of

- their entitlement to restored benefits,
- the amount and method of restoration,
- any claim offset, and
- the right to appeal.

B—850 Disputed Benefits

Revision 13-3; Effective July 1, 2013

TANF and SNAP

If the household disagrees with the amount of restored benefits, or any other action the advisor takes to restore them, the household may request a hearing within 90 days of the notice date. The advisor continues the restoration while waiting for the hearing decision and adjusts the benefits according to the hearing officer's decision.

The household may request a hearing if the household believes it is entitled to restored benefits but the advisor does not agree. Document on the appropriate worksheet the request for restored benefits, the justification to deny them, and the date.

B—860 Method of Restoration

Revision 13-3; Effective July 1, 2013

TANF

Restore all benefits owed to the household at the same time. Issue a separate benefit for each month the household is owed benefits.

SNAP

Restore all benefits owed the household at the same time.

Issue a separate EBT benefit for each month the household is owed restored benefits.

B—870 Changes in Household Composition

Revision 01-3; Effective April 1, 2001

TANF and SNAP

If household membership changes, issue restored benefits to the household containing a majority of the persons who were household members when the loss occurred.

If the worker cannot locate an individual or determine which household contains a majority of members, restore benefits to the household that includes the person who was the head of the household when the loss occurred.

B—880 Procedure for Authorizing Restored Benefits

Revision 13-3; Effective July 1, 2013

TANF and SNAP

Authorize the restoration within 30 days of the date the agency discovers the underpayment.

A Second Level Review (SLR) is required when, in TIERS Eligibility:

- Restored benefits are being issued for more than three months prior to the current date.
- The total restored benefit amount (prior to offset) for TANF is equal to or greater than $50.
- The total restored benefit amount (prior to offset) for SNAP is equal to or greater than $125.

An SLR is required for all restored benefits requested in Manual Issuance.

B—890 Documentation Requirements

Revision 13-3; Effective July 1, 2013

TANF and SNAP

Advisors are required to document

- why the household is entitled to restored benefits;
- the month the loss of benefits began;
- the time frames for benefits owed;
- computations;
- if there is a claim against the household; and
- the amount of restoration approved if the household has an offset.

Note: The documentation requirements will be met if appropriate entries are made on the Restored Benefits Details page or Request Manual Issuance page.

Document in the case record the:

- request for restored benefits;
- justification to deny the request; and
- date according to B-850, Disputed Benefits.

Related Policy
Documentation, C-940
The Texas Works Documentation Guide

TWH, B-900, Referrals for Intentional Program Violation (IPV)

Revision 15-4; Effective October 1, 2015

B—910 General Policy

Revision 15-4; Effective October 1, 2015

All Programs

An IPV occurs when a person intentionally makes a false or misleading statement, or misrepresents, conceals, or withholds facts for the purpose of receiving assistance under Texas Health and Human Services Commission (HHSC) benefit programs.

Note: A person may be charged with an IPV, even if benefits the person was not entitled to receive have not actually been received.

SNAP

An IPV occurs when a person commits an act that constitutes a violation of the Food and Nutrition Act, the Supplemental Nutrition Assistance Program (SNAP) regulations, or any state statute for the purpose of using, presenting, transferring, acquiring, receiving, possessing, or trafficking of benefits, authorization cards, or reusable documents used as part of an electronic benefit delivery system (Electronic Benefit Transfer [EBT]).

B—911 Elements of an IPV

Revision 11-4; Effective October 1, 2011

All Programs

An IPV must contain at least one or more of the following elements:

- a falsified document,
- a falsified statement,
- a falsified interview,
- a continuing scheme, or
- trafficking of benefits.

See Glossary for definitions of the above terms.

B—912 IPV Disqualification Penalties

Revision 15-4; Effective October 1, 2015

General Policy

There is no IPV disqualification or disqualification penalty imposed for Medicaid or the Children's Health Insurance Program (CHIP). However, the Office of Inspector General (OIG) may establish an overpayment claim for an individual found guilty of committing fraud in these programs.

SNAP and TANF

A person found guilty by a court for an IPV will be disqualified as specified by the court. If the court fails to specify a disqualification, OIG will impose the appropriate IPV disqualification penalty as listed below.

TANF

A person found guilty of having committed an IPV through an administrative disqualification hearing (ADH) or having signed a waiver of an ADH for conduct that constitutes an IPV and that conduct occurred on or after September 1, 2003, will be disqualified:

- 12 months for the first offense, and
- permanently for the second offense.

A person convicted for conduct that constitutes an IPV of a state or federal offense, or granted deferred adjudication or placed on community supervision for that conduct, will be permanently disqualified from receiving financial assistance.

A person found guilty of an IPV in federal or state court, or in an ADH for making a fraudulent statement or representation with respect to the identity or residence of the individual in order to receive multiple benefits simultaneously, will be disqualified for 10 years.

SNAP

A person found to have committed an IPV either through an ADH or by a federal, state, or local court, or to have signed either a waiver of right to an ADH or a disqualification consent agreement in cases referred for prosecution, will be disqualified:

- 12 months for the first offense,
- 24 months for the second offense, and
- permanently for the third offense.

SNAP Specified Offenses

- A person found guilty of an IPV in federal or state court, or in an ADH for making a fraudulent statement or representation with respect to the identity or residence of the individual in order to receive multiple benefits simultaneously, will be disqualified for 10 years.
- A person found guilty of an IPV in federal, state, or local court of having used or received benefits in a transaction involving the sale of a controlled substance will be disqualified:
  - 24 months for the first occasion, and
  - permanently for the second occasion.
- A person convicted by a federal, state, or local court of an IPV due to trafficking in SNAP benefits or program access devices, such as EBT cards, and the conviction is for an aggregate amount of $500 or more, will be permanently disqualified.
- A person found guilty of an IPV in federal, state, or local court of having used or received benefits in a transaction involving the sale of firearms, ammunition, or explosives will be permanently disqualified.

B—920 When to File an IPV Referral

Revision 15-4; Effective October 1, 2015

All Programs

Staff are responsible for reporting to OIG any acts of fraud, waste, abuse, or misconduct in the following HHSC benefit programs:

- Temporary Assistance for Needy Families (TANF),
- SNAP,
- Medicaid, and
- CHIP.

B—930 How to File an IPV Referral

Revision 15-4; Effective October 1, 2015

All Programs

Staff submit a fraud or IPV referral using either the:

- Automated System for Office of Inspector General (ASOIG), or
- Texas Integrated Eligibility Redesign System (TIERS) referral interface.

Note: If the fraud allegation contains confidential information and/or the person making the allegation requests to remain anonymous, the referral is submitted using ASOIG. Any supporting information and/or evidence should be attached to the referral using ASOIG. The TIERS referral interface does not allow attachments.

Staff must follow instructions in B-770, Filing an Overpayment Referral, for submitting a referral using either ASOIG or the TIERS referral interface.

B—940 Texas Works (TW) Responsibilities

Revision 15-4; Effective October 1, 2015

All Programs

TW staff:

- identify potential fraud or IPV;
- submit fraud or IPV referrals, using ASOIG or the TIERS referral interface, within 30 days of the date the IPV is identified;
- process fair hearing requests related to claims or collections following instructions in B-1035, Appeals Related to Accounts Receivable Tracking System (ARTS), in TIERS;
- forward any payments received in the local office to:

  Texas Health and Human Services Commission
  Fiscal Management Services
  ARTS Billing
  P.O. Box 149055
  Austin, TX 78714-9055

- refer questions regarding collections on established claims to Fiscal Management Services (FMS);

  Note: The FMS hotline number is 1-800-666-8531. ARTS is administered by FMS staff who monitor and process payments from HHSC claims.
- report fraud and/or violations of SNAP rules by drug addict/alcohol treatment centers and group living arrangement facilities by emailing Form H1095, Treatment Facility Fraud Referral, along with Form H1096, Notification Letter, and if applicable, Form H1853, Documentation of Findings for Form H1852, to OIG General Investigations at OIG_GI@hhsc.state.tx.us; and
- report retail stores allowing unauthorized purchases and accepting benefits for previous purchase to Lone Star Business Services at LoneStar@hhsc.state.tx.us.

B—941 Disqualifying a Household Member with a Current SNAP Out-of-State IPV Disqualification

Revision 15-4; Effective October 1, 2015

SNAP

When out-of-state SNAP IPV disqualification data from the SNAP federal Electronic Disqualified Recipient System (eDRS) is identified on Data Broker, the advisor must discuss the IPV with the member to determine whether the member agrees with or disputes the information. The advisor must complete as much of the application process as possible and dispose the application for other programs if applicable; however, the advisor must follow procedures below for SNAP. **Exception:** This policy does not impact SNAP Combined Application Project (SNAP-CAP) or SNAP Supplemental Security Income (SNAP-SSI) Eligibility Determination Groups (EDGs) administered by Centralized Benefit Services (CBS), with one exception in SNAP-CAP as described in B-475.2.1, Identifying Intentional Program Violations (IPVs) and Felony Drug Convictions.

Procedures When Data Broker Identifies an eDRS Match

If the situation is ...	then ...
1. an expedited SNAP application, and the household does not dispute the IPV data,	the advisor must: • complete Form H1856, SNAP Out-of-State Intentional Program Violations, indicating it is for an expedited application; • send a copy for imaging; • email the form using secure Voltage to Customer Care Center (CCC)-eDRS eligibility staff at HHSC OES CCC IC, indicating **Expedited** in the email subject line; and • document this action in case comments. CCC-eDRS staff will review the form for accuracy and forward it immediately to OIG-Central Disqualification Unit (CDU) at CDU@hhsc.state.tx.us. If the email is received by 4:30 p.m. Central Standard Time, OIG-CDU staff will take action the same day to enter the IPV disqualification data from Form H1856 into TIERS, create a reported change task to notify the advisor to complete and dispose the SNAP EDG, and also email notice of this to the advisor. **Exception:** Out-of-state IPVs with non-standard penalty periods are noted on Data Broker and require secondary verification as described in Box D.
2. an expedited SNAP application, and the household **disputes** the IPV disqualification,	the advisor must: • postpone verification of the IPV penalty and certify the application without the penalty; • complete Form H1856, indicating it is for an expedited application; • send a copy for imaging; • email Form H1856 using secure Voltage to CCC-eDRS eligibility staff at HHSC OES CCC IC to obtain secondary verification of the out-of-state IPV data; and • document this action in case comments. If the out-of-state IPV verification is: • received by the final due date, the CCC-eDRS advisor forwards Form H1856 to OIG, who will enter the IPV disqualification data from Form H1856 into TIERS and create a reported change task to notify the local office advisor to complete and dispose the SNAP EDG. • not received by the final due date, the local office advisor must dispose the application without imposing the IPV disqualification. When the secondary verification is subsequently received, the CCC-eDRS advisor forwards Form H1856 to OIG-CDU staff at CDU@hhsc.state.tx.us, who will enter the IPV disqualification data from Form H1856 into TIERS and create a reported change task to notify CCC to dispose the penalty as a change and create an overpayment claim referral back to OIG.
3. a SNAP non-expedited application, household addition or redetermination,	the advisor must discuss the out-of-state IPV disqualification with the household to confirm the IPV data if possible. If the household does not dispute the IPV data, the advisor must: • complete Form H1856, • send a copy for imaging, • email Form H1856 using secure Voltage to CCC-eDRS eligibility staff at HHSC OES CCC IC, and • document this action in case comments. CCC-eDRS staff will review the form for accuracy and forward it immediately to OIG-CDU at CDU@hhsc.state.tx.us.

OIG-CDU staff will enter the IPV disqualification data from Form H1856 into TIERS and create a reported change task to notify the advisor to complete and dispose the EDG. **Exception:** Out-of-state IPVs with non-standard penalty periods are noted on Data Broker and require secondary verification as described in Box D.

If not possible to contact the household or the household disputes the IPV, then the advisor must:

- manually pend the SNAP EDG action until the final due date for CCC-eDRS staff to complete secondary verification,
- complete Form H1856,
- send a copy for imaging,
- email Form H1856 using secure Voltage to CCC-eDRS staff at HHSC OES CCC IC for a secondary verification as described above, and
- document this action in case comments.

If the secondary verification is not received and OIG has not entered the IPV disqualification by the:

- final due date on an application or redetermination, process it without imposing the IPV disqualification.
- 20th day after sending Form H1856 on a requested household addition, process the change without imposing the IPV disqualification.

When the CCC-eDRS advisor subsequently receives the out-of-state IPV verification, the CCC-eDRS advisor forwards it to OIG. OIG-CDU staff will enter the IPV disqualification data from Form H1856 into TIERS and create a reported change task to notify the advisor to dispose the EDG and create an overpayment claim referral back to OIG.

4. the IPV data on a Data Broker report is marked as "non-standard" (i.e., the penalty period listed is not a standard length),	the advisor must: • manually pend the SNAP EDG action until the final due date for CCC-eDRS staff to complete secondary verification, • complete Form H1856, • send a copy for imaging, • email Form H1856 using secure Voltage to CCC-eDRS eligibility staff at HHSC OES CCC IC to obtain secondary verification of the IPV before imposing the disqualification in Texas, and • document this action in case comments. **Note:** Postpone verification if expedited. If not expedited, process the application as explained in Box C.

Note: If the individual is not active on a SNAP EDG or the application has already been denied, OIG will enter this out-of-state IPV data into TIERS since the individual is known to TIERS. No advisor action is required in this situation.

B—942 Disqualifying a Household Member with a Current TANF Out-of-State IPV Disqualification

Revision 15-4; Effective October 1, 2015

TANF

When the advisor discovers that an individual has an out-of-state TANF IPV disqualification, the advisor must discuss the IPV with the individual to determine whether the individual disputes the information.

If the household does not dispute the IPV data …	the advisor must …
	• complete as much of the application process as possible and dispose the application for other programs if applicable, • pend the TANF EDG until OIG notifies the advisor to complete and dispose the EDG, and • send a secure email referral to OIG-CDU staff at CDU@hhsc.state.tx.us containing the following information:

Subject: TANF Out-of-State IPV

Out-of-state IPV information:

- TANF EDG number
- Originating state where IPV occurred
- Disqualified individual's:
  - Name
  - Social Security number (SSN)
  - Date of birth (DOB)
- Client number in originating state
- Number of disqualified months
- Disqualified begin date
- Disqualified end date
- Offense occurrence
- Offense description
- Federal or state court or administrative hearing decision date

Document the IPV information and the email sent to OIG in TIERS Case Comments.

OIG-CDU staff will enter the IPV disqualification data from the email into TIERS and create a reported change task to notify the advisor to complete and dispose the EDG.

If unable to contact the household or the household disputes the IPV data …

the advisor must …

- complete as much of the application process as possible and dispose the application for other programs if applicable,
- pend the TANF EDG until OIG notifies the advisor to complete and dispose the EDG*, and
- send a secure email referral to CCC-eDRS staff at HHSC OES CCC IC containing the following information:

  Subject: TANF Out-of-State IPV – Pending Secondary Verification

  Out-of-state IPV information:
  - TANF EDG number
  - Originating state where IPV occurred
  - Disqualified individual's:
    - Name
    - SSN
    - DOB
  - Client number in originating state
  - Number of disqualified months
  - Disqualified begin date
  - Disqualified end date
  - Offense occurrence
  - Offense description
  - Federal or state court or administrative hearing decision date
  - Whether the individual was/wasn't contacted
  - If the individual disputes the IPV, details regarding why the claim is disputed

    Document the IPV information and the email sent to CCC-eDRS in TIERS Case Comments.

    CCC-eDRS staff will obtain secondary verification of the IPV and immediately forward the secondary verification to OIG. OIG will enter the IPV information into TIERS.

    * If OIG has not entered the IPV disqualification by the final due date, process the application or redetermination without imposing the IPV disqualification.

B—943 Expiration of an IPV Disqualification Penalty

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Once the IPV disqualification penalty begins, it continues even when benefits expire or the EDG is denied. If the person reapplies for benefits, advisors must ensure that the person has served the IPV disqualification penalty before certifying the person for benefits.

Example: A person reapplies for TANF and SNAP on April 4, 2011, for herself and her three children.

The advisor checks the person's IPV disqualification status by viewing the person's Individual-Summary using the hover menu IPV Sanctions page. The person was found guilty of committing an IPV offense on February 4, 2011, resulting in a 12-month SNAP IPV disqualification beginning March 1, 2011, through February 28, 2012. Since the disqualification period has not expired, the advisor must continue the person's disqualification.

Notes:

- Form OIG5042, Notice of Disqualification Enforcement, may be viewed under Case Data Search.
- To determine eligibility for the remaining household members, advisors use the budgeting procedures in:
  - A-1362.2, TANF — Budgeting for a Household Member Disqualified for Noncompliance with SSN, TPR, Failure to Timely Report a Certified Child's Temporary Absence, Intentional Program Violation, Being a Fugitive or a Felony Drug Conviction; and
  - A-1362.4, SNAP — Budgeting for Persons Disqualified for Intentional Program Violations, SNAP Employment Services Noncompliances, Felony Drug Convictions or Being a Fugitive.

B—944 Reinstatement of an IPV Disqualified Person

Revision 14-1; Effective January 1, 2014

TANF and SNAP

When the IPV disqualification penalty period expires on an active EDG, TIERS automatically adds the formerly IPV disqualified person to the household and adjusts benefits accordingly.

B—945 Request for New Administrative Disqualification Hearing (ADH)

Revision 15-4; Effective October 1, 2015

TANF and SNAP

When a person disqualified for an IPV contacts the local office and claims that the individual did not receive an ADH notice and requests a new hearing, staff must notify the Office of Social Services (OSS) – Eligibility Services Support (ESS) Centralized Representation Unit (CRU). CRU coordinates with OIG in processing new ADH requests.

Staff provide CRU the following information:

- person's name,
- EDG number,
- date of disqualification, and
- status of the person's EDG (active, denied, pending).

Note: If the ADH officer grants a person's request for a new hearing, the CDU:

- removes the IPV disqualification, and
- contacts Texas Works to re-run the budget to allow for the person’s continued benefits pending the new ADH.

B—950 OIG Responsibilities

Revision 15-4; Effective October 1, 2015

All Programs

OIG General Investigations is organized as follows:

- State Office Operations Unit,
- Central Disqualification Unit,
- Claims Investigations (CI) units, and
- Field Investigations (FI) units.

OIG staff:

- review allegations of HHSC benefit program recipient fraud, including employee fraud as well as recipient and/or retailer EBT trafficking fraud;
- investigate allegations of recipient and/or employee fraud to determine whether fraud exists and, if applicable, the amount of an overpayment;
- establish fraud claims through the Fiscal Management Services Accounts Receivable Tracking System;
- coordinate with the HHSC Fair and Fraud Hearings Division for investigations submitted for ADH;
- coordinate with the local district attorney office for investigations submitted for prosecution;
- coordinate with U.S. Department of Agriculture (USDA) EBT trafficking investigations;
- dispose investigations based on the results of either prosecution or ADH;
- impose an IPV disqualification penalty, if applicable; and
- coordinate with the HHSC-OSS – Eligibility Operations CCC to adjust active HHSC program benefit amounts, if appropriate.

B—951 Facts Do Not Support an IPV

Revision 15-4; Effective October 1, 2015

All Programs

The facts do not support an IPV when:

- OIG staff review and determine that the facts do not support the allegation,
- a court determines the person is not guilty, or
- an ADH hearing officer determines that no IPV was committed.

OIG staff may process these claims as inadvertent household errors/misunderstandings.

B—952 Facts Support an IPV

Revision 15-4; Effective October 1, 2015

All Programs

When OIG determines that the facts support an IPV allegation, OIG submits the case to either the:

- local district attorney for prosecution, or
- Fair and Fraud Hearings Division for an ADH.

Note: A person may waive the right to an ADH by signing Form OIG5040, which allows OIG to establish a fraud claim and impose an IPV disqualification.

B—953 Enforcement of IPV Disqualification

Revision 15-4; Effective October 1, 2015

TANF and SNAP

OIG-CDU staff enforce the IPV Disqualification and associated disqualification penalty.

B—953.1 Notice of an IPV Disqualification

Revision 15-4; Effective October 1, 2015

TANF and SNAP

CDU staff receive the following notices that a household member has been disqualified due to an IPV:

- Form H1856, SNAP Out-of-State Intentional Program Violations. TW staff submit this form to CDU upon discovery of a person's current IPV disqualification that was administered by another state. See B-941, Disqualifying a Household Member with a Current SNAP Out-of-State IPV Disqualification, for directions.
- Form OIG5038, Notice of Disqualification Decision. OIG staff submit this form to CDU indicating when a court finds a person guilty of an IPV, or a court defers adjudication and the person voluntarily signs Form OIG5036, Disqualification Consent Agreement.
- Form OIG5040/5040S, Waiver of Disqualification Hearing. OIG staff submit this form to CDU indicating when a person waives the right to an ADH.
- Form H4857, Notice of Decision, Administrative Disqualification Hearing. ADH hearing officers submit this form to CDU indicating the ADH decision that a person committed an IPV.

B—953.2 Imposing an IPV Disqualification

Revision 15-4; Effective October 1, 2015

TANF and SNAP

CDU staff has primary responsibility for enforcing IPV disqualifications upon receipt of:

- Form H1856, SNAP Out-of State Intentional Program Violations;
- Form OIG5040, Waiver of Disqualification Hearing, signed by the person;
- Form H4857, Notice of Decision, Administrative Disqualification Hearing; or
- Form OIG5038, Notice of Disqualification Decision.

CDU imposes the IPV disqualification penalty:

- by the court-specified date (as indicated on Form OIG5038);
- within 45 days of the court disqualification decision date (as indicated on Form OIG5038) if the court did not specify a disqualification date;
- within 45 days of the date the person signs Form OIG5036, Disqualification Consent Agreement;
- the first month after the date the local OIG office receives a signed Form OIG5040; or
- the month after the date the person receives Form H4857.

CDU enters the IPV disqualification details in the disqualified individual's IPV Sanction screen and:

- sends an email request to the OSS - Eligibility Operations CCC to rebudget the household's future SNAP EDG benefit amount when the interface record exceptions out of a mass update or the IPV was manually entered by OIG staff; and
- sends Form OIG5042, Notice of Disqualification Enforcement, notifying:
  - the household of:
    1. the begin and end dates of the IPV disqualification penalty period; and
    2. its new benefit amount (if applicable); and

- TW staff of the enforcement of the IPV disqualification penalty.

When an IPV disqualification is not imposed in a timely manner, CDU staff initiate an overpayment referral to establish an agency error overpayment claim for any months the household received benefits to which it was not entitled.

B—953.3 Amendment of IPV Disqualification Penalties

Revision 15-4; Effective October 1, 2015

All Programs

CDU staff are authorized to modify IPV disqualification information if applicable. TW staff should contact CDU if TW staff believe IPV information is incorrect. CDU will research and respond to the problem.

B—960 Fiscal Management Services (FMS) Responsibilities

Revision 11-4; Effective October 1, 2011

B—961 IPV Claim Collection

Revision 15-4; Effective October 1, 2015

All Programs

FMS establishes repayment agreements and collects on IPV claims including court-deferred adjudications.

TANF

When the person fails to comply with its repayment agreement, FMS initiates recoupment at 10 percent of the household's recognizable needs.

SNAP

When the person fails to comply with its repayment agreement, FMS initiates recoupment at 20 percent of the household's allotment or $10, whichever is greater. When a current household member is disqualified for an IPV, recoupment is computed using the allotment the household would receive if the disqualified member were included in the household size.

B—970 HHSC Employee Fraud

Revision 15-4; Effective October 1, 2015

All Programs

Staff are responsible for reporting allegations of fraud involving HHSC benefit program certification procedures by HHSC employees to the unit supervisor. The supervisor forwards the report to the program manager.

Program managers report serious violations of HHSC employee fraud to the OIG director of general investigations at 512-491-2823.

Note: Allegations of employee fraud reported by email must be reported using an electronically secure mode.

B—980 Documentation Requirements

Revision 15-4; Effective October 1, 2015

All Programs

Staff must document the reason(s) for creating a fraud or IPV referral in the case comments.

Note: If the reason contains confidential information and/or the person making the allegation requests to remain anonymous, the referral must be submitted using ASOIG. Any supporting information and/or evidence should be attached to the referral using ASOIG. The TIERS referral interface does not allow for attachments. Staff must follow instructions in B-771, Filing an Overpayment Referral Using Automated System for the Office of Inspector General (ASOIG).

Related Policy
Documentation, C-940
The Texas Works Documentation Guide

TWH, B-1000, Fair Hearings

Revision 17-1; Effective January 1, 2017

B—1010 Right to Appeal

Revision 15-4; Effective October 1, 2015

All Programs

A request for a hearing is a clear expression, oral or written, by the household or its representative that indicates that the household wishes to appeal a decision. The freedom to make a request for a hearing must not be limited or interfered with in any way.

If any member of a household or the household's representative expresses dissatisfaction with a decision regarding benefits or services, the advisor takes the following actions:

- Explain the basis for the decision and the applicable policies;
- Provide the household an opportunity to have a conference with the supervisor;
- Provide the household an opportunity to request a fair hearing;
- Provide the individual with copies of all documents before the hearing that will be entered into evidence during the fair hearing; and
- Consult with the supervisor if the individual requests information the advisor considers confidential. **Note:** The individual is entitled to any information that was used to determine suspension, reduction or termination of benefits. See B-1210, Disclosure of Information, for information that is considered to be confidential.

The household or the household's representative must make a request to withdraw an appeal in writing. Staff must fax the written withdrawal request to the designated hearings office. If a written withdrawal request is not obtained, staff must notify the hearings officer via email. If email is not an option, staff must notify the hearings officer via fax or phone.

SNAP

If the household requests a conference with the supervisor after a denial for expedited service, the advisor must schedule the conference within two workdays of the request, unless the household prefers a later date. The advisor must document that the household requested a later date.

B—1020 Time Period for Requesting Fair Hearing

Revision 15-4; Effective October 1, 2015

All Programs

Individuals have the right to appeal within 90 days from the effective date of any Texas Health and Human Services Commission (HHSC) action. The individual's request may be oral or in writing.

Advisors may not prevent an individual from filing an appeal, even if the appeal was not requested within 90 days from the effective date of the action. Only the hearings officer has the authority to decide the timeliness of filed appeals and can accept untimely filed appeals in order to determine whether there was good cause for the delay in filing the appeal.

SNAP

The household may appeal the denial of a request to restore benefits that were lost within one year before the request. In addition, a household may appeal its current level of benefits during a certification period.

B—1030 Appeals Procedures

Revision 15-4; Effective October 1, 2015

All Programs

All fair hearing requests are processed in the State Portal. The local office staff (including Customer Care Center [CCC] staff) and Centralized Representation Unit (CRU) staff have separate responsibilities and must follow the following procedures when processing fair hearing requests and appeals.

B—1031 Local Office Procedures for Hearing Requests

Revision 15-4; Effective October 1, 2015

When any member of a household or the household's representative expresses dissatisfaction with a decision regarding benefits or services, the local office staff takes the following actions:

- Review the Eligibility Determination Group (EDG) to determine accuracy of the action;
- Take action to correct any agency error that results in an increase in benefits;
- Clearly document any discovered error and the action taken to correct the error;
- Explain the basis for the decision and the applicable policies to the individual;
- Provide the individual an opportunity to have a conference with the supervisor (including a conference within two workdays for an individual who wants to contest an expedited services decision); and
- Provide the individual an opportunity to request a fair hearing.

The same day a fair hearing request is received:

- in person, over the telephone or in writing — the advisor/supervisor enters the fair hearing request with the Add New Appeal tab in the State Portal Appeals/RFR (Request for Revision). These entries automatically create an **Appeal Request for (Program/TOA)** for CRU staff.
- by fax or mail — the advisor/supervisor faxes or mails the appeal using the fair hearing cover sheet to the expedited fax line (1-866-559-9628) for processing. The advisor must **not:**
  - complete and submit Form H4800, Fair Hearing Request Summary;
  - enter the fair hearing request in State Portal; or
  - enter the fair hearing request through left navigation in the Texas Integrated Eligibility Redesign System (TIERS).
- advisors must consult with the supervisor if the individual requests information staff considers confidential.

B—1031.1 Office of Attorney General (OAG) Child Support Division Region Contacts

Revision 15-4; Effective October 1, 2015

OAG Region	Primary Contact	Secondary Contact	Physical Mailing and Centralized Email Addresses
1 Lubbock	Angelia Gregg 806-761-4715 Fax: 806-763-7579	Renee DeLaRosa 806-761-4704 Fax: 806-763-7579	4630 50th Street, Ste 500 Lubbock, TX 79414-3521 OAGarea1.FairHearing@texasattorneygeneral.gov
2 San Antonio	Vanessa Vasquez 210-804-6488 Fax: 210-930-3625	Martin Martinez 210-804-6489 Fax: 210-930-3625	3460 Northeast Parkway San Antonio, TX 78218-3304 OAGarea2.FairHearing@texasattorneygeneral.gov
3 McAllen	Anna Rangel 956-926-4524 Fax: 956-631-2451	Vacant	3331 N. McColl Road McAllen, TX 78501-5536 OAGarea3.FairHearing@texasattorneygeneral.gov
4 Dallas	Nancy Hernandez 214-915-3721 Fax: 214-915-3750	Oscar Sanchez 214-915-3720 Fax: 214-915-3750	400 South Zang Blvd. Ste. 1100 Dallas, TX 75208-6646 OAGarea4.FairHearing@texasattorneygeneral.gov
5 Tyler	Christy Cates 903-533-4005 Fax: 903-592-5732	Glen Elliott 903-533-4009 Fax: 903-592-5732	200 N. Broadway Avenue, Ste 355 Tyler, TX 75702-5747 OAGarea5.FairHearing@texasattorneygeneral.gov
6 Houston	Mark Jones 713-948-7673 Fax: 713-910-4806	Melissa Jimenez 713-787-7146 Fax: 713-789-7665	8866 Gulf Freeway, Ste 200 Houston, TX 77017-6529 OAGarea6.FairHearing@texasattorneygeneral.gov
7 Austin	Patricia Roark 512-358-3242 Fax: 512-892-8967	Annette Hernandez 512-358-3249 Fax: 512-892-8967	2512 S IH 35 Ste 200 Austin, TX 78704-5751 OAGarea7.FairHearing@texasattorneygeneral.gov
8 El Paso	Lorraine Sanchez-Rayas 915-782-4211 Fax: 915-782-4276	Barbara Ramirez 915-782-4236 Fax: 915-782-4276	6090 Surety Dr., Ste 250 El Paso, TX 79905-2062 OAGarea8.FairHearing@texasattorneygeneral.gov
9 Ft. Worth	Elizabeth House 817-834-7048 Fax: 817-834-7066	Kelly Robison 817-834-7038 Fax: 817-834-7066	2001 Beach St. Ste 700 Ft. Worth, TX 76103 Regional email not yet established

OAG – Counties Served by Each Area

Region	Counties Served
1 Lubbock	Archer, Armstrong, Bailey, Baylor, Briscoe, Brown, Callahan, Carson, Castro, Childress, Clay, Cochran, Coke, Coleman, Collingsworth, Comanche, Concho, Cottle, Crockett, Crosby, Dallam, Dawson, Deaf Smith, Dickens, Donley, Eastland, Fisher, Floyd, Foard, Gaines, Garza, Grey, Hale, Hall, Hansford, Hardeman, Hartley, Haskell, Hemphill, Hockley, Hutchinson, Irion, Jack, Jones, Kent, Kimble, King, Knox, Lamb, Lipscomb, Lubbock, Lynn, Mason, McCulloch, Menard, Mitchell, Montague, Moore, Motley, Nolen, Ochiltree, Oldham, Parmer, Potter, Randall, Reagan, Roberts, Runnels, Schleicher, Scurry, Shackelford, Sherman, Stephens, Sterling, Stonewall, Sutton, Swisher, Taylor, Terry, Throckmorton, Tom Green, Wheeler, Wichita, Wilbarger, Yoakum, Young
2 San Antonio	Atascosa, Bandera, Bexar, Comal, Dewitt, Dimmit, Edwards, Frio, Gillespie, Gonzales, Guadalupe, Karnes, Kendall, Kerr, Kinney, LaSalle, Maverick, McMullen, Medina, Real, Uvalde, Val Verde, Wilson, Zavala
3 McAllen	Brooks, Cameron, Duval, Hidalgo, Jim Hogg, Jim Wells, Kenedy, Kleberg, Nueces, Starr, Webb, Zapata
4 Dallas	Collin, Cooke, Dallas, Denton, Ellis, Erath, Hood, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somerville, Tarrant

Region	Counties Served
5 Tyler	Anderson, Angelina, Bowie, Camp, Cass, Chambers, Cherokee, Delta, Fannin, Grayson, Gregg, Hardin, Harrison, Henderson, Hopkins, Houston, Hunt, Jasper, Jefferson, Lamar, Liberty, Marion, Morris, Nacogdoches, Newton, Orange, Panola, Polk, Rains, Red River, Rusk, Sabine, San Augustine, San Jacinto, Shelby, Smith, Titus, Trinity, Tyler, Upshur, Van Zandt, Wood
6 Houston	Austin, Brazoria, Ft Bend, Galveston, Harris, Matagorda, Montgomery, Waller, Wharton
7 Austin	Aransas, Bastrop, Bee, Bell, Blanco, Bosque, Brazos, Burleson, Burnett, Caldwell, Calhoun, Colorado, Coryell, Falls, Fayette, Freestone, Goliad, Grimes, Hamilton, Hays, Hill, Jackson, Lampasas, Lavaca, Lee, Leon, Limestone, Live Oak, Llano, Madison, McLennan, Milam, Mills, Refugio, Robertson, San Patricio, San Saba, Travis, Victoria, Walker, Washington, Williamson
8 El Paso	Andrews, Borden, Brewster, Crane, Culberson, East El Paso, Ector, Glasscock, Howard, Hudspeth, Jeff Davis, Loving, Martin, Midland, Pecos, Presidio, Reeves, Terrell, Upton, Ward, Winkler

B—1031.2 Providing Form H4800-A, Fair Hearing Request Summary (Addendum), to Hearings Division

Revision 17-1; Effective January 1, 2017

Form H4800-A, Fair Hearing Request Summary (Addendum), provides a method to send documents or evidence used in a hearing that were not sent with the original submission and to report changes of address or other corrections to the appropriate hearings officer.

B—1032 Centralized Representation Unit (CRU)

Revision 15-4; Effective October 1, 2015

The CRU is a staff unit within Eligibility Services Support (ESS) that represents HHSC in fair hearings and implements hearing officers' decisions.

B—1032.1 Centralized Representation Unit (CRU) Staff Responsibilities

Revision 15-4; Effective October 1, 2015

CRU staff completes the following actions:

- claim the **Appeal Request for (Program/TOA)** task from the Task List Manager (TLM) Global Queue;
- review the EDG to determine if any correction is needed and take appropriate action;
- prepare the evidence packet and mail to the Document Processing Center (DPC) for imaging;
- ensure the hearing procedures are explained in a language the individual understands;
- mail a copy of the evidence packet to the individual, legal representative, authorized representative and any other witnesses participating in the hearing;
- create and send a fair hearing request in TIERS;
- enter in TIERS any necessary accommodations; and
- mark the task as **Task Completed**.

Once the fair hearings request has been scheduled by Hearings Division staff, a **Fair Hearing Appointment for a (Program) Case** task will be routed to the Fair Hearings Centralized Representation Unit TLM Global Queue.

CRU will:

- assign an agency representative for each hearing;

- attend the fair hearing as the agency representative; and
- present the agency's case by explaining the action being appealed, the documents submitted and how the agency policy applies to the issue(s) on appeal.

B—1033 Appeals Related to Decisions/Actions of an Electronic Benefit Transfer (EBT) Vendor

Revision 14-2; Effective April 1, 2014

All Programs

When an EBT vendor cannot resolve an account balance dispute or error resolution related to benefits to an individual's satisfaction, the vendor refers the individual to Lone Star Business Services (LSBS) for a second review. The individual may contact LSBS staff to request a fair hearing if still not satisfied with the results of the second review. CRU processes the appeal following the policy and procedures outlined in this section.

B—1034 Appeals Related to Services for Medicaid Recipients

Revision 15-4; Effective October 1, 2015

All Programs

The Texas Department of State Health Services (DSHS) handles appeals concerning specific services for Medicaid recipients including:

- lock-in;
- medical necessity for prior authorization of services; and
- denial, termination, suspension or reduction of covered services, or payment for services rendered.

For individuals who want to appeal service-related issues, staff must refer them to DSHS. DSHS individual notification letters include an address and telephone number for requesting appeals. Individuals who do not have a notification letter should be referred to the Medicaid Hotline at 1-800-252-8263.

Note: DSHS does not allow individuals to appeal decisions made by the Health Insurance Premium Payment (HIPP) program. To obtain assistance in resolving problems or issues with the HIPP contractor:

- individuals must contact the Medicaid Hotline at 1-800-252-8263.
- staff must contact the Third-Party Resource (TPR) Unit at 1-800-846-7307.

B—1035 Appeals Related to Accounts Receivable Tracking System (ARTS)

Revision 15-4; Effective October 1, 2015

All Programs

For all individual requests for appeals related to ARTS collection notices, the advisor must make the following entries on Form H4800, Fair Hearing Request Summary:

1. In the **From** box, if the appeal is regarding a:
   - Claims Investigation (CI) collection notice, enter the CI unit supervisor, mail code, and phone number.
   - Treasury Offset Program (TOP) collection notice, enter ARTS Hearing Representative, 512-406-3800, at mail code E-411.

   Note: If the individual does not know if the collection notice is a result of a CI claim or TOP, enter the CI unit supervisor.

2. In Section 1, Program, check the appropriate program box.

3. In Section 2, Agency Action Resulting in a Hearing Request, check D, Not Benefit Amount Related. This will indicate to the hearing officer that the appeal does not affect current benefits.
4. In Section 8, Summary of Agency Action and Applicable Handbook Reference(s) or Rules, enter the following message: "Collection Notice - Overpayment Claim" (See B-700, Claims).

The advisor must notify the appropriate Claims Investigations Unit supervisor and ARTS supervisor of the hearing request. The advisor sends a copy of Form H4800 to the local Claims Investigation Unit supervisor or the ARTS supervisor, as appropriate, and faxes a copy of Form H4800 to ARTS at 512-438-3061.

B—1040 Timely Action on Fair Hearings

Revision 15-4; Effective October 1, 2015

All Programs

Hearing decisions must comply with federal law and regulations and be based on the evidence and testimony of the hearing.

Once the fair hearing has been held and a decision rendered, the hearings officer records the decision in TIERS, and a TLM task is created and routed to the Fair Hearings Centralized Representation Unit TLM Global Queue for processing.

1. If the decision is reversed, a Process Fair Hearings Reversal Decision for (Program/TOA) TLM task is created and routed to the CRU TLM Global Queue.
2. If the decision is sustained, a Fair Hearings Sustain Decision for (Program/TOA) task will be created and routed to the CRU TLM Global Queue for processing.
3. A Fair Hearings Decision Issued for (Program/TOA) task will be created for issued decisions that do not typically require an agency action.

CRU will follow these procedures to timely implement the hearing officer's instructions:

If the hearing decision results in restored benefits, an increase in benefits for the current month and/or future months, and ...	then ...
no additional information or verification is needed,	ensure within 10 days from the date the decision task is received that: • benefits for future months are increased, and • all benefits the household is entitled to are provided. Authorize restored Temporary Assistance for Needy Families (TANF) benefits in Eligibility or by manual issuance within 10 days from the date Form H4807, Action Taken on Hearing Decision, is received.
additional information or verification is needed,	send the individual Form H1020, Request for Information or Action, **within 10 days** from the date the decision task is received. List on Form H1020 the **specific** information/verification needed in order to provide benefits. If the individual: • provides all of the requested information and verification, then increase benefits for future months and/or provide benefits for the current/past months within **three workdays** from receipt of the information/verification; • provides part but not all of the requested information and verification, then increase benefits for future months and/or provide benefits for each month for which information/verification is provided **within three workdays** of receipt of the remaining information/verification; or • fails to provide the requested information and/or verification, then follow the normal eligibility determination process in B-600, Changes, and complete/deny the EDG without the missing information/verification.

Notes:

- Upon the individual's request, CRU will offer reasonable assistance in obtaining the necessary verification. The individual's statement is acceptable as verification if no other documentary or collateral information is available.
- Restored benefits are not denied for any months solely because a person outside the household refuses to cooperate in providing verification.

SNAP

- Benefits are not restored for any months more than 12 months prior to the date a fair hearing was requested.
- If the hearing officer authorized restored benefits, TIERS sends Form H1825, Entitlement to Restored Benefits, to the household, along with a copy to the hearing officer, when benefits are approved either in Eligibility or by manual issuance.

B—1041 Completing and Reporting Timely Action on Fair Hearings

Revision 15-4; Effective October 1, 2015

SNAP

Once all restored and/or supplemental benefits have been issued, the advisor must:

- enter all decision implementation information in TIERS in the Decision Implementation page;
- clear any delays entered in the Implementation Delay page; and
- enter all necessary information in the Implementation Details page and submit for supervisor review.

The supervisor must:

- review the EDG information and all supporting documentation in accordance with agency procedures and time frames; and
- approve the Implementation Details page.

B—1050 Handling of Benefits During the Appeal Process

Revision 01-3; Effective April 1, 2001

B—1051 Continued Benefits

Revision 15-4; Effective October 1, 2015

All Programs

Households previously certified for ongoing benefits are entitled to continued benefits if they make a timely request for a fair hearing after receiving Form TF0001, Notice of Case Action. A request is timely if it is made within 13 days of the adverse action notice (including a mailed request postmarked during the 13-day period). If a household fails to make a timely request for a hearing, but has good cause for the failure, benefits are reinstated at the previous level if the household did not waive its right to continue benefits.

TANF and Medical Programs

Households receiving an adequate notice of adverse action are not entitled to continued benefits when benefits are lowered or denied because of reasons listed in A-2344.1, Form TF0001 Required (Adequate Notice).

Exception: If the household received a notice of adverse action based on noncompliance with child support or Choices, continued benefits are allowed if the individual timely requests a fair hearing.

SNAP

Households receiving a notice of adverse action are not entitled to continued benefits when benefits are lowered or denied because of:

- a verbal request to voluntarily withdraw, conducted in the advisor's presence;
- verification provided by the household that was previously postponed during expedited services;
- the household's failure to provide verification postponed during expedited services; or
- the expiration of the certification period.

B—1052 Waiver of Continued Benefits

Revision 13-3; Effective July 1, 2013

All Programs

The household may waive its right to continued benefits by providing a signed and dated statement to this effect. If the household waives this right, TIERS will reduce or deny benefits when the 13-day notice period (plus 2 days mail time) expires in advance notice situations.

B—1053 Reducing or Ending Benefits Before the Hearing Decision

Revision 15-4; Effective October 1, 2015

All Programs

Continued or reinstated benefits must not be reduced or denied during the appeal period before the official hearing decision unless:

- another change adversely affects the household and the household does not appeal the adjustment for the later change. Benefits are reduced based on the change, and the advisor sends Form TF0001, Notice of Case Action.
- a mass change affects the household's eligibility. Benefits should be adjusted accordingly.

SNAP

When a certification period expires and the household reapplies, the EDG is certified at the appropriate level of benefits.

If the hearing officer determines the only issue being appealed is federal law or regulation and there are no computation errors or misapplied law, the hearing officer instructs the advisor to reduce or deny benefits as required by the policy change.

B—1054 Time Frame to Stop Providing Continued Benefits

Revision 15-4; Effective October 1, 2015

All Programs

When a hearing officer’s decision sustains the agency action, CRU must take action to stop continued benefits and file a claim for any overpayment within 10 days of receiving the hearing decision and order. Advance notice is not provided. If the hearing decision and order are received within 10 days before cutoff, CRU must make every attempt to process the EDG action before cutoff to prevent issuing continued benefits in the next month.

B—1060 Fair Hearings Held by Telephone

Revision 15-4; Effective October 1, 2015

All Programs

Fair hearings may be conducted by telephone. However, an appellant may still request a face-to-face hearing. Upon requesting a face-to-face hearing, the appellant is notified of the date, time and location of the hearing using Form H4803, Notice of Hearing.

There are two versions of Form H4803 that indicate how a fair hearing is conducted:

If the fair hearing is scheduled using ...	then ...
Form H4803-T/H4803-TS, Notice of Hearing,	the hearing officer calls the appellant, the agency representative and all other fair hearing participants at the time, date and telephone number indicated on the form.
Form H4803-P, Notice of Hearing,	the appellant, agency representative and all other fair hearing participants must call the Fair Hearing 1-800-Call-In number, using the toll-free number and access code at the scheduled time indicated on the form.

B—1070 Administrative and Judicial Reviews

Revision 15-4; Effective October 1, 2015

All Programs

Effective September 1, 2007, if an individual expresses dissatisfaction with a decision rendered by the fair hearings officer, the individual may have the right to have the decision reviewed. The types of review to which the individual may be entitled are an administrative review and a judicial review, depending on which program is appealed.

If the individual or individual's authorized representative is dissatisfied with a …	then the individual is entitled to an administrative review.	then the individual is entitled to a judicial review.
Supplemental Nutrition Assistance Program (SNAP) or Medicaid fair hearing decision,	Yes	Yes
TANF fair hearing decision,	Yes	No
SNAP administrative disqualification hearing (ADH) decision,	Yes	Yes
TANF ADH decision,	No	Yes

B—1071 Administrative Review

Revision 15-4; Effective October 1, 2015

All Programs

An administrative review is a review of the hearing record conducted by an agency attorney to determine if the hearing officer's decision was correct. The agency attorney issues a new decision, which includes the hearings officer's signature in all administrative reviews, and this decision is the agency's final action. Administrative reviews apply to SNAP, TANF and Medicaid fair hearing decisions and SNAP ADH decisions.

If the individual or individual's authorized representative is dissatisfied with a fair hearing decision issued on or after September 1, 2007, an administrative review may be requested but must be submitted in writing within 30 calendar days from the date of the hearing officer's decision. The request for an administrative review must be mailed to the following address:

Hearings Administrator
P.O. Box 149030, Mail Code W-613
Austin, TX 78714-9030

Notes:

- For TANF fair hearings, the individual's request for an administrative review only requires that the agency attorney review the hearing record for procedural and programmatic accuracy. The case is returned to the fair hearing officer for the final decision.
- An administrative review of the fair hearing or ADH decision by an agency attorney must be requested and completed before a judicial review is allowed. **Exception**: There is no prerequisite for an administrative review for a TANF ADH before a judicial review is requested.

B—1071.1 Centralized Representation Unit (CRU) Staff Responsibilities Following an Administrative Review

Revision 15-4; Effective October 1, 2015

All Programs

CRU Staff

When a fair hearing decision is reversed because of an administrative review, the agency must take action on the agency attorney's decision, as described in B-1040, Timely Action on Fair Hearings.

CRU:

- completes actions as required by the administrative review decision; and
- notifies the agency attorney and hearing officer that the required action has been completed.

Note: Continued benefits are not provided if the hearing officer sustains the agency action.

CRU Supervisory Staff

The CRU supervisor reviews the actions taken on the reversal and ensures all actions are complete and correct.

B—1072 Judicial Reviews

Revision 15-4; Effective October 1, 2015

All Programs

A judicial review is a review of the hearing decision by the court to determine whether the decision taken by the agency was correct. ADH decisions must be filed by the individual in a district court in Travis County. The court will determine whether the decision of the agency is correct. The individual must file a petition for a judicial review within 30 calendar days after the date the administrative review decision is rendered. The individual must complete the administrative review process before filing a petition for a judicial review.

An individual dissatisfied with a TANF ADH decision has the right to file for a judicial review in the district court in the county in which the violation occurred no later than the 30th calendar day after the date the hearing officer makes the determination.

Exception: There are no judicial review rights for a TANF fair hearing decision, but the appellant may still request a procedural review of the hearing officer's decision. A procedural review is a review of the hearing record by an agency attorney to ensure procedural and programmatic accuracy.

B—1072.1 Agency Staff Responsibilities Following a Judicial Review

Revision 15-4; Effective October 1, 2015

All Programs

Local Office and CCC Staff

If the agency's decision is reversed as a result of a judicial review, staff must implement the decision within the time frames as specified within the final orders of the court.

Note: Continued benefits are not provided due to a request for a judicial review.

B—1080 Verification Requirements

Revision 15-4; Effective October 1, 2015

All Programs

Advisors must verify that the household waived its right to continued benefits according to B-1052, Waiver of Continued Benefits.

Related Policy
Questionable Information, C-920
Providing Verification, C-930

B—1090 Documentation Requirements

Revision 15-4; Effective October 1, 2015

All Programs

Advisors must document the reason why the household is not entitled to continued benefits according to B-1051, Continued Benefits.

Related Policy
Documentation, C-940
The Texas Works Documentation Guide

TWH, B-1100, Reserved for Future Use

TWH, B-1200, Confidentiality

Revision 15-4; Effective October 1, 2015

B—1210 Disclosure of Information

Revision 15-4; Effective October 1, 2015

All Programs

Advisors must disclose information to applicants or individuals who want to review their case records for information used in the eligibility determination. Advisors must withhold confidential information from the case record, such as:

- names of persons who disclosed information about the household without the household's knowledge, and
- the nature or status of pending criminal prosecution.

TANF and Medical Programs

Advisors must disclose information about applicants or individuals to federal, state, or local agencies, if the information is directly connected with:

- administration of a program approved under any of the following titles of the Social Security Act:
  - Title IV-A (Temporary Assistance for Needy Families [TANF]/Choices)
  - Title IV-B (Child Protective Services [CPS])
  - Title IV-D (Child Support)
  - Title IV-E (Foster Care and Adoption Assistance)
  - Title XVI (Supplemental Security Income [SSI])
  - Title XIX (Medicaid)
  - Title XX (Social Services/Child Care)

Disclosure of information is permitted for any case audits, reviews of expenditure reports, financial reviews, investigation, prosecution, or criminal or civil proceeding conducted in connection with the administration of these programs.

- administration of any other federal or federally assisted program that provides assistance directly to individuals on the basis of need.

Individuals or the representatives of these agencies may review the individuals' case records in the advisor's office or receive a reply in writing. Information furnished to these agencies must be:

- factual,
- sufficiently current to serve its purpose, and
- limited to the purpose of the disclosure.

In a written reply, the inquiring agency must:

- agree to keep the information confidential, and
- use the information only for the purpose stated in its request.

Advisors must disclose information about applicants or individuals to Medicaid providers or their contractors that is needed for the providers to submit claims for reimbursement of Medicaid services provided to individuals. See the list of releasable data items in B-1230, Releasable Information for Medicaid Providers and Their Contractors.

SNAP

Advisors must disclose information about applicants or individuals to persons or agencies directly connected to the administration or enforcement of:

- the Supplemental Nutrition Assistance Program (SNAP);
- food distribution programs for households on Indian reservations; or
- other federal assistance programs or federally aided programs that base assistance on an individual's income and resources.

  Such programs include, but are not limited to: Women, Infants, and Children (WIC); TANF; Medicaid; Child Protective Services; and SSI.

Advisors must disclose information about applicants or individuals to employees of the U.S. Comptroller General's Office for audit purposes.

Individuals or the representatives of these agencies may review the individuals' case records in the advisor's office or receive a reply in writing. Information furnished to these agencies must be:

- factual,
- sufficiently current to serve its purpose, and
- limited to the purpose of the disclosure.

In a written reply, the inquiring agency must:

- agree to keep the information confidential, and
- use the information only for the purpose stated in its request.

B—1211 Reporting Abuse and Neglect

Revision 15-4; Effective October 1, 2015

All Programs

Policies on confidentiality do not prohibit reporting abuse or neglect that threatens the health or welfare of a child or an elderly adult or adult with disabilities. Advisors must report instances of suspected:

- physical or mental injury,
- sexual abuse,
- exploitation, and
- neglect.

Exception: Advisors are not required to report family violence.

Advisors must inform adults or their personal representative (PR) when reporting abuse or neglect of an adult, unless the advisor believes that informing the individual or PR would place the individual at risk of serious harm.

B—1212 Personal Representatives

Revision 15-4; Effective October 1, 2015

All Programs

Only the individual's PR can exercise the individual's rights with respect to individually identifiable health information. Therefore, only an individual's PR may authorize the use or disclosure of individually identifiable health information or obtain individually identifiable health information on behalf of an individual. Individually identifiable health information is information that identifies or could be used to identify an individual and that relates to the:

- past, present, or future physical or mental health or condition of the individual;
- provision of health care to the individual; or
- past, present, or future payment for the provision of health care to the individual.

Note: An authorized representative (AR) is not automatically a PR.

B—1212.1 Adults and Emancipated Minors

Revision 15-4; Effective October 1, 2015

All Programs

If the individual is an adult or emancipated minor, including married minors, the individual's personal representative is a person who has the authority to make health care decisions about the individual and includes a:

- person the individual has appointed under a medical power of attorney, a durable power of attorney with the authority to make health care decisions, or a power of attorney with the authority to make health care decisions;
- court-appointed guardian for the individual; or
- person designated by law to make health care decisions when the individual is in a hospital or nursing home and is incapacitated or mentally or physically incapable of communication. Advisors follow regional procedures to contact the regional attorney for approval.

B—1212.2 Unemancipated Minors

Revision 15-4; Effective October 1, 2015

All Programs

A parent is the personal representative for a minor child except when:

- the minor child can consent to medical treatment by him or herself. Under these circumstances, do not disclose to a parent information about the medical treatment to which the minor child can consent. A minor child may consent to medical treatment by him or herself when the:
  - minor is on active duty with the US military;
  - minor is age 16 or older, lives separately from the parents and manages his own financial affairs;
  - consent involves diagnosis and treatment of disease that must be reported to the local health officer or the Texas Department of State Health Services;

    - minor is unmarried and pregnant and the treatment (other than abortion) relates to the pregnancy;
    - minor is age 16 or older and the consent involves examination and treatment for drug or chemical addiction, dependency or use at a treatment facility licensed by the Texas Council on Alcohol and Drug Abuse;
    - consent involves examination and treatment for drug or chemical addiction, dependency or use by a physician or counselor at a location other than a treatment facility licensed by the Texas Council on Alcohol and Drug Abuse;
    - minor is unmarried, is the parent of a child, has actual custody of the child and consents to treatment for the child; or
    - consent involves suicide prevention or sexual, physical or emotional abuse.
- a court is making health care decisions for the minor child or has given the authority to make health care decisions for the minor child to an adult other than a parent or to the minor child. Under these circumstances, the advisor must not disclose to a parent information about the health care decisions not made by the parent.

B—1212.3 Deceased Individuals

Revision 15-4; Effective October 1, 2015

All Programs

The PR for a deceased individual is an executor, administrator, or other person with authority to act on behalf of the individual or the individual's estate. These individuals include:

- an executor, including an independent executor;
- an administrator, including a temporary administrator;
- a surviving spouse;
- a child;
- a parent; and
- an heir.

Advisors may consult the regional attorney with questions about whether a particular person is the PR of an applicant or individual.

B—1213 Establishing Identity for Contact Outside the Interview Process

Revision 15-4; Effective October 1, 2015

All Programs

All information the Texas Health and Human Services Commission (HHSC) has about an individual or any person on the individual's case must be kept confidential. Confidential information includes, but is not limited to, individually identifiable health information.

Before discussing or releasing information about an individual or any person on the individual's case, steps must be taken to reasonably ensure that the person receiving the confidential information is either the individual or a person the individual authorized to receive confidential information (such as an attorney or personal representative).

Related Policy
Identifying Applicants Interviewed by Phone and Prevention of Duplicate Participation, A-2000

B—1213.1 Telephone Contact

Revision 15-4; Effective October 1, 2015

All Programs

Advisors must establish a person's identity when contacting the individual, AR or PR by telephone. Refer to A-2020, Authenticating a Caller, for identity authentication policy.

Advisors must establish the identity of attorneys or legal representatives by asking the individual to provide Form H1826, Case Information Release, completed and signed by the individual. Advisors refer to B-1220, Specific Information That May Be Released, for authorization requirements.

Establish the identity of legislators or their staff by following regional procedures.

Related Policy
Identifying Applicants Interviewed by Phone and Prevention of Duplicate Participation, A-2000

B—1213.2 In-Person Contact

Revision 15-4; Effective October 1, 2015

All Programs

Advisors must establish the identity of a person who presents himself as an individual or individual's representative at a local eligibility determination office by:

- driver's license,
- date of birth,
- Social Security number (SSN), or
- other identifying information.

Advisors must establish the identity of other staff, federal agency staff, researchers, or contractors by:

- employee badge, or
- government-issued identification card with a photograph.

Advisors must identify the need for other staff, federal staff, research staff, or contractors to access confidential information through:

- official correspondence or phone call from state or regional offices, or
- contact with a regional attorney.

Advisors must contact appropriate regional or state office staff when federal agency staff, contractors, researchers, or other staff, etc., come to the office without prior notification or adequate identification and request permission to access HHSC records.

B—1220 Specific Information That May Be Released

Revision 15-4; Effective October 1, 2015

All Programs

Advisors must give individual addresses or other case information **only** to a person who has written permission from the individual to obtain the information. The individual authorizes the release of information by completing and signing:

- Form H1826, Case Information Release; or
- a document containing all of the following information:
  - the applicant/individual's full name (including middle initial) and case number, or full name (including middle initial) and either the date of birth or Social Security number;
  - a description of the information to be released;

    Note: If a general release is authorized, the advisor must provide the information that can be disclosed to the individual described in B-1210, Disclosure of Information, under All Programs.

  - statement specifically authorizing HHSC to release the information;
  - the name of the person or agency to whom the information will be released;
  - purpose of the release;
  - an expiration event that is related to the individual, the purpose of the release, or an expiration date of the release;
  - statement about whether refusal to sign the release affects eligibility for or delivery of services;
  - a statement describing the applicant's or individual's right to revoke the authorization to release information;
  - the date the document is signed; and
  - the signature of the applicant or individual.

    If the case information being released includes individually identifiable health information, the document must also inform the applicant or individual that the information released under the document may no longer be private and may be further released by the person receiving the information.

Note: Advisors must not include Form H1826 or other information release authorization documents in application packets.

Advisors must give information to government agencies conducting case audits, reviewing expenditure reports, or conducting financial reviews.

Advisors must give an applicant or individual's most recent address and place of employment to Parent Locator services in state or local offices.

Advisors must refer all requests from federal, state, or local law enforcement officials for case information to the local investigation division office.

Reasonable efforts must be made to limit the use, request, or disclosure of individually identifiable health information to the minimum necessary to determine eligibility and operate the program.

The disclosure of individual medical information from agency records must be limited to the minimum necessary to accomplish the requested disclosure. For example, if an individual authorizes release of income verification, including disability income, related case medical information must not be released unless specifically authorized by the individual.

TANF and Medical Programs

Advisors must release identifying information (such as the name and address of the individual's friends and relatives) to funeral homes, police, or agencies attempting to locate friends or relatives of deceased individuals.

Advisors reply to inquiries and complaints concerning the status of an individual's case from public officials or interested citizens who are acting as an agent for and have the consent of the individual. The case status includes whether an application was filed, action taken by HHSC and the reason for the agency's action.

Advisors provide only the specific information stated in a summons on an Internal Revenue Service (IRS) Form 2039 to the IRS representative.

Advisors provide only the following information to the Armed Forces:

- whether an individual is receiving TANF, and
- the amount of the TANF grant.

Advisors provide only the information in B-1230, Releasable Information for Medicaid Providers and Their Contractors, to Medicaid providers and their contractors. **Note:** Advisors must verify the contract with the Medicaid provider by obtaining:

- the contract with the provider, or
- a written document from the provider confirming the contract.

SNAP

Advisors release the names and addresses of participating individuals to persons or agencies directly connected with nutrition education.

B—1230 Releasable Information for Medicaid Providers and Their Contractors

Revision 15-4; Effective October 1, 2015

All Programs

Applicant Data	• Name • SSN* • Social Security Claim Number (SSCN or PCN)* • Date of Birth • Sex	• HHSC County Code • Category Code • Application Number • Application Disposition Date • Application Status • Client Number

Client Data	• Name
	• Client Number
	• SSN*
	• SSCN*
	• Date of Birth
		• Third-Party Resource (TPR) Policy Occurs (most recent three):
		  ○ Ins. Policy Number
		  ○ Ins. Policy Sequence
		  ○ Ins. Information Status

	• Sex
	• HHSC County Code
	• Certification Date
	• Claims Administrator Update Date (Ins Sub Date)
	• Last Medical Update Date
	• Code for Type Change in Medical Coverage
	• Medicaid:
	  ○ Open Date
	  ○ Close Date
	  ○ Type Coverage
	  ○ Category
	  ○ Type Program
	  ○ Qualified Medicare Beneficiary (QMB) Indicator, if applicable
	  ○ Medically Needy Indicator, if applicable
	  ○ Client Medical Record
	  ○ Case Numbers (active)
		○ Type Coverage
		  ○ Company Number
		  ○ Group Number
		  ○ Ins. Begin Date
		  ○ Ins. End Date
		  ○ Ins. Policy Holder
		  ○ Ins. Employer
		• Medicare (Yes or No)
		• THSteps Data:
		  ○ THSteps Decision Date
		  ○ Dental Treatment Date
		  ○ Medical Screen Date
		• Lock-in Data (most recent six):
		  ○ Provider Type
		  ○ Provider Name
		  ○ Start Date
		  ○ Through Date

Public Assistance (PA) Case Data	• Case Number
	• Eligibility Determination Group (EDG) Number
	• Case Name
	• Case Status
	• Three Month Prior Date
	• End Date (For Medically Needy)
	• Denial Reasons **
		• Type Program
		• Active Clients List:
		  ○ Client Number
		  ○ Name
		  ○ Date of Birth
		  ○ Sex
		• Three Months Prior with Spend Down (not the spend down amount)

* Advisors must confirm that the number given by the requestor is correct. Advisors do not release Social Security numbers.

** Only the following denial reasons can be released:

Reason
Refusal to furnish information
Failure to furnish information
Appointment not kept (application/review)
Unable to locate
Voluntary withdrawal

B—1240 Preventing Disclosure of Information

Revision 15-4; Effective October 1, 2015

All Programs

If the advisor receives a request for information which cannot be released, the advisor must inform the person requesting the information about the confidentiality of case records based on federal and state laws.

If the advisor receives a subpoena to appear in court with an individual's record, the advisor must notify the supervisor about the hearing. The advisor must take the case record and appear in court. When asked to disclose information from the case record, the advisor must ask the judge to be excused from disclosing information because of the laws concerning confidentiality. The advisor must abide by the judge's ruling.

See Part I, Section 3000, Health Insurance Portability and Accountability (HIPPA), in the Texas Department of Aging and Disability Services *Operational Handbook* for more information on disclosure of information laws.

B—1241 Destruction of Confidential Material

Revision 07-3; Effective July 1, 2007

Confidential material that includes identifying information such as name, address or Social Security number must be disposed of according to local office procedures.

B—1250 Reporting Unauthorized Inspection or Disclosure of Social Security Administration (SSA)-Provided Information

Revision 14-4; Effective October 1, 2014

All Programs

Staff who become aware of an incident of unauthorized access to or disclosure of restricted information (i.e., IRS Federal Tax Information and verified SSA information) or confidential information must immediately contact the HHSC IRS coordinator by sending a secure email to HHSC IRS_FTI_Safeguards@hhsc.state.tx.us.

The HHSC IRS coordinator will report the incident by contacting the information security officer (ISO).

If a person is responsible for a security breach or a person's employment is terminated, the user's access to all information must be removed. Supervisors must follow agency procedures for removing access for employees, contractors, vendors or trainees.

Related Policy
Reporting a Security Incident Regarding Internal Revenue Service (IRS) Federal Tax Information (FTI), C-1060

B—1260 Verification Requirements

Revision 15-4; Effective October 1, 2015

All Programs

Advisors must verify the identity of the person who contacts the advisor with a request to disclose individually identifiable health information, using sources found in A-621, Verification Sources. In addition, Form H1826, Case Information Release, presented by a legal representative or with an employee badge, may be used to identify the person.

B—1270 Documentation Requirements

Revision 15-4; Effective October 1, 2015

All Programs

If disclosing individually identifiable health information, the advisor must document how the identity of the person was verified when contact occurs outside of the interview.

Advisors must document:

- the name of the personal representative (see B-1212, Personal Representatives);
- the reason why a parent is not considered a PR for an unemancipated minor (see B-1212.2, Unemancipated Minors);
- that the inquiring agency will agree to keep information confidential; and
- that the information is limited to the purpose of the disclosure.

Related Policy
Documentation, C-940
The Texas Works Documentation Guide

TWH, B-1300, Nondiscrimination

Revision 15-4; Effective October 1, 2015

B—1310 Nondiscrimination Policy

Revision 15-4; Effective October 1, 2015

All Programs

The Texas Health and Human Services Commission (HHSC) does not discriminate against any applicant or participant in any aspect of program administration. All eligible households receive benefits without regard to age, race, color, sex, disability, religious creed, national origin, or political beliefs.

HHSC must:

- inform the public of this nondiscrimination policy and the applicable complaint procedures, and
- provide access to nondiscrimination information within 10 days of a request.

Individuals should be referred to the Civil Rights Office toll-free at 1-888-388-6332. Staff can email the individual's request to HHSCivilRightsOffice@hhsc.state.tx.us.

SNAP

Each certification office must display the nondiscrimination poster provided by the United States Department of Agriculture (USDA).

B—1320 Racial and Ethnic Data Collection

Revision 15-4; Effective October 1, 2015

All Programs

HHSC obtains racial and ethnic information about all individuals. The racial or ethnic categories are: American Indian or Alaskan Native, Asian or Pacific Islander, black (not of Hispanic origin), Hispanic, and white (not of Hispanic origin). Individuals are requested to voluntarily identify their race or ethnicity on the applications for HHSC assistance. If this information is not voluntarily provided on the application form, the advisor must determine the category by asking an individual to self-identify the individual's race. The individual's racial identity is self-declared. If the individual does not want to provide the information, the individual's race is listed as "unknown." In the Individual Household logical unit of work (LUW) on the individual's Add New Individual Information, Edit Existing Individual ID Information **or** Edit New Individual Information page, the advisor must select the appropriate ethnicity and race from the drop-down menus.

TWH, B-1400, Complaints

Revision 15-4; Effective October 1, 2015

B—1410 Discrimination Complaints

Revision 15-4; Effective October 1, 2015

All Programs

Texas Health and Human Services (HHS) Circular C-001 found at www.hhsc.state.tx.us/news/circulars/c-001.shtml describes general discrimination complaint procedures.

SNAP

Explain the following procedures to individuals who feel they have been discriminated against in the Supplemental Nutrition Assistance Program (SNAP) and want to complain about it.

- Individuals may submit their complaint to the United States Department of Agriculture (USDA), any Texas Health and Human Services Commission (HHSC) certification office, or both. Individuals may submit complaints to, or obtain information from, USDA at either of these addresses:

  Food and Nutrition Service
  United States Department of Agriculture
  Washington, D.C. 20250

  or

  Food and Nutrition Service
  United States Department of Agriculture
  1100 Commerce Street
  Suite 5-C-30
  Dallas, TX 75242

- Individuals must file their complaints in writing within 180 days of the incident that caused the complaint.

If submitting a complaint to HHSC, individuals use Form H4870, Client Complaint of Discrimination. For verbal or hotline complaints, staff accepting the complaint complete Form H4870 for the individual. Advisors and other staff handle hotline complaints the same as any other complaints.

B—1420 Office of the Ombudsman

Revision 15-4; Effective October 1, 2015

All Programs

Office of the Ombudsman operates a toll-free customer service hotline during normal office hours. The Office of the Ombudsman assists the public with issues or complaints about health and human services programs that have not been resolved under the agency's normal resolution process. If an individual has a problem or complaint, the individual is encouraged to first discuss it with the person, program staff or office staff involved. Many times they can explain a specific policy or resolve the concern immediately.

People who need assistance or information about local resources or programs are encouraged to call 2-1-1 for access to information about health and human services in their community, including information on the location and phone number of local HHSC offices.

If an individual has problems with or complaints about a health and human services program that is not resolved to their satisfaction, the individual has four ways to send a question or file a complaint:

1. **Call:** 1-877-787-8999 (toll-free)
2. **Online:** hhs.texas.gov/about-hhs/your-rights/office-ombudsman/ombudsman-contact-us
3. **Fax:** 1-888-780-8099 (toll-free)
4. **Mail:** Texas Health and Human Services Commission
   Office of the Ombudsman, MC H-700
   P.O. Box 13247
   Austin, Texas 78711-3247

Ombudsman staff:

- conduct reviews of complaints concerning HHSC policy or practices;
- ensure case actions related to complaints are consistent with the policies and practices of HHSC;
- provide information to individuals about their rights and responsibilities;
- coordinate the resolution of complaints or requests for information with appropriate agency staff;
- refer individuals who request other state health and human services to the appropriate area;
- screen, document and track all complaints and inquiries received using the HHS Enterprise Administrative Report and Tracking System (HEART);
- compile and share various weekly, monthly and quarterly reports with designated executive, state and regional staff, providing complaint and inquiry volume and trend analysis.

Note: Ombudsman staff cannot determine eligibility or make changes to cases.

Medicaid Managed Care Helpline

The Medicaid Managed Care Helpline is designed to help people who receive Medicaid and need help accessing health care services. The HHSC Medicaid Managed Care Helpline helps Medicaid individuals:

- navigate the managed care system (STAR, STAR+PLUS, Primary Care Case Management [PCCM]).
- understand their Medicaid coverage.
- understand their rights.
- advocate for themselves.
- resolve problems, including access to care.

The Medicaid Managed Care Helpline also provides general information about managed care programs to providers, health plans, community based organizations and other stakeholders. Individuals may contact the Medicaid Managed Care Helpline at 1-866-566-8989.

Related Policy
Managed Care, A-821.2
Managed Care Plans, C-1116

TWH, Part C, Appendix

TWH, C-100, Income Limits and Proration Charts

Revision 17-4; Effective October 1, 2017

C—110 TANF

Revision 11-4; Effective October 1, 2011

C—111 Income Limits

Revision 17-4; Effective October 1, 2017

TANF

Temporary Assistance for Needy Families (TANF) Budgetary Allowances (October 1, 2017)

	Non-Caretaker Cases			Caretaker Cases Without Second Parent			Caretaker Cases With Second Parent		
Family Size	**Bud Needs (100%)**	**Rec Needs (25%)**	**Max Grant**	**Bud Needs (100%)**	**Rec Needs (25%)**	**Max Grant**	**Bud Needs (100%)**	**Rec Needs (25%)**	**Max Grant**
1	$256	$64	$99	$313	$78*	$121	---	---	---
2	369	92	143	650	163	251	498	125**	192
3	518	130	200	751	188	290	824	206	318
4	617	154	238	903	226	348	925	231	357
5	793	198	306	1003	251	387	1073	268	414
6	856	214	330	1153	288	445	1176	294	453
7	1068	267	412	1252	313	483	1319	330	509
8	1173	293	452	1425	356	549	1422	356	548
9	1346	337	519	1528	382	589	1595	399	615

	Non-Caretaker Cases			Caretaker Cases Without Second Parent			Caretaker Cases With Second Parent		
10	1450	363	559	1701	425	656	1698	425	655
11	1623	405	626	1804	451	695	1871	468	721
12	1726	432	665	1977	494	762	1975	494	761
13	1899	475	732	2080	520	802	2147	537	828
14	2003	501	772	2253	563	868	2251	563	868
15	2174	544	838	2356	589	908	2423	606	934
Per each additional member	173	43	67	173	43	67	173	43	67

* Caretaker of child receiving Supplemental Security Income (SSI)
** Caretaker and second parent of child receiving SSI
"Bud Needs" is budgetary needs.
"Rec Needs" is recognizable needs.

C—112 How to Prorate TANF Grants

Revision 15-4; Effective October 1, 2015

TANF

After eligibility is determined, the TANF grant amount is prorated for the first month of eligibility using the following steps:

1. Calculate the certified group's recommended grant amount for the month based on the household size and net income. (See Step 5, line 3, page 3 of Form H1101, TANF Worksheet, or Step 5, line 3, page 2 of Form H1102, TANF Worksheet for Special Reviews and Denials.)
2. Determine the earlier of the certification date or the 30th day after the file date. Using the chart in C-112.1, Proration Multiplier Chart, determine the appropriate proration multiplier.
3. Multiply the recommended grant amount from Step 1 by the multiplier from Step 2.
4. Round the amount from Step 3 down to the next dollar. If the resulting prorated grant is less than $10, the household is not eligible for a grant in the first month. The grant effective date is the first day of the following month.

Note: One-Time TANF (OTTANF) or One-Time Grandparent payments are not prorated.

C—112.1 Proration Multiplier Chart

Revision 01-7; Effective October 1, 2001

TANF

Date Financial Eligibility Begins	Proration Multiplier
1	1
2	.97
3	.93
4	.90
5	.87
6	.83

Date Financial Eligibility Begins	Proration Multiplier
7	.80
8	.77
9	.73
10	.70
11	.67
12	.63
13	.60
14	.57
15	.53
16	.50
17	.47
18	.43
19	.40
20	.37
21	.33
22	.30
23	.27
24	.23
25	.20
26	.17
27	.13
28	.10
29	.07
30/31	.03

C—120 Supplemental Nutrition Assistance Program (SNAP)

Revision 08-1; Effective January 1, 2008

C—121 Maximum Income Limits

Revision 17-4; Effective October 1, 2017

SNAP

SNAP Maximum Income Limits Effective October 1, 2017

Household Size	Gross (130%)	Net (100%)	165%*
1	$1,307	$1,005	$1,659
2	1,760	1,354	2,233

Household Size	Gross (130%)	Net (100%)	165%*
3	2,213	1,702	2,808
4	2,665	2,050	3,383
5	3,118	2,399	3,958
6	3,571	2,747	4,532
7	4,024	3,095	5,107
8	4,477	3,444	5,682
9	4,930	3,793	6,257
10	5,383	4,142	6,832
Each additional person	+453	+349	+575

* The figures in the 165 percent column are used to determine if an elderly person or a person with a disability living with others may claim separate household status even though the person purchases or prepares food with the others. The figures in this column are also the income limits for categorically eligible households.

C—121.1 Deduction Amounts

Revision 17-4; Effective October 1, 2017

SNAP

- Standard

If the eligible household size is ...	then the standard deduction is ...
Three or less	$160
Four	$170
Five	$199
Six or more	$228

- Standard medical expense — $137 (minus $35)
- Actual medical expense (minus $35)
- Homeless shelter standard — $143
- Maximum excess shelter — $535
- Standard utility allowance — $342
- Basic utility allowance — $316
- Telephone standard — $37

Note: A disqualified member in the household size is not used when applying the standard deduction.

Related Policy
Deductions, A-1400

C—122 How to Determine Monthly SNAP Allotments

Revision 17-4; Effective October 1, 2017

SNAP

To determine the monthly allotment for a household, advisors use the chart in C-1431, Whole Monthly Allotments by Household Size. The monthly allotment for a household with more than 10 people is determined by first determining the maximum:

- monthly allotment by adding $144 for each additional person to the maximum SNAP allotment for a household of 10 people ($1,441);
- gross income by adding $453 for each additional person to the maximum gross income for a household of 10 people ($5,383); and
- net income by adding $349 for each additional person to the maximum net income for a household of 10 ($4,142).

The monthly allotment is determined by:

- multiplying the household's net monthly income by .30;
- rounding the cents to the next higher whole dollar amount; and
- subtracting the rounded sum from the maximum monthly allotment for the household size.

Example: A 12-person household with a net monthly income of $964 has a monthly allotment of $1,439 ($964 × .30 = $289.20 or $290; $1,441 + $144 + $144 = $1,729; $1,729 - $290 = $1,439).

Note: The shaded portions on the table in C-1431 indicate allotments available only to categorically eligible households.

Related Policy
How to Prorate Benefits, C-123
Whole Monthly Allotments by Household Size, C-1431
Prorated SNAP Allotments by Application Date, C-1432

C—123 How to Prorate Benefits

Revision 15-4; Effective October 1, 2015

SNAP

A prorated allotment for the month of application is determined by using the chart in C-1432, Prorated SNAP Allotments by Application Date, or by:

- subtracting the date of the application from 31;
- multiplying the sum by the amount of the whole monthly allotment; and
- dividing that amount by 30. If the date of the application is the 30th or 31st, the whole allotment is divided by 30. All cents are disregarded.

Example: A household with a whole monthly allotment of $395 applies on June 17. The household's prorated allotment for June is $184. (31 - 17 = 14; $395 × 14 = $5,530; $5,530 ÷ 30 = $184.33 or $184)

Note: Some categorically eligible households can receive ongoing monthly allotments of less than $10. Do **not** issue allotments that are prorated to less than $10. A one- or two-person household that qualified for a minimum monthly allotment of $16 can receive a prorated allotment of less than $16 but not a prorated allotment of less than $10.

Benefits are not prorated if the household includes a member who meets both of the following criteria:

- is a seasonal or migrant farm worker (in or out of the workstream), and
- was certified for SNAP in Texas or another state the month before the household applied.

Related Policy
Whole Monthly Allotments by Household Size, C-1431

C—130 Medical Programs

Revision 12-1; Effective January 1, 2012

C—131 Income Limits

Revision 13-3; Effective July 1, 2013

C—131.1 Federal Poverty Income Limits (FPIL)

Revision 17-2; Effective April 1, 2017

TP 33, TP 34, TP 35, TP 36, TP 43, TP 44, TP 48, TP 40, TP 42, TA 74, TA 75 and TA 76

Family Size	133% FPIL (3-1-17) TP 44, 34, TA 76	144% FPIL (3-1-17) TP 48, 33, TA 75	198% FPIL (3-1-17) TP 40, 42, 43, 36, 35, TA 74
1	$1,337	$1,448	$1,990
2	1,800	1,949	2,680
3	2,264	2,451	3,370
4	2,727	2,952	4,059
5	3,190	3,454	4,749
6	3,654	3,956	5,439
7	4,117	4,457	6,129
8	4,580	4,959	6,818
9	5,043	5,460	7,508
10	5,507	5,962	8,198
11	5,970	6,464	8,887
12	6,433	6,965	9,577
13	6,897	7,467	10,267
14	7,360	7,968	10,956
15	7,823	8,470	11,646
For each additional member	464	502	690

Note: See C-1114, Guidelines for Providing Retroactive Coverage for Children and Medical Programs, for the income limits.

TP 02, TA 84 (CHIP), TA 85 (CHIP-P), TA 77 and TP 70

Family Size	200% FPIL (3-1-17) TA 41	201% FPIL (3-1-17) TA 84	202% FPIL (3-1-17) TA 85	400% FPIL (3-1-17) TA 77	413% FPIL (3-1-17) TP 70
1	$2,010	$2,021	$2,031	$4,020	$4,151
2	2,707	2,721	2,734	5,414	5,590
3	3,404	3,421	3,438	6,807	7,028
4	4,100	4,121	4,141	8,200	8,467
5	4,797	4,821	4,845	9,594	9,906
6	5,494	5,521	5,549	10,987	11,344
7	6,190	6,221	6,252	12,380	12,783

Family Size	200% FPIL (3-1-17) TA 41	201% FPIL (3-1-17) TA 84	202% FPIL (3-1-17) TA 85	400% FPIL (3-1-17) TA 77	413% FPIL (3-1-17) TP 70
8	6,887	6,922	6,956	13,774	14,221
9	7,584	7,622	7,660	15,167	15,660
10	8,280	8,322	8,363	16,560	17,099
11	8,977	9,022	9,067	17,954	18,537
12	9,674	9,722	9,771	19,347	19,976
13	10,370	10,422	10,474	20,740	21,415
14	11,067	11,122	11,178	22,134	22,853
15	11,764	11,823	11,881	23,527	24,292
For each additional member	697	701	704	1,394	1,439

Related Policy
Limits, A-1220
Certified Group, A-242
General Policy, M-210
General Policy, F-210

C—131.2 Medically Needy and Parents and Caretaker Relatives Medicaid

Revision 15-4; Effective October 1, 2015

TA 31, TP 08, TP 32, TP 56 and TA 86

-	-	TP 08, TA 31 and TA 86	
Family Size	**TP 32 and TP 56**	**One Parent**	**Two Parents**
1	$104	$103	$N/A
2	216	196	161
3	275	230	251
4	308	277	285
5	357	310	332
6	392	356	367
7	440	389	412
8	475	441	447
9	532	476	500
10	567	527	535
11	624	562	587
12	659	613	622
13	716	648	675
14	751	700	710
15	808	734	762
Per each additional member	57	52	52

C—131.3 Transitional Medicaid

Revision 17-2; Effective April 1, 2017

TP 07 and TP 37

Family Size	185% FPIL (3-1-17) TP 07 and TP 37
1	$1, 860
2	2,504
3	3,149
4	3,793
5	4,437
6	5,082
7	5,726
8	6,371
9	7,015
10	7,659
11	8,304
12	8,948
13	9,593
14	10,237
15	10,882
Per each additional person	645

C—131.4 Standard MAGI Income Disregard

Five Percentage Points of FPIL	
Family Size	**2017 Monthly Disregard Amount**
1	$50.25
2	67.70
3	85.10
4	102.50
5	119.95
6	137.35
7	154.75
8	172.20
9	189.60
10	207
11	224.45
12	241.85
13	259.25
14	276.70
15	294.10
Per each additional person	17.45

C—131.5 IRS Monthly Income Thresholds

Revision 17-2; Effective April 1, 2017

Each year, the Internal Revenue Service (IRS) establishes income thresholds for earned and unearned income. Individuals whose income (earned, unearned, or a combination) exceeds the federal income tax filing threshold are "expected" by the IRS to file a federal income tax return under federal law. The IRS monthly income thresholds are used to determine if an individual's income must be counted when calculating Modified Adjusted Gross Income (MAGI) financial eligibility, as explained in A-1341, Income Limits and Eligibility Tests, for Medical Programs, Step 3.

Determining whether an individual is expected to be required to file a federal income tax return is determined by comparing the specified income types to the IRS thresholds in the following table.

Five Percentage Points of FPIL

Type of Income	2017 Threshold	Apply Threshold Value in Form H1042, Modified Adjusted Gross Income (MAGI) Worksheet: Medicaid and CHIP
Unearned Income	$87.50	• Pages 5-7, Step 3, Line 6 • Pages 5-7, Step 3, Line 8
Earned Income	525	• Pages 5-7, Step 3, Line 7

TWH, C-200, Opening, Denial, and Reinvestigation Codes (Retired as of July 1, 2013)

Revision 12-1; Effective January 1, 2012

C—210 TANF Codes

Revision 08-1; Effective January 1, 2008

C—211 Opening Codes

Revision 02-3; Effective April 1, 2002

TANF

Select a code for the occurrence during the six months prior to certification that is the primary reason the household needs Temporary Assistance for Needy Families (TANF). Use these codes only in Item 132 on Form H1000-A, Notice of Application.

024	**Period of Lump Sum Ineligibility Shortened** Use this code to open a case previously denied because of a lump sum if the household becomes eligible because its period of ineligibility is shortened.

Earnings Lost or Reduced in the Last Six Months Because ...

025

Father Incapacitated
Earnings of the father in the home have terminated or decreased because of his illness, injury, or impairment. The onset of the disability may have occurred prior to the last six months. The disabled father must be in the home unless he is receiving medical treatment out of the home.

026 **Mother Incapacitated**
Earnings of the mother in the home have terminated or decreased because of her illness, injury, or impairment.

027 **Other Caretaker Incapacitated**
Earnings of the children's caretaker in the home, other than the father or mother, have terminated or decreased because of the caretaker's illness, injury, or impairment. Use this code if the caretaker had been supporting the children before the loss of or decrease in earnings.

028 **Father Laid Off**
Earnings of the children's father in the home have terminated or decreased because he has been laid off or discharged from his job or discontinued his self-employment.

029 **Mother Laid Off**
Earnings of the children's mother in the home have terminated or decreased because she has been laid off or discharged from her job, or discontinued her self-employment.

030 **Other Caretaker Laid Off**
Earnings of the children'scaretaker in the home, other than the children's mother or father, have terminated or decreased because the caretaker has been laid off or discharged from a job, or discontinued self-employment. Use only if the caretaker had been supporting the children before the loss or decrease in earnings.

Support from the Caretaker Lost or Reduced in the Last Six Months Because the Caretaker ...

031 **Died**
Use to indicate death of the caretaker who supported the children during the six months prior to death.

032 **Left Home**
Use if the caretaker supported the children during the six months prior to leaving and has not provided sufficient support since leaving.

033 **Was Incarcerated**
Use if the caretaker supported the children during the six months prior to incarceration.

Support from Person in the Home Other Than Father, Mother, or Other Caretaker Was Lost or Reduced in the Last Six Months Because the Person ...

034 **Died**
Use to indicate death of the person who supported the children during the six months prior to death.

035 **Left**
Use if the person supported the children during the six months prior to leaving and has not provided sufficient support since leaving.

036 **Is Incapacitated**
Use if the person is unable to continue supporting the children because of the person's disability.

037 **Is Laid Off**
Use if the person is unable to continue supporting the children because of a change in employment status.

Support from Person Outside the Home Lost or Reduced in the Last Six Months Because ...

039 **Absent Father Discontinued or Reduced the Children's Support Payments**
Use if the children's father has been absent for the past six months; if father left home in the past six months, use code 032.

040 **Another Person Discontinued or Reduced the Children's Support Payments**
Use if someone outside the home other than the children'sfather stopped or reduced the children's support payments.

Other Income Lost or Reduced in the Last Six Months Because ...

041 **TANF Father, Mother, or Other TANF Caretaker Lost or had a Reduction in Income Not Listed in Codes 025-040**
Examples of income include RSDI; allowance, pension, or other payment connected with military service; unemployment benefits; workers' compensation; and rental income. Do not include the loss of any income based on need.

Depletion of the Family's Assets in the Last Six Months Because of ...

042 **Medical Care Cost**
Medical care cost includes all items for medical or remedial care, including care in nursing facilities.

043 **Other Living Costs**
These costs do not include medical care costs.

044 **Other Material Change**
Examples of circumstances include loss of investments through business failure or loss of home or other buildings by fire. Do not use if the assets produced income that provided full or partial support. Use code 041, loss of or reduction in other income.
Use if the household was previously certified under the real property exemption based on good faith effort to sell, and the family sold the property or it is no longer accessible.

No Change in Income or Resources During the Last Six Months. The Only Change in the Last Six Months Is ...

046 **Increased Need or Other Budget Items**
A change in household composition or living arrangements resulted in increased needs for the TANF family.

047 **No Proration of Benefits**
TP 01, use this code when certifying

- a stepchild and his parent after they have been removed from a TANF incapacity or a TANF-SP TP 61 case that is transferring to MAO, TP 07, 37, or Medical Programs for Families and Children. See B-483 for more information.
- an other-related child after he has been removed from an existing TANF/TANF-SP case. See B-482, Separating Household Members, for more information.

SAVERR enters asix-month periodic review in Item 141.

Use to administratively reopen a TP 01 or 61 case after denying a TP 01 or 61 case on hold in order to prevent the automated systems from counting a month(s) toward a individual's time limit.

When used,

- TANF grants will not be prorated, and
- SAVERR will enter a six-month periodic review in Item 141.

No Change in Income or Resources During the Last Six Months. The Only Change in the Last Six Months Is ...

049 **The Applicant Met the Eligibility Requirement for Residence**

050 **The Applicant Met the Eligibility Requirement for Citizenship**

052 **The Applicant Met Another Technical Eligibility Requirement**

053 **The Applicant Applied for Assistance**

056 **A Change That Cannot Be Related to Codes 045-053**
Example is the departure of an unemployed caretaker who has not provided support.

Administrative Opening Codes

054 **Post (Child Support) or Transitional Medicaid Reinstatement**
Use to reinstate a denied

- TP 20 household that returns to live in Texas, or
- TP 07 or TP 37 household that meets the requirements in A-800, Medicaid Eligibility.

055 **Denied in Error**
Use to reopen a case or application that was denied by mistake.

057 **Medicaid Administrative Opening Code**
Use to open a

- TP 07, 20, 29, or 37 case
- Medical Programs for Families and Children case

When the TP 01 or TP 61 case on hold was denied, instead of transferred, in order to prevent the automated systems from counting a month(s) toward anindividual's time limit.
"Person(s) meet Medicaid eligibility requirements."
"Persona(s) llena los requisitos de elegibilidad de Medicaid."
For TPs 07, 29, and 37, also include the following message:
"While receiving transitional Medicaid, you must report to HHSC within 10 days after you move and after anyone moves in or out of your household."
"Mientras reciba Medicaid de transición, tiene que avisar a la HHSC dentro de los 10 días de su cambio de case o del cambio del número de personas de su casa."

C—212 Denial Codes

Revision 12-1; Effective January 1, 2012

TANF

Reasons for denying cases and applications are classified into three groups:

1. ineligibility because of death of a member;
2. need; and
3. miscellaneous reasons.

Select the code reflecting the primary reason for denial. If a reason related to need and another reason occur at the same time, use the need code. Enter in Item 132 of Form H1000-A, Notice of Application, and Form H1000-B, Record of Case Action.

Death (058-059)

058 **Death of Caretaker**
No Notice.

059 **Death of Child – A-500, Age/Relationship**
"You no longer have children in your home who are eligible for assistance."
"Ya no hay niños en su casa que califican para asistencia."

Need (060-075)

060 **Earnings of Father, Legal or Stepfather — A-1323.5, Wages, Salaries, Commission and Tips**
Use for applications and ongoing cases that are not eligible for post-medical coverage.
"Earnings of father meet needs that can be recognized by this agency."
"El padre gana suficiente para cubrir las necesidades reconocidas por esta agencia."

061 **Earnings of Mother, Legal or Stepmother — A-1323.5, Wages, Salaries, Commission and Tips**
Use for applications and ongoing cases that are not eligible for post-medical coverage.
"Earnings of mother meet needs that can be recognized by this agency."
"La madre gana suficiente para cubrir las necesidades reconocidas por esta agencia."

062 **Earnings of TANF Child – A-1323.1, Children's Earned Income**
Use for applications and ongoing cases that are not eligible for post-medical coverage.
"Earnings of child meet needs that can be recognized by this agency."
"Su hijo/hija gana suficiente para cubrir las necesidades reconocidas por esta agencia."

063 **Earnings of Non-Parent Caretaker — A-1323.5, Wages, Salaries, Commission and Tips**
Use for applications and ongoing cases that are not eligible for post-medical coverage.
"Earnings of other person in your home meet needs that can be recognized by this agency."
"Una persona que vive en su casa gana suficiente para cubrir las necesidades reconocidas por esta agencia."

064 **Support from Absent Father — A-1326.1, Cash Gifts and Contributions; A-1326.2, Child Support; A-1334, Vendor Payments**
(See chart in C-241, TANF and Medical Programs Chart, for appropriate reference codes.)
"Income from children's father who is outside the home meets needs that can be recognized by this agency."
"El padre que no vive en la misma casa manda suficiente dinero para cubrir las necesidades reconocidas por esta agencia."

065 **Pursuit of Texas Works Activities — A-1527, The Texas Works Message**

"You have chosen to pursue employment opportunities and/or save your time-limited benefits for another time."
"Usted decidió buscar empleo y/o usar sus beneficios de tiempo limitado en ortra occasión."

066 **Support from Other Person Outside the Home, Including Mother — A-1326.2, Child Support; A-1334, Vendor Payments** (See chart in C-241, TANF and Medical Programs Chart, for appropriate reference codes.)
"Income available to you from a person outside the home meets needs that can be recognized by this agency."
"El dinero que recibe de un pariente fuera de su casa es suficiente para cubrir las necesidades reconocidas por esta agencia."

067 **RSDI — A-1324.15, Retirement, Survivors, and Disability Insurance(RSDI)**
"Income available to you from social security benefit meets needs that can be recognized by this agency."
"El cheque que usted recibe ahora, o va a recibir, del seguro social es suficiente para cubrir las necesidades reconocidas por esta agencia."

068 **Other Federal Benefits — A-1324.19, Veterans Benefits**
"Income available to you from federal benefit or pension meets needs that can be recognized by this agency." "El dinero que usted recibe ahora de beneficios o pensiones federales es suficiente para cubrir las necesidades reconocidas por esta agencia."

069 **State and Local Benefits — A-1326.9, Pensions; A-1324.18, Unemployment Compensation; A-1321.4, Workers Compensation**(See chart in C-241 for appropriate reference codes.)
Includes workers' compensation, unemployment compensation, state and local government retirement benefits. "Income available to you from state or local benefit or pension meets needs that can be recognized by this agency."
"El dinero que usted recibe de beneficios o pensiones de gobierno local o del estado es suficiente para cubrir las necesidades reconocidas por esta agencia."

070 **Non-Governmental Benefits — A-1326.9, Pensions**
"Income available to you from pension or benefit meets needs that can be recognized by this agency."
"El dinero que recibe usted de pensiones or beneficios es suficiente para cubrir las necesidades reconocidas por esta agencia."

071 **Income Not Codes 060 — 070 — A-13XX** (See chart in C-241, TANF and Medical Programs Chart, for appropriate reference codes.) **A-800, Medicaid Eligibility, for TP 07/37**
"Income available to you meets needs that can be recognized by this agency."
"El dinero que gana o recibe usted es suficiente para cubrir las necesidades reconocidas por esta agencia."

072 **Resources — A-12XX** (See chart in C-241, TANF and Medical Programs Chart, for appropriate reference codes.)
"Resources available to you from other property meets needs that can be recognized by this agency."
"Los recursos que tiene usted en propiedades or dinero son suficientes para cubrir las necesidades reconocidas por esta agencia."

074 **Fewer Members in Certified Group — A-1341, Income Limits and Eligibility Tests**
"No unmet need for the current family size."
"Ahora que usted tiene menos familia, sus entradas son suficientes para cubrir las necesidades reconocidas por esta agencia."

075 **Conflicting Information on Management — A-1700,Management**
"Information on management indicates additional income."
"Según la información que tenemos acerca de su situación económica, parece ser que usted no reportó toda su entrada."

076 **Refusal to Furnish Information — B-100, Processes and Processing Time Frames**
Use only if a Form H1010-B, Application for Assistance -Part B: Information We Need Know, is on file. Use code 091 for failure to return Form H1010-B.
"You did not wish to furnish enough information for this agency to establish eligibility for assistance."
"Usted no quiso darnos suficiente información para poder establecer su calificación para asistencia."

077 **Refusal to Follow Agreed Plan — A-1311, Requirement to Pursue Income**
Use to deny ongoing cases when an individual fails to pursue potential sources of income or resources that would be made available through the individual's efforts. "You did not wish to follow agreed plan so that eligibility for assistance could be continued."
"Usted ya no califica para asistencia porque no quiso utilizar, según el plan que hablamos, otros posibles recursos."

078 **Earnings/Child Support Payments Terminate — A-800, Medicaid Eligibility**
Use to deny Medicaid coverage before the end of the four- or twelve-month period for

- TP 07 or TP 37 transitional Medicaid when the caretaker relative has no earnings for one month on the 7th or 10th month Medicaid Report, or
- TP 20 Medicaid when child support payments terminate.

"Your Medicaid coverage following denial of your grant has ended as agreed."
"Como fue acordado al terminar su concesión, su calificación para los beneficios de Medicaid termina ahora."

083 **Federal Time Limits — A-1900, Federal Time Limits (FTLs)**
Use to deny an application or ongoing case because a household member has received 60 months of TANF assistance. "Your household is ineligible for TANF due to federal time limits, because the following person has received 60 months of TANF cash assistance. Your family may still be eligible for Medicaid. Contact your local office for information."
"Debido alos límites de tiempo federal su unidad familiar no tiene derecho a TANF porque la siguiente persona ha recibido asistencia económica de TANF 60 meses. Es posible que sue familia todavía tenga derecho a Medicaid. Comuníquese con la oficina local para recibir información."

086 **Child Admitted to Institution, Including Foster Care —A-900,Domicile**
"Your child has been admitted to an institution." "Su niñoha sido admitido a un hospital u otra institución."

087 **No Eligible Child – A-900, Domicile, or A-800, Medicaid Eligibility, for TP 07/37**
Use to deny applications or ongoing cases because the child does not meet relationship requirements or is no longer in the home.
"You no longer have children in your home who are eligible for assistance."
"Usted ya no tiene niños en su casa que califican para asistencia."

088 **Residence Requirement Not Met — A-700, Residence**
Use for applications and for ongoing cases when the household moves out of state. "Residence requirements are not met."
"Sus niños no califican para asistencia porque no cumplen con el requisito de residencia en el estado."

089 **Citizenship or Acceptable Alien Status — A-300, Citizenship**
"Your children do not meet acceptable alien status or citizen requirements for assistance."
"Sus niños no son elegibles para asistencia porque no cumplen con el requisito de ciudadanía ni de inmigrante elegible."

090 **Prior Eligibility — A-800, Medicaid Eligibility; A-1900, Federal Time Limits (FTLs); A-2400, One Time Payments**

- Use to authorize Medicaid or TANF warrants for
  - denied households eligible for restored benefits.
  - deceased individuals.
  - individuals eligible for three months prior Medicaid only.
  - applicants eligible for Medicaid for the application month but ineligible for TANF or Medicaid for the month following the application month.
  - applicants eligible for TANF and Medicaid for the current month but ineligible for future months.

  "Assistance was granted during a prior period, but you are not eligible now for medical or financial assistance."
  "Usted calificó anteriormente para asistencia pero ahora ya no califica para asistencia económica ni para beneficios médicos."
- Use to open and close TP 37 between cutoff in the 11th and 12th months.
  "Your original period of transitional Medicaid has been reinstated."
  "Su cobertura bajo Medicaid de transición ha sido aprobada de nuevo para el periodo originalmente especificado."
- Use to authorize OTTANF benefits. "Your family will receive $1,000 for mm/dd/yy. Your family will be ineligible to apply for TANF, TANF-SP, or OTTANF until mm/dd/yy."

091 **Failure to Furnish Information — B-100, Processes and Processing Time Frames**
Use this code if the applicant/individual fails to return the application form. "You failed to complete and return the necessary eligibility form."
"Usted no ha entregado la forma completa que necesitamos para determinar su elegibilidad para asistencia."

092 **Other Eligibility Requirements — A-132, Eligibility Factors**
Use to deny applications and ongoing cases for reasons other than need but not covered by codes 076-091. It cannot be entered by advisors to deny medical assistance only cases. "You do not meet eligibility requirements for assistance."
"Usted no califica para asistencia."
Note: SAVERR enters this code at the end of the Medicaid period for TP 07, TP 20 and TP 37.
"Your Medicaid coverage has ended."
"Su cobertura de Medicaid ha terminado."

093 **Adult Earnings (Refugee Only) — R-700, Age/Relationship**
Use to deny RCA applications and ongoing cases that are not eligible for post medical coverage. Use only if the case is an adult case with no children.
"You will not be eligible for Medicaid after mm/dd/yy."
"La elegibilidad para Medicaid termina el mm/dd/yy."

094 **Appointment Not Kept, Application/Review — B-100, Processes and Processing Time Frames**
"You failed to keep your appointment."
"Usted no vino a la cita que le dimos."

095 **Unable to Locate — A-700, Residence**
"You cannot be located."
"No podemos localizar al solicitante."

096 **Refugee Exceeds Eight-Month Limit — R-100, RCA/RMA**
Use to deny an RCA application or ongoing case because the household members entered the U.S. more than eight months ago.
"You will not be eligible for TANF after mm/dd/yy."
"La elegibilidad para Medicaid termina el mm/dd/yy."

097 **Filed In Error — No Notice**
Use to deny a Notice of Application (NOA) that was created erroneously.

098 **Voluntary Withdrawal — A-100, Application Processing**
Use only if an applicant requests that the application be withdrawn, or a current recipient requests that HHSC discontinue the case and the advisor cannot determine the reason. Otherwise use the applicable code.

"You have advised us that you no longer want to apply for TANF."
"Usted nos avisó que ya no desea solicitar TANF."
"You have advised us that you no longer want to receive TANF."
"Usted nos avisó que ya no desea recibir TANF."

Other Miscellaneous — A-1000, Deprivation

099
- Use to deny TP 01 coverage for members who must be added to a TANF-SP case.
  "Your needs are now included in the TANF-SP case."
  "Ahora el caso de TANF-SP cubre sus necesidades."
- Use to deny a case for other miscellaneous reasons.
  "You do not presently meet eligibility requirements."
  Usted presentemente no califica para asistencia."

Refusal to Assign Child Support Rights — A-1100, Child Support
134 Use to deny an application or ongoing case because the caretaker's needs are removed for refusal to make assignment and income meets the needs of the remaining members.
"You did not wish to assign support rights to the state."
"No quiso usted conceder al estado el derecho de cobrar sostenimiento."

Provide AP's Info or Location — A-1100, Child Support
135 Use to deny an application or an ongoing case because the caretaker's needs are removed for refusal to provide information on the absent parent or cooperate in locating the absent parent, and income meets the needs of the remaining members.
"You did not supply information on the absent parent or assist support officer in locating the absent parent."
"Usted no dio información sobre el padre o la madre ausente, o no ayudó al funcionario de manutención de niños a localizar a dicha persona."

Provide Verification of Citizenship — A-350, Verification Requirements
136 Use to deny an application or ongoing case because all members in the certified group failed to provide verification of citizenship.
"You did not provide proof of U.S. Citizenship."
"Usted no presentó prueba de ciudadanía estadounidense."

Refusal to Help to Establish Paternity — A-1100, Child Support
137 Use to deny acase because the caretaker's needs are removed for refusal to cooperate in establishing paternity and income meets needs of remaining members.
"You chose not to help in establishing paternity."
"No quiso usted ayudar a establecer la paternidad."

Increased Earnings from Employment Services — A-1323.5, Wages, Salaries, Commission and Tips
180 Use to deny cases not eligible for post medical coverage if the denial results from employment or increased earnings within six months after participation in employment services. Also use to deny RCA cases because of failure to comply with employment/training requirements.
"You are now ineligible due to increased earnings after employment services."
"Usted no califica porque su salario aumentó después de su en el programa de servicios de empleo."

Refusal to Comply With Employment Services, Caretaker —A-1800, Employment Services
181 Use to deny a case because the caretaker'sneeds are removed for failure to comply and income meets needs of remaining members.
"You are now ineligible due to caretaker's refusal to register for employment services."
"Usted no califica porque no quiso inscribirse en el programa de servicios de empleo."

Failed to Sign the Responsibility Agreement — A-2100, Personal Responsibility Agreement
196 "Failure to sign the Responsibility Agreement."
"Usted no firmó el Acuerdo de Responsabilidad Personal."

Time Limit or Hardship Ends/Household Member Disqualified – A-2500, State Time Limits
200 "You are ineligible for TANF because _____'s needs were removed following time limit policies."
"Usted no será elegible para TANF porque _____ dejó de ser elegible según las normas de los límites de tiempo."

OT Ineligibility Period – A-2400, One Time Payments
201 "You are currently not eligible to receive TANF, OTTANF, or TANF-SP because you have received OTTANF during the past 12 months."
"En este momento usted no es elegible para recibir TANF, OTTANF, ni TANF-SP porque usted ya recibió OTTANF que cubre los últimos 12 meses."

Income Over 185% FPIL or No Earnings During the Fourth Month Transitional Reporting Period
217 "Your transitional Medicaid will be shortened to six months because you had no income or your gross earnings meet the needs that can be recognized by this agency."
"Su Medicaid de transición se recortará a seis meses porque usted no tuvo ingresos o su salario bruto es suficiente para cubrir las necesidades que este departamento puede reconocer."

230 **Transitional Medicaid Expired at the End of the 12th Month — Computer Sent**

C—213 Reinvestigation Codes

Revision 02-8; Effective October 1, 2002

TANF

Select the code that best represents the reason for the case action. Enter it in Item 132, Form H1000-B, Record of Case Action, if taking action to raise, lower, sustain, or transfer a case to another type program.

Reasons for Raised Grants

101 "Your available income or resources are less."
"Usted tiene ahora menos ingresos o recursos."

102 "Needs this agency can include in your check are more."
"Ahora usted tiene más necesidades que esta agencia puede cubrir con su cheque."

103 "Your income and needs have changed."
"Sus ingresos y sus necesidades cambiaron."

Reasons for Lowered Grants

104 "Your available income or resources have increased."
"Usted tiene ahora másingresos o recursos."

105 "Needs this agency can include in your check are less."
"Ahora usted tiene menos necesidades que esta agencia puede cubrir con su cheque."

106 "Your income and needs have changed."
"Sus ingresos y sus necesidades cambiaron."

Reasons for Sustained Grants and Medical Assistance

107 "Needs included in your check remain the same."
"Las necesidades cubiertas por su cheque no han cambiado."

108 "Changes in income and needs do not affect check."
"Los cambios en sus ingresos y en sus necesidades no afectan su cheque."

109 "You are receiving the maximum assistance check."
"Usted recibe la máxima cantidad de assistencia que se da."

110 "You remain eligible for medical coverage."
"Usted sigue siendo elegible para beneficios médicos."

Reasons for Change in Assistance Status

111 Use when transferring from TP 01 or 61 to any income assistance medical program.
"You are now eligible for medical coverage only."
"Usted es elegible ahora sólo para beneficios médicos."
Use when transferring from TP 01 or 61 to TP 40 to provide continuous coverage for a pregnant woman.
"The pregnant woman on your TANF case is eligible for continuous medical coverage."
"La mujer de su caso de TANF que está embarazada es elegible para cobertura médica continua."

112 Use when transferring from any income assistance medical program to TP 01 or 61.
"You are eligible for financial and medical assistance."
"Usted es elegible para beneficios médicos y asistencia financiera."

Reasons for Lowered Grants Because of Employment Services Program (ESP) Participation

115 "Earnings after ESP training have increased."

"Las entradas aumentaron después de su entrenamiento para empleo."

116 "Adult's needs removed due to refusal to participate in employment services."
"Las necesidades del adulto que se negó a participar en los servicios de empleo no pueden ser consideradas."

Transfers To and From Income Assistance Grant Programs

118 "Your family is now eligible for TANF-SP benefits only."
"Ahora su familia es elegible solamente para beneficios de TANF-SP."

119 "Your family is now eligible for regular TANF benefits only."
"Ahora su familia es elegible solamente para beneficios regulares de TANF."

Payee Change

120 Use when changing the payee from one designated relative to another relative when there is no break in assistance to the TANF children included in the case.
"You will now receive the assistance payment."
"Ahora va a recibir el cheque de asistencia a nombre de usted."

Transfers To and From Medical Programs for Families and Children

121 Use when transferring from any medical assistance program to another medical assistance program. This includes TP 07, 20, 29, 37, 40, 42, 43, 44, 45, 47, 48, and 55.
"You have been transferred to another type of medical assistance."
"Le cambiaron de una categoria del programa médico aotra."
Use when transferring from any medical assistance program to TP 40 to allow continuous coverage for a pregnant woman. This includes TPs 07, 29, 37, 47 or an active TP 55 to TP 40.
"The pregnant woman on your Medicaid case is eligible for continuous medical coverage."
"La mujer de su caso de Medicaid que está embarazada es elegible para cobertura médica continua."

Reasons for Change in Transitional Medicaid Assistance Status

123 Use for TP 07 and TP 37 when

- shortening transitional Medicaid to end after six months, or
- restoring transitional Medicaid back to the original 12 months.

"Your transitional Medicaid has changed because of the fourth-month Medicaid report."
"Sus beneficios de transición de Medicaid han cambiado debido a su reporte para Medicaid del cuarto mes."

Reasons for Sustaining or Raising Benefits Because of Child Support

125 Removal of child's needs due to child support from absent parent, and income changes do not affect check.
Use when removing a child's needs from the budget because of child support but other household income changes result in no grant change.

126 Sustained benefits.
"Child support activities do not affect your TANF or Medicaid benefits."
"Las actividades relacionadas con sostenimiento para niños no afectan sus beneficios de TANF ni de Medicaid."

127 Child's needs removed due to child support and your income has changed.
Use when

- removing the needs of a child receiving child support from an absent parent, but
- raising the grant because other income has decreased.

128 Raised grant.
"Your needs have increased and child support no longer exceeds the grant."
"Sus necesidades han aumentado y el pago de sostenimiento para niños que recibe ya no sobrepasa la cantidad de la concesión."

Reasons for Lowering Benefits Because of Child Support

129 Child's needs removed due to child support received from absent parent.
Use when lowering a grant because the needs of a child who is receiving child support from an absent parent are removed from the budget.

130 "You did not wish to assign support rights to the state."
"No quiso usted conceder al estado el derecho de cobrar sostenimiento."

131 "You did not wish to supply information on absent parent."
"No quiso usted dar informes acerca del padre/de la madre ausente."

132 "You chose not to cooperate with the child support officer."
"No quiso usted colaborar con el encargado de los cobros de sostenimiento para niños."

133 "You chose not to assist in establishing paternity."
"No quiso usted ayudar aaclarar la paternidad."

139 "Your grant has been reduced because a household member became eligible for SSI or SSA disability."

Reason/Message for Lowered Grant Because of Time Limits

138 Time Limit or Hardship Ends/Household Member Disqualified
"Your grant was lowered because _____'s needs were removed following time-limit policies."
"Se redujo su pago mensual porque _____ dejó de ser elegible según las normas de los límites de tiempo."

Reason/Message for Raised Grant Because of Time Limits

150 Time Limit or Hardship Ends/Household Member Disqualified
"Your grant was raised. However, _____'s needs were removed following time-limit policies."
"Se sebió su pago mensual. Sin embargo, _____ dejó de ser elegible según las normas de los límites de tiempo."

Reason/Message for Sustained Grant and Medical Assistance Because of Time Limits

160 Time Limit or Hardship Ends/Household Member Disqualified
Use when sustaining TP 01 or 61.
"Your grant remains the same. However, _____'s needs were removed following time-limit policies."
"Su pago mensual seguirá igual. Sin embargo, _____ dejó de ser elegible según las normas de los límites de tiempo."

Reason/Message for Change in Assistance Status Because of Time Limits

170 Time Limit or Hardship Ends/Household Member Disqualified
Use when transferring from TP 01 or 61 to any income assistance medical program.
"You are eligible for medical assistance only. You are ineligible for a TANF grant because_____'s needs were removed following time-limit policies."
"Usted es elegible para recibir solamente ayuda médica. Dejó de ser elegible para pagos mensuales de TANF porque _____ dejó de ser elegible según las normas de los límites de tiempo."
When transferring to TP 29, also include the following message:
"While receiving transitional Medicaid, you must report to HHSC within 10 days after you move and after anyone moves in or out of your household."
"Mientras reciba Medicaid de transición, tiene que avisar a HHSC dentro de los 10 días de su cambio de casa o del cambio del número de personas de su casa."

C—220 Supplemental Nutrition Assistance Program (SNAP) Codes

Revision 09-3; Effective July 1, 2009

C—221 Denial Codes

Revision 12-1; Effective January 1, 2012

SNAP

601 **Excess Income, see C-242 for appropriate reference codes**
"The amount of money you get each month is over the allowed amount."
"La cantidad de dinero que recibe cada mes sobrepasa la cantidad límite."

602 **Excess Resources, see C-242 for appropriate reference codes**
"The value of the things you own (resources) goes over the allowed amount."
"El valor de las cosas de las que es dueño (recursos) sobrepasan la cantidad límite."

603 **Transferred Resources — A-1212**
"You knowingly transferred resources to qualify for SNAP food benefits."
"Transfirio sus recursos con la intención de recibir beneficios de comida del Programa SNAP."

604 **Death**
No notice will be sent.

605 **Program Violation**
No notice will be sent.

606 **Ineligible Students — A-200**
"All members of your household are ineligible students."
"Todos los miembros de su casa son estudiantes inelegibles."

607 **Refusal to Cooperate — C-920**
"You refused to cooperate."
"Usted se negó a cooperar."

608 **Voluntary Withdrawal — A-100**
"You have advised us that you no longer wish to receive SNAP food benefits."
"Nos dijo que ya no quiere recibir beneficios de comida del Programa SNAP."

609 **Failure to Provide Information — B-100 and C-900**
"You did not provide enough information for this office to determine eligibility for SNAP food benefits."
"No nos dio información suficiente para determinar si puede recibir beneficios de comida del Programa SNAP."

610 **Work Registration — A-1800**
See Form H1017, Notice of Benefit Denial or Reduction, instructions for specific individual messages.

611 **Voluntary Quit — A-1800**
"The household's primary wage earner voluntarily left his most recent job without good cause."
"La persona que mantenia la casa dejó su empleo voluntariamente sin tener una razón aceptable."

612 **Unable to Locate — A-700**
"You cannot be located at the address you gave us."
"En la dirección que usted nos dió, no se le puede localizar."

613 **Moved from State —**
No notice will be sent.

614 **Other, enter the appropriate reference**
Indicate the specific reason.

615 **Missed Appointment — B-100**
"You failed to keep your appointment after submitting an application for SNAP food benefits."
"No se presento´ a la cita que le demos despues de presentar la solicitud de beneficios de comida del Programa SNAP."

616 **No Citizens or Eligible Aliens — A-300**
"No member of the household is a U.S. citizen or an alien eligible for SNAP food benefits."
"Ninguno de los miembros de su familia es ciudadano de los Estados Unidos o, elegible para recibir beneficios de comida del Programa SNAP."

617 **Application Filed in Error — No Notice**
Use to deny a Notice of Application (NOA) that was created erroneously.

621 **Work Registrant Earnings — A-1323.5**
"The amount of money you got from jobs (wages) goes over the allowed amount."
"La cantidad de dinero que recibio de trabajos (salario) sobrepasa el limite establecido."

622 **Postponed Verification Not Provided – Expedited – A-145**
"Your benefits were denied because you failed to provide the proof we requested when you were certified for expedited (emergency)

services."
"Esta negación de beneficios se debe a que usted nunca entregó las pruebas que se le pidieron cuando le declararon elegible para los beneficios de emergencia."

625 **State Office Use Only (SAVERR default code – open/close)**
No notice.

626 **State Office Use Only (CCDMI/permanent move)**
No notice.

627 **18-50 Denial — A-1900**
"You have been disqualified for failing to meet the requirement for working 20 hours per week. To avoid the denial of benefits, you must begin working an average of 20 hours per week."
"Usted ha sido descalificado por no satisfacer el requisito de trabajar 20 horas por semana. Para evitar la negación de beneficios, usted tiene que comenzar a trabajar un promedio de 20 horas por semana."

630 **State Office Use Only (Certification period expired)**
No notice.

C—230 Medical Programs Codes

Revision 02-6; Effective July 1, 2002

C—231 Opening Codes

Revision 02-6; Effective July 1, 2002

Medical Programs

048 **TP 40**
Use when providing continuous coverage for pregnant woman on TP 40 using Form H1000-A.
"The pregnant woman in your household is eligible for continuous medical coverage."
"La mujer de su caso de Medicaid que está embarazada es elegible par cobertura médica continua."

TP 43, TP 44, TP 47 and TP 48
Use when providing continuous coverage for a child on TP 43, 44, 47, or 48.
"The following people in your household are eligible for continuous medical coverage."
"Las siguientes personas de su casa son elegibles para cobertura medica continua."

052 **TPs 40, 43, 44, 45, 48, and 55 without spenddown**
"Meets eligibility requirements."
"Llena los requisitos de elegibilidad."

055 **TPs 40, 43, 44, 45, 48, and 55 without spenddown**
Use to reopen a case or application that was denied by mistake.
"Denied in error."
"Se negó por equivocación."

057 **TPs 40, 43, 44, 45, 48, and 55 without spenddown**
Use when opening a case instead of transferring from TP 01 or 61 in order to prevent the automated systems from counting a month(s) toward a individual's time limit.
"Person(s) meet Medicaid eligibility requirements."
"Persona(s) llena los requisitos de elegibilidad de Medicaid."

C—232 Denial Codes

Medical Programs

Death of Child (TPs 43, 45, 44, and 48) — A-500
059 "You no longer have children in your home who are eligible for assistance."
"Ya no hay niños en su casa que califican para asistencia."

Earnings (TPs 43, 44, 47, 48, and 55)

Earnings of Father — A-1323.5
060 "Earnings of father meet needs that can be recognized by this agency."
"El padre gana suficiente para cubrir las necesidades reconocidas por esta agencia."

Earnings of Mother — A-1323.5
061 "Earnings of mother meet needs that can be recognized by this agency."
"La madre gana suficiente para cubrir las necesidades reconocidas por esta agencia."

Earnings of Child – A-1323.1
062 "Earnings of child meet needs that can be recognized by this agency."
"Su hijo/hija gana suficiente para cubrir las necesidades reconocidas por esta agencia."

Earnings of Non-Parent Caretaker — A-1323.5
063 "Earnings of other person in your home meet needs that can be recognized by this agency."
"Una persona que vive en su casa gana suficiente para cubrir las necesidades reconocidas por esta agencia."

Financial Support (TPs 43, 44, 47, 48, and 55)

Support from Absent Father — A-1300
064 "Income from children's father who is outside the home meets needs that can be recognized by this agency."
"El padre que no vive en la misma casa manda suficiente dinero para cubrir las necesidades reconocidas por esta agencia."

Support from Relative in Household
065 "Income from relative in your household meets needs that can be recognized by this agency."
"El dinero que recibe de un pariente que vive en su casa es suficiente dinero para cubrir las necesidades reconocidas por esta agencia."

Support from Person Outside the Home
066 "Income available to you from a person outside the home meets needs that can be recognized by this agency."
"El dinero que recibe de un pariente fuera de su casa es suficiente para cubrir las necesidades reconocidas por esta agencia."

RSDI (TPs 40, 43, 44, 47, and 48) — A-1324.15
067 "Income available to you from social security benefit meets needs that can be recognized by this agency."
"El cheque que usted recibe ahora, o va a recibir, del seguro social es suficiente para cubrir las necesidades reconocidas por esta agencia."

Other Federal Benefits (TPs 43, 44, 47, 48, and 55) —A-1324.19
068 "Income available to you from Federal benefit or pension meets needs that can be recognized by this agency."
"El dinero que usted recibe ahora de beneficios o pensiones Federales es suficiente para cubrir las necesidades reconocidas por esta agencia."

State and Local Pensions or Benefits (TPs 43, 44, 47, 48, and 55) —A-1300
069 "Income available to you from state or local benefit or pension meets needs that can be recognized by this agency."
"El dinero que usted recibe de beneficios o pensiones del gobierno local o del estado es suficiente para cubrir las necesidades reconocidas por esta agencia."

Non-Governmental Pensions or Benefits (TPs 43, 44, 47, 48, and 55) —A-1326.9
070 "Income available to you from pension or benefit meets needs that can be recognized by this agency."
"El dinero que recibe usted de pensiones o benficios es suficiente para cubrir las necesidades reconocidas por esta agencia."

Excess Assets Income (TPs 40, 43, 44, 47, and 48) — A-13XX (See chart in C-241 for appropriate reference codes.)
"Income available to you meets needs that can be recognized by this agency."
"El dinero recibe ustedes suficiente para cubrir las necesidades reconocidas por esta agencia."

071 **(TPs 55 and 30) — A-13XX** (See chart in C-241 for appropriate reference codes.)
"Income available to you exceeds the medically needy needs allowance and you have no medical expenses to spend down your income."
"Usted dispone de ingresos que sobrepasan el limite para ser elegible para beneficios por necesidad médica yusted no tiene gastos médicos que se pudieran desontar de sus ingresos."

072 **Excess Assets — Resources (TPs 43, 44, 47, 48, and 55) — A-12XX** (See chart in C-241 for appropriate reference codes.)

"Resources available to you from other property meets needs that can be recognized by this agency."
"Los recursos que tiene usted en propiedades o dinero son suficientes para cubrir las necesidades reconocidas por esta agencia."

Fewer Members in Certified Group (TPs 40, 43, 44, 47, 48, and 55) —A-1341
074 "No unmet need for the current family size."
"Ahora, que usted tiene meno familia, sus entradas son suficientes para cubrir las necesidades reconocidas por esta agencia."

Conflicting Information on Management (TPs 40, 43, 44, 47, 48, 55, and 30)— A-1700
075 "Information on management indicates additional income."
"Según la información que tenemos, acerca de su situacióneconómica, parece ser ue usted no reportó toda su entrada."

Refusal to Furnish Information (TPs 40, 45, 43, 44, 47, 48, 55, and 30)— B-100
076 "You did not wish to furnish enough information for this agency to establish eligibility for assistance."
"Usted no quiso darnos suficiente información para poder establecer su calificación para asistencia."

Refusal to Follow Agreed Plan (TPs 40, 43, 44, 47, and 48) —A-1311
077 "You did not wish to follow agreed plan so that eligibility for assistance could be continued."
"Usted ya no califica para asistencia porque no quiso utilizar, según el plan que hablamos, otros posibles recursos."

078 **Automatic Denial (TP 40)**
Automatic denial because of anticipated pregnancy termination.

Refusal to Obtain Medical Information for Pregnancy or Disability Determinations (TPs 40, 55, and 30) — A-800
079 "You did not wish to obtain required medical verification."
"Usted no quiso obtener la verificación médica requerida."

Parent Not Incapacitated (TPs 55 and 30) — A-1000
080 "You do not meet the agency's definition of incapacity."
"Según la definición de 'incapacidad' de esta agencia, usted no califica."

Legal Marriage (TPs 40 and 55)
"Your children are not deprived of parental support. The primary wage earner does not meet the employment or work history
082 requirements."
"A sus niños no les falta el sostenimineto paterno. El sostén principal de la casa no cumple con los requisitos con respecto a desempleo."

Child Admitted to Institution (TPs 40, 45, 43, 44, 47, 48, 55, and 30)— A-900
086 "Your child has been admitted to an institution."
"Su niño ha sido admitido a un hospital u otra institución."

No Eligible Child (TPs 40, 45, 43, 44, 47, 48, and 55) —A-900
087 "You no longer have children in your home who are eligible for assistance."
"Usted ya no tiene niños en su casa que califican para asistencia."

Residence (TPs 40, 45, 43, 44, 47, 48, 55, and 30) —A-700
088 "Residence requirements are not met."
"Sus niños no califican para asistencia porque no complen con el requisito de residencia en el estado."

Citizenship or Acceptable Alien Status (TPs 40, 45, 43, 44, 47, 48, 55, and 30) — A-300
089 "Citizenship or acceptable alien status requirements are not met."
"No cumplen con los requisitos de ciudadanía ni de inmigrante elegible."

Open/Close Coverage (TPs 40, 45, 43, 44, 47, 48, 55, and 30)
090 "Assistance was granted during a prior period, but you are not eligible now for medical assistance."
"Usted calificó anteriormente para asistencia pero ahora ya no califica para beneficios médicos."

Failure to Furnish Information (TPs 40, 45, 43, 44, 47, 48, 55, and 30)— B-100
091 "You failed to complete and return the necessary eligibility form."
"Usted no ha entregado la form completa que necesitamos para determinar su elegibilidad."

Other Eligibility Requirements (TPs 40, 45, 43, 44, 47, 48, 55, and 30)— A-100
Use for denying TP 45 because

092
- the certified child becomes one year old, or
- the child's mother is no longer eligible for Medicaid.

"You do not meet eligibility requirements for assistance."
"Usted no califica para asistencia."

Appointment Not Kept (TPs 40, 45, 43, 44, 47, 48, 55, and 30) —B-100
094 "You failed to keep your appointment."
"Usted no vino a la cita que le dimos."

095 **Unable to Locate (TPs 40, 45, 43, 44, 47, 48, 55, and 30) —A-700**

"You cannot be located."
"No lo podemos localizar a usted."

096 **Refugee Exceeds Eight-Month Limit (TP 55) — R-430**

097 **Filed In Error (TPs 40, 45, 43, 44, 47, 48, 55, and 30) — No Notice**
Use to deny a Notice of Application (NOA) that was created erroneously.

098 **Voluntary Withdrawal (TPs 40, 45, 43, 44, 47, 48, 55, and 30) —A-100**
"You have requested that your application for assistance be withdrawn."
"Usted nos pidió que fuera retirada su solicitud osu concesión para asistencia."

099 **Other Miscellaneous (TPs 40, 45, 43, 44, 47, 48, 55, and 30) —A-100**
"You do not presently meet eligibility requirements."
"Usted presentemente no califica para asistencia."

134 **TP 55 without spenddown**
"You did not wish to assign support rights to the state."
"No quiso usted conceder al estado el derecho de cobrar sostenimineto."

135 **Provide AP's Info or Location — (A-1100)**
Use to deny an application or an ongoing case because the caretaker's needs are removed for refusal to provide information on the absent parent or cooperate in locating the absent parent, and income meets the needs of the remaining members.
"You did not supply information on the absent parent or assist support officer in locating the absent parent."
"Usted no dio información sobre el padre o la madre ausente, o no ayudó al funcionario de manutención de niños a localizar a dicha persona."

136 **Provide Verification of Citizenship — (A-350)**
Use to deny an application or ongoing case because all members in the certified group failed to provide verification of citizenship.
"You did not provide proof of U.S. Citizenship."
"Usted no presentó prueba de ciudadanía estadounidense."

137 **TP 55 without spenddown**
"You chose not assist in establishing paternity."
"No quiso usted ayudar a establecer la paternidad."

195 **Monthly Income Exceeds Maximum Limits (TPs 40, 43, 44, 47, and 48)**
"You are ineligible because your monthly income exceeds the needs recognized by this agency."
"Usted no es elegible porque sus ingresos mensuales sobrepasan las necesidades reconocidas por esta agencia."

C—233 Reinvestigation Codes

Revision 01-7; Effective October 1, 2001

Medical Programs

110 **(TPs 40, 45, 43, 44, 47, 48, and 55 without spenddown)**
"You remain eligible for medical coverage."
"Sigue siendo elegible para asistencia médica."

120 **(TPs 45, 43, 44, 47, 48, and 55 without spenddown)**
"You will now receive the medical coverage on behalf of the children."
"Ahora usted va a recibir los beneficios médicos para sus hijos."

Use the following codes to clear Form H1708, Report of Noncooperation:

126 **(TPs 45, 43, 44, 47, 48, and 55 without spenddown)**
"Child support activities do not affect your TANF or Medicaid benefits."
"Las actividades con respecto a sostenimiento para niños no afectan sus beneficios de TANF y los de Medicaid."

132 **(TPs 45, 43, 44, 47, 48, and 55 without spenddown)**
"You chose not to cooperate with the child support officer."
"No quiso usted colaborar con el encargado de los cobros de sostenimiento para niños."

C—240 Expanded Denial Code Reference Charts

Revision 02-3; Effective April 1, 2002

C—241 TANF and Medical Programs Chart

Revision 02-3; Effective April 1, 2002

TANF and Medical Programs

Action Code	GWS Screen	New Reference	
060 Earnings of Father	Earned Income	A-1323.5	Wages, Salaries
061 Earnings of Mother	Earned Income	A-1323.5	Wages, Salaries
062 Earnings of TANF Child	Earned Income	A-1323.1	Earnings of Child
063 Earnings of Non-parent Caretaker	Earned Income	A-1323.5	Wages, Salaries
064 Support from Absent Father	Contributions, Child Support, or Vendor Payments	A-1326.1 A-1326.2 A-1334	Gifts or Contributions Child Support Vendor Payments– Legally Obligated
066 Support from Other Person Outside the Home, Including Mother	Contributions or Vendor Payments	A-1326.1 A-1334	Gifts or Contributions Vendor Payments– Legally Obligated
067 RSDI	RSDI	A-1324.15	RSDI
068 Other Federal Benefits	VA	A-1324.19	VA Benefits
069 State and Local Pensions or Benefits	Retirements Workers' Compensation Unemployment	A-1326.9 A-1321.4 A-1324.18	Pensions Workers' Compensation Unemployment Benefits
070 Non-Governmental Benefits	Retirements	A-1326.9	Pensions

Action Code	GWS Screen	New Reference	
071 Income Not Codes 060 - 070 Excess Assets – Income	All Types of Countable Income	A-1324.17 A-1326.1 A-1326.2 A-1326.6 A-1322.2 A-1331 A-1326.9 A-1324.15 A-1326.9 A-1323.4 A-1324.18 A-1334 A-1324.19 A-1323.5 A-1321.4 A-1310	Non-Generic TANF Gifts or Contributions Child Support Interest – Bank Account Unearned – WIOA Lump Sum Income Pensions RSDI RR Retirement Self Employment Income Unemployment Benefits Vendor Payments – Legally Obligated VA Benefits Wages, Salaries Workers' Compensation Other types of income which do not have a designated GWS screen.
072 Resources Excess Assets – Resources	All Countable Resources	A-1210 A-1210 A-1232.2 A-1242 A-1231.4 A-1238 A-1200	Cash-on-Hand, Stocks, Bonds, Bank Accounts Land, Oil, and Mineral Rights, PASS Accounts Prepaid Burial Lump Sum Payments Retirement – Pensions Vehicles Includes all other types of resources which do not have adesignated GWS Screen.

C—242 SNAP Chart

Revision 01-7; Effective October 1, 2001

SNAP

Action Code	GWS Screen	New Reference

Action Code		GWS Screen	New Reference	
601	Excess Income	Income – Earned or Unearned	A-1324.17 A-1326.1 A-1326.2 A-1322.1 A-1326.6 A-1322.2 A-1331 A-1326.9 A-1324.15 A-1324.16 A-1323.4 A-1324.18 A-1334 A-1324.19 A-1323.5 A-1321.4 A-1310	TANF Grant Gifts or Contributions Child Support Educational Assistance – Non Title IV Bank Accounts– Interest Unearned – WIOA Lump Sum Income Pensions RSDI SSI Self Employment Unemployment Benefits Vendor Payments– Legally Obligated VA Benefits Wages and Salaries Workers' Compensation Other income which does not have a designated GWS screen.
602	Excess Resources	Resources – Countable	A-1210 A-1210 A-1242 A-1236.4 A-1231.4 A-1238 A-1200	Cash-on-Hand, Stocks, Bonds, Bank Accounts Land, Oil, and Mineral Rights Lump Sum Payments Real Property Retirement Accounts Vehicles Other resources not listed in this section because they do not have a designated GWS screen.

TWH, C-300, County Charts

Revision 18-1; Effective January 1, 2018

C—310 Full and Minimum Service Choices Counties by Region

Revision 12-3; Effective July 1, 2012

TANF

The following is a list of full and minimum service Choices counties.

Region	Full Service Counties	Minimum Service Counties
Region 1	Armstrong, Bailey, Briscoe, Carson, Castro, Childress, Cochran, Collingsworth, Crosby, Dallam, Deaf Smith, Dickens, Donley, Floyd, Garza, Gray, Hale, Hall, Hansford, Hartley, Hemphill, Hockley, Hutchinson, Lamb, Lipscomb, Lubbock, Lynn, Moore, Motley, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Sherman, Swisher, Terry, Wheeler, Yoakum	King
Region 2	Archer, Baylor, Brown, Callahan, Clay, Coleman, Comanche, Cottle, Eastland, Fisher, Foard, Hardeman, Haskell, Jack, Jones, Knox, Mitchell, Montague, Nolan, Runnels, Scurry, Shackelford, Stephens, Stonewall, Taylor, Throckmorton, Wichita, Wilbarger, Young	Kent
Region 3	Collin, Cooke, Dallas, Denton, Ellis, Erath, Fannin, Grayson, Hood, Hunt, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somervell, Tarrant, Wise	Not applicable
Region 4	Anderson, Bowie, Camp, Cass, Cherokee, Delta, Franklin, Gregg, Harrison, Henderson, Hopkins, Lamar, Marion, Morris, Panola, Rains, Red River, Rusk, Smith, Titus, Upshur, Van Zandt , Wood	Not applicable
Region 5	Angelina, Hardin, Houston, Jasper, Jefferson, Nacogdoches, Newton, Orange, Polk, Sabine, San Augustine, San Jacinto, Shelby, Trinity, Tyler	Not applicable
Region 6	Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Harris, Liberty, Matagorda, Montgomery, Walker, Waller, Wharton	Not applicable
Region 7	Bastrop, Bell, Blanco, Bosque, Brazos, Burleson, Burnet, Caldwell, Coryell, Falls, Fayette, Freestone, Grimes, Hamilton, Hays, Hill, Lampasas, Lee, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Travis, Washington, Williamson	Not applicable
Region 8	Atascosa, Bandera, Bexar, Calhoun, Comal, DeWitt, Dimmit, Edwards, Frio, Gillespie, Goliad, Gonzales, Guadalupe, Jackson, Karnes, Kendall, Kerr, Kinney, LaSalle, Lavaca, Maverick, Medina, Real, Uvalde, Val Verde, Victoria, Wilson, Zavala	Not applicable
Region 9	Andrews, Coke, Concho, Crane, Crockett, Dawson, Ector, Gaines, Glasscock, Howard, Irion, Kimble, Martin, Mason, McCulloch, Menard, Midland, Pecos, Reagan, Reeves, Schleicher, Sterling, Sutton, Terrell, Tom Green, Upton, Ward, Winkler	Borden, Loving
Region 10	Brewster, Culberson, El Paso, Hudspeth, Jeff Davis, Presidio	Not applicable
Region 11	Aransas, Bee, Brooks, Cameron, Duval, Hidalgo, Jim Hogg, Jim Wells, Kenedy, Kleberg, Live Oak, McMullen, Nueces, Refugio, San Patricio, Starr, Webb, Willacy, Zapata	Not applicable

C—320 TANF State Time Limit County Hardship Lists

Revision 12-3; Effective July 1, 2012

C—321 Current TANF State Time Limit County Hardship List

Revision 18-1; Effective January 1, 2018

TANF

Benefits Issued for January 2018 Through March 2018

Region	County	County Code
4	Morris	172
5	Sabine	202
8	Maverick	159

	Zavala	254
10	Presidio	189
	Starr	214
	Willacy	245
11	Brooks	024
	Duval	066
	Jim Wells	125
	Zapata	253

C—322 Previous TANF State Time Limit County Hardship Lists

Revision 18-1; Effective January 1, 2018

TANF

Benefits Issued for October 2017 Through December 2017

Region	County	County Code
4	Morris	172
5	Sabine	202
8	Maverick	159
	Zavala	254
10	Presidio	189
	Starr	214
	Willacy	245
11	Brooks	024
	Duval	066
	Jim Wells	125
	Zapata	253

Benefits Issued for July 2017 Through September 2017

Region	County	County Code
4	Morris	172
5	Sabine	202
8	Maverick	159
	Zavala	254
10	Presidio	189
11	Starr	214
	Willacy	245
	Brooks	024
	Duval	066

Region	County	County Code
	Jim Wells	125
	Zapata	253

Benefits Issued for April 2017 Through June 2017

Region	County	County Code
4	Morris	172
5	Sabine	202
8	Maverick	159
	Zavala	254
10	Presidio	189
	Starr	214
	Willacy	245
11	Brooks	024
	Duval	066
	Jim Hogg	124
	Jim Wells	125
	Zapata	253

C—330 SNAP ABAWD Work Requirement Waiver Counties

Revision 16-2; Effective April 1, 2016

C—331 Current SNAP ABAWD Work Requirement Waiver Counties

Revision 17-4; Effective October 1, 2017

SNAP

Effective October 2017

Region	County	County Code
None	None	None

C—332 Previous SNAP ABAWD Work Requirement Waiver Counties

Revision 17-4; Effective October 1, 2017

SNAP

Effective October 2016

Region	County	County Code
None	None	None

C—340 SNAP Employment and Training Counties

Revision 17-4; Effective October 1, 2017

Region	SNAP Employment and Training Counties
Region 1: High Plains	Bailey, Deaf Smith, Garza, Hale, Hockley, Hutchinson, Lamb, Lubbock, Potter, Randall, Terry
Region 2: Northwest Texas	Archer, Baylor, Brown, Clay, Coleman, Comanche, Cottle, Eastland, Foard, Hardeman, Jack, Mitchell, Montague, Nolan, Scurry, Taylor, Wichita, Wilbarger, Young
Region 3: Metroplex	Collin, Cooke, Dallas, Denton, Ellis, Erath, Fannin, Grayson, Hood, Hunt, Johnson, Jones, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somervell, Tarrant, Wise
Region 4: Upper East Texas	Anderson, Bowie, Camp, Cherokee, Delta, Franklin, Gregg, Harrison, Henderson, Hopkins, Lamar, Marion, Morris, Panola, Rains, Red River, Rusk, Smith, Titus, Upshur, Van Zandt, Wood
Region 5: Southeast Texas	Angelina, Houston, Jasper, Jefferson, Nacogdoches, Orange, Polk, Shelby
Region 6: Gulf Coast	Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Harris, Liberty, Matagorda, Montgomery, Walker, Waller, Wharton
Region 7: Central Texas	Bastrop, Bell, Blanco, Brazos, Burleson, Burnet, Caldwell, Coryell, Falls, Fayette, Freestone, Grimes, Hays, Hill, Lampasas, Lee, Leon, Llano, Madison, McLennan, Milam, Robertson, Travis, Washington, Williamson
Region 8: Upper South Texas	Atascosa, Bandera, Bexar, Calhoun, Comal, DeWitt, Dimmit, Edwards, Frio, Gillespie, Goliad, Gonzales, Guadalupe, Jackson, Karnes, Kendall, Kerr, Kinney, LaSalle, Lavaca, Limestone, Maverick, Medina, Real, Uvalde, Val Verde, Victoria, Wilson, Zavala
Region 9: West Texas	Coke, Concho, Crockett, Dawson, Ector, Howard, Irion, Kimble, Mason, McCulloch, Menard, Midland, Pecos, Reagan, Reeves, Schleicher, Sterling, Sutton, Tom Green, Ward
Region 10: Upper Rio Grande	Brewster, El Paso, Presidio
Region 11: Lower South Texas	Aransas, Bee, Brooks, Cameron, Hidalgo, Jim Hogg, Jim Wells, Kleberg, Nueces, Refugio, San Patricio, Starr, Webb, Willacy, Zapata

C—341 SNAP Non-Employment and Training Counties

Revision 17-4; Effective October 1, 2017

Region	SNAP Non-Employment and Training Counties
Region 1: High Plains	Armstrong, Briscoe, Carson, Castro, Childress, Cochran, Collingsworth, Crosby, Dallam, Dickens, Donley, Floyd, Gray, Hall, Hansford, Hartley, Hemphill, King, Lipscomb, Lynn, Moore, Motley, Ochiltree, Oldham, Parmer, Roberts, Sherman, Swisher, Wheeler, Yoakum
Region 2: Northwest Texas	Callahan, Fisher, Haskell, Kent, Knox, Runnels, Shackelford, Stephens, Stonewall, Throckmorton
Region 4: Upper East	Cass

Texas	
Region 5: Southeast Texas	Hardin, Newton, Sabine, San Augustine, San Jacinto, Trinity, Tyler
Region 7: Central Texas	Bosque, Hamilton, Mills, San Saba
Region 9: West Texas	Andrews, Borden, Crane, Gaines, Glasscock, Loving, Martin, Upton, Winkler
Region 10: Upper Rio Grande	Culberson, Hudspeth, Jeff Davis
Region 11: Lower South Texas	Duval, Kenedy, Live Oak, McMullen

C—350 County Lists

Revision 12-2; Effective April 1, 2012

All Programs

- Alphabetical County Names, Codes and Regions

TWH, C-400, Reserved for Future Use

TWH, C-500, Form H1000-A, Form H1000-B and Form H1000-C Instructions (Retired as of July 1, 2013)

Revision 10-4; Effective October 1, 2010

C—510 General Information

Revision 05-4; Effective August 1, 2005

General Information

All Programs

Form H1000-A, Notice of Application, Form H1000-B, Record of Case Action, and Form H1000-C, Secondary Client Input, are manual forms used in all programs to report applications, the subsequent denial or certification of eligibility, and changes and deletions to information for certified and denied cases. Use a separate Form H1000-A, Form H1000-B or Form H1000-C to report actions taken in each individual program.

Form H1000-A is a four-part form. Each part has the same control number.

- Part 1, Notice of Application (NOA) is a short form that
  - indicates that an application was filed and the date filed, and
  - gives information for an NOA report to field staff about individual information already in the computer file.
- Part 2, Input Document, is a page advisors use for handwritten entries during the decision process. Use the input document to
  - report the final disposition of an application,

    - correct Items 01 through 38 already sent on the NOA,
    - authorize the issuance of benefits, or
    - establish a central file on all individual data.
- Part 3, Case Record Copy, is a carbon copy of Part 2. It contains information on the NOA and the disposition of an application for audits.
- Part 4, Case Index Card, is a carbon copy of the NOA used to
    - make a central file of pending applications in the local office, and
    - report changes on pending applications.

Form H1000-B is a three-part form. The assigned case number and sequence number appears on all copies of the form. To request Form H1000-B, use Form H1004, Request for Form H1000-B.

- Part 1, Record of Case Action, is a computer-generated form that shows current case information.
- Use the Part 2, Input Document, to
    - update information;
    - report the disposition of a redetermination; or
    - authorize, adjust, or cancel benefits.
- Part 3, Case Record Copy, is identical to Part 2, Input Document. All items entered on the input document appear on the Case Record Copy.

Form H1000-C is a one-part form. Use this form to enter

- start and end dates for PRA penalties and good cause,
- finger image code and vun, and
- disqualifications and Supplemental Nutrition Assistance Program (SNAP) work requirement countable months.

Advisors must submit Form H1000-A or Form H1000-B with Form H1000-C.

C—511 Form H1000-A

Revision 05-4; Effective August 1, 2005

All Programs

Correct any errors made on Part I, Notice of Application (NOA), before submitting the form for processing.

You must process the NOA before entering the input document information. Batch and submit the NOA before, or on the same day as, the input document.

If staff damage or lose Form H1000-A, Notice of Application, substitute the same form from another set. Block out the preprinted application number and enter the application number of the original NOA.

If the number of applicants listed on Form H1010-B, Application for Assistance - Part B: Information We Need to Know, exceeds 11 people, complete an additional set of forms. Complete Item 04, Page, on the first NOA. Block out the preprinted application number on the additional NOA forms and enter the original application number of the first NOA. Make entries in

Item 04, Page;
Item 06, Budgeted Job Number;
Item 07, Mail Code;
Item 09, Case Name; and
Items 33-38. Make sure to begin with line "b" in Items 33-38.

Staple the NOAs together and batch as one.

When an applicant moves and the move requires the transfer of a pending application to another office, forward all material, including Form H1031, Case Record Transfer. The receiving office is responsible for updating the new budgeted job number, mail code, and county number.

C—512 Form H1000-B

Revision 02-3; Effective April 1, 2002

All Programs

The Form H1000-B, Record of Case Action, input document is identical to theForm H1000-A, Notice of Application input document. The following items appear on the record of case action, input document, and case record copy:

Item 01, Case number;
Item 02, Category;
Item 03, Sequence;
Item 09, Case name; and
Item 32, Client number.

Enter changes in the case information in red ink. To report a change or correction:

- circle the section number.
- circle the individual line indicator in the section where the change is entered. If a change is made in Section III only, circle the individual line indicator in both Sections II and III.
- enter the new information.
- enter the client number in Item 50, Client Number Validation, if changing the name and date of birth of the same client.

You may not change:

Item 08, Date Filed;
Item 32, Client Number;
Item 37, Social Security Number (SSN) validated with an asterisk;
Item 38, Social Security Claim Number validated with acode 1 or 3;
Item 48, PA – Refugee; and
Item 129, Grant Effective Date(TANF only).

Additionally for TANF Medicaid Programs you may not change

Item 02, Category; and
Item 46, Medical Effective Date (over six months old).

To delete income amounts and social security account numbers without asterisks (Item 37), enter azero in the item. Delete all other information (including the social security claim number, Item 38) by entering a pound sign (#) in the first position of the item. Do not use a pound sign as an abbreviation for number.

To delete an individual name and individual information, enter a pound sign in Item 33, Client Name. If deleting a TANF or Medical Programs individual due to death, re-enter the original status-in-group code for the deceased individual plus status-in-group code X in Item 40, Status in Group. Enter the individual's date of death in Item 47, Death/Denial Date.

If you delete a

- TANF certified member, adjust the total needs amount in Item 66.
- Medical Programs budget group member, adjust the total needs amount in Item 66, and the number of adults/children included in the budget group in Items 125, and 126.

C—520 Form H1000-A and Form H1000-B Completion Instructions

Revision 02-3; Effective April 1, 2002

C—520.1 Section I, Items 01 - 31

Revision 02-3; Effective April 1, 2002

All Programs

Items 01 through 39 are listed on the Notice of Application. On the NOA, complete all items except Items 32 and 39. Items 02, 06, 07, 08, 09, 13, 15, 16, 17 and 25 cannot be deleted, but may be updated.

ITEM 01: Case Number

All Programs

If known, enter the previously assigned case number. To reassign a number, ensure that the case name is identical to the name as it appeared at the time of denial. The reassigned case number must have been active within the past year for non-public assistance (PA) Supplemental Nutrition Assistance Program (SNAP) and within the past two years for PA SNAP, TANF and Medical Programs for Families and Children.

ITEM 02: Category

TANF and Medical Programs

On the NOA, enter the code in the left-hand box that describes the type of assistance. Enter changes or corrections in the right-hand box.

2 — TANF/Medical Programs

5 — Refugee Cash Assistance (RCA)

SNAP

On the NOA, enter the code in the left-hand box that describes the type of assistance. Enter changes or corrections in the right-hand box.

6 — PA SNAP

8 — All members are refugees, other than Cuban/Haitian entrants, receiving TANF or RCA (Aid Type 5)

9 — Non-PA SNAP

ITEM 03: Sequence No. (SEQ)

All Programs

For a TANF/Medical Programs NOA, enter code Y if the case name received TANF/Medical Programs within the past two years.

The sequence is computer-printed on 1000-B turnaround. The initial Form H1000-B from the Form H1000-A input document is always sequence 02. Use only the most current sequence to update information. The sequence number cannot exceed the number 99. After 99 the sequence begins at 02 again.

ITEM 04: Page

All Programs

If more than one form is required, enter the page number in the first space and the total number of pages in the second space.

ITEM 05: Print Date

All Programs

Computer printed on 1000-B turnaround. This is the date the information from the input form is entered into SAVERR.

ITEM 06: Budgeted Job Number

All Programs

Enter the first eight alphanumeric characters of the budget job number assigned to the application.

ITEM 07: Mail Code

All Programs

Enter the mail code of the budgeted job number assigned to the application.

ITEM 08: Date Filed

All Programs

Enter the file date of application for assistance. Use month, day, year sequence.

Note: When adding a child to a new program, the file date is the date of the reported change.

SNAP

Also enter the date on the SNAP Form H1000-B, Record Of Case Action, when a new Form H1010-B, Application for Assistance - Part B: Information We Need to Know, is received.

Medical Programs

For reopened three months prior applications, enter the date the applicant requests the application be reopened. Enter the month and year of the original file date in Item 134, Three Months Prior Application Date.

ITEM 09: Case Name

All Programs

Enter on the NOA the individual's last name, comma, first name, space, middle name, or initial until the name is complete or the maximum of 22 positions is reached. The 22 positions include alphanumeric characters, commas, and spaces. If the last name includes Jr, Sr, etc., enter this after the last name(**Example:** SmithJr,Robert).

ITEM 10: Case Name Change

All Programs

To report a change or correction in case name, enter the complete name in the 22 positions provided in the format described in Item 9, Case Name. If the case name is on a line other than "a," Section II, of the NOA, enter

- the correct name in Item 10; and
- a pound sign (#) on line "a" of Section II, Item 33, Client Name, if you are removing the person reported on line "a."

If the person reported on line "a" remains a part of the ...	then enter the appropriate status-in-group code ...
TANF case,	for this person on line "a" of Section III, Item 40, Status-in-Group, and the appropriate entry in Item 41, ESP Code.
SNAP case,	if any, or a pound sign in Item 40, Status-in-Group to delete a code that is no longer applicable.
Medical Programs case,	for this person on line "a" of Section III, Item 40, Status-in-Group.

If the new case name is not reported on the NOA, add the person's name and information on the first available line of Section II, Item 33, Client Name. Enter the appropriate codes in Item 40 for all programs and in Item 41 for TANF and SNAP on the line where the new case name is listed.

The computer automatically realigns names to ensure the correct name is on line "a." Do not attempt to move names from line to line on Form H1000-A orForm H1000-B.

ITEM 11: Reserved

ITEM 12: Employee Number

All Programs

Enter the employee number of staff assigned the application.

ITEM 13: Mailing Address, First Line

All Programs

Enter the street number and name, rural free delivery, or post office box number using these abbreviations:

Ave — Avenue

Blvd — Boulevard

Cir — Circle

CT — Court

Dr — Drive

Gen Del — General Delivery

Hwy — Highway

Ln — Lane

PO Box — Post Office Box

Rd — Road

RFD — Rural Free Delivery

RR — Rural Route

St — Street

Do not use a pound sign (#) as a part of an address. See example in B-222.1, Mailing Addresses for Issuing Benefits, for cases with P.O. Box addresses.

TANF

When a TANF case has a guardian or protective payee, use their mailing address in Items 13-17.

ITEM 14: Mailing Address, Second Line

All Programs

Use this space if additional lines are required for the mailing address.

ITEM 15: City

All Programs

Enter the name of the city or town used in the mailing address.

ITEM 16: State

All Programs

Enter the two-letter postal abbreviation of the state used in the mailing address. Allowed abbreviations are:

TX — Texas

AR — Arkansas

LA — Louisiana

NM — New Mexico

OK — Oklahoma

ITEM 17: ZIP Code

All Programs

Enter the ZIP code of the mailing address.

ITEMS 18 - 24 ARE NOT PRINTED ON THE NOA.

TANF and Medical Programs

Use Items 18-23 to mail Form H3087, Medicaid Identification, to a temporary address. To change any of these items on a Form H1000-B, Record of Case Action, input document, re-enter all items. Use a pound sign (#) to delete items.

ITEM 18: Temporary Address, First Line

TANF and Medical Programs

Enter the temporary mailing address.

ITEM 19: Temporary Address, Second Line

TANF and Medical Programs

Use this space if additional lines are required for the temporary address.

ITEM 20: Temporary Address, City

TANF and Medical Programs

Enter the name of the city or town.

ITEM 21: State

TANF and Medical Programs

Enter the two-digit postal abbreviation of the state.

ITEM 22: ZIP Code

TANF and Medical Programs

Enter the ZIP code.

ITEM 23: Temporary Address; Months; Begin Month

TANF and Medical Programs

Months: Enter the number of months, not to exceed three, that Form H3087, Medicaid Identification, is to be sent to atemporary address.

Begin Month: Enter the month the temporary address becomes effective.

ITEM 24: Residence Address

All Programs

Enter the residence address, street, and city only if different from the mailing address. Always enter the entire address.

TANF and TP 40

Enter the telephone number, if provided, for an application from a pregnant woman.

ITEM 25: County

All Programs

Enter the three-digit code for the county associated with advisor's BJN.

Note: For TANF and Medical Programs, enter the individual'sresidence code in Item 164. See C-350 for the county codes.

Items 26 - 27 are not printed on the NOA.

ITEM 26: Protective Payee (TANF/Medical Programs); Authorized Representative (FS)

Enter the last name, comma, first name, space, middle name or initial until the name is complete or the maximum of 22 positions is reached. Enter the name of the institution in usual word order omitting commas, if the guardian is an institution (such as, First National Bank), or the representative payee is alicensed residential child care facility. The 22 positions include alphanumeric characters, comma, and space. If staff make an entry in this item, they must also make an entry in Item 27, Modifier.

TANF and Medical Programs

Enter the name of the legal guardian (exactly as shown on guardianship papers), protective payee, or representative payee.

SNAP

Enter the name of the authorized representative. If the authorized representative is an institution such as a halfway house, enter the name of the employee designated by the institution to act as authorized representative on its behalf.

ITEM 27: Modifier (M)

All Programs

Enter the code that identifies the person listed in Item 26.

TANF and Medical Programs

P — Protective Payee

Note: Also use P for those cases in which a representative payee is designated to receive and manage the benefits for an individual who is incompetent or incapacitated.

R — Representative Payee

SNAP

I — Authorized representative is a member of household (under the same roof).

O — Authorized representative is not a member of household (not under the same roof).

F — Authorized representative is an employee of a drug and alcohol treatment/group living arrangement facility.

ITEM 28: Indicator (I) Code

TANF

Enter on NOA. Enter only changes or corrections on Form H1000-A, Form H1000-B and Form H1000-C.

For TANF, enter code M in this item if potential eligibility is based on an incapacity determination.

For TANF-SP, make no entry. SAVERR prints U when TP 61 transfers to TP 07, 20, or 37.

SNAP

1 — Streamlined reporting (SR) household with total gross monthly income that is less than or equal to 130% FPIL.

2 — SR household with total gross monthly income that is greater than 130% FPIL.

3 — Non-SR household.

ITEM 29: Action Notice (MMDDYY)

All Programs

On Form H1000-A/B, enter the date you give the individual Form H1017, Notice of Benefit Denial or Reduction. This entry is mandatory for all denials except for Application Filed in Error, denials. For Medical Program individuals, enter the date you give the individual Form

H1122, Medicaid Action Notice.

ITEM 30: Medical Delay

Medical Programs

Use for emergency medical conditions. Make an entry, using four alphanumeric characters, when more than 10 days elapse between giving/mailing a request for medical information and the date the local office receives the information. Enter code E and the number of days over 10. **Example:** E015.

TANF

Use when a TANF applicant applies in pay for performance and must demonstrate cooperation. Aperiod of up to 40 days is excluded from the timeliness calculation. Enter Code E and the number of days after the interview date needed to demonstrate cooperation. **Example:** E030. Do not allow more than 40 days.

ITEM 31: Medical Programs Application Indicator

Medical Programs

Make an entry only on the NOA. Enter

- W to identify a TP 40 application or TANF application with a pregnant woman; or
- Y to distinguish Medical Programs applications from other Category 02 applications. Do not enter on Form H1000-B.

C—520.2 Section II, Items 32 - 39

Revision 10-4; Effective October 1, 2010

All Programs

This section contains identifying information for each person listed on the form. Always use line"a" to enter information about the head of household (case name). Items 32, 33, 34, 35, 36, and 39 cannot be deleted, but may be updated.

ITEM 32: Client Number

All Programs

When certifying a case, for each person listed in Section II, enter

- the nine-digit individual number or
- Code 2. This code tells SAVERR to check for an existing client number. If a number exists, SAVERR will reassign the client number. If a number does not exist, SAVERR will assign a number.

If Form H1000-A, Notice of Application, or Form H1000-B, Record of Case Action, will not process because of error message 307, "client is already active in same program on another case," research the case to determine if the individual is currently active in another case in the same program.

If the individual is ...	then ...
not currently active in the same program or is entitled to dual SNAP participation as aresident of a shelter for battered persons,	follow procedures in B-454.1, Duplicate Participation Procedures.
currently active in the same program and is not entitled to dual benefits,	take appropriate action to prevent duplicate participation. Process an overpayment, if applicable. The advisor who discovers duplicate participation is responsible for notifying the other offices involved.

SAVERR does not assign a client number on denied initial applications.

See C-800, Automated Support Systems, for individual merge/separate information.

To reassign a client number without an entry in Item 50, Client Number Validation, enter Code 2 in Item 32 and the person's name, birth date, social security account number, and social security claim number so that they match the information already in the computer file.

To correct biographical information enter:

- up to three corrections on the input document. Ensure that at least one item matches the information already on file.
- the client number in Item 32 and Item 50, Client Number Validation.

Using Item 50 allows the client number to be reassigned, but hierarchy may still prevent using the biographical data.

ITEM 33: Client Name

All Programs

Enter the name(s) of the people listed on Form H1010-B. Type the last name, comma, first name, space, middle name or initial until the name is complete or you reach the maximum 22 positions. The 22 positions include alphanumeric characters, comma, and spaces.

The only spaces allowed are after the first name. Do not use spaces within a last or first name. If the name includes a Jr., Sr., II, III, etc., it must follow the last name. **Example:** SmithJr, John Z. Enter the individual's name from line a in Item 09, Case Name, instead of Item 33.

Some eligible non-U.S. citizens traditionally use a name order that is different from the customary U.S. order (first name, middle name, last or family name). Advisors should determine name order according to U.S. custom, and enter it appropriately on Form H1000-A and Form H1000-B. **Example:** Vietnamese name on I-94: Nguyen(last) Thi(first) Mai(middle) Enter on Form H1000-Aand Form H1000-B: Nguyen,Thi Mai.

Medical Programs

Enter the names of all persons in the budget group. This group includes all the eligible and ineligible people whose needs, income, resources, and medical expenses are used to determine eligibility and/or spend down.

ITEM 34: Birth Date

All Programs

Enter the birth date for each person listed.

ITEM 35: Sex

All Programs

Enter the sex for each person listed.

M — Male

F — Female

ITEM 36: Race

All Programs

Enter the code that describes the race, color, national origin for each person listed:

1 — White (not Hispanic) – People whose origins derive from the original people of Europe, North Africa, or the Middle East.

2 — Black (not Hispanic) – People whose origins derive from the black racial groups of Africa.

3 — Hispanic – People of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin.

4 — American Indian or Alaskan Native – People whose origins derive from the original people of North America.

5 — Asian or Pacific Islander – People whose origins derive from the original people of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes China, Japan, Korea, the Philippine Islands, and Samoa.

6 — State Office Use Only – A code entered by the computer if the worker makes no entry or enters an inappropriate code. Staff must take action to correct.

ITEM 37: Social Security Number (SSN)

All Programs

Enter the social security number (SSN) for each person listed. Following the nine-digit entry is aspace used to indicate the verification status of the SSN. A computer printed asterisk (*) indicates Social Security Administration verified the SSN. A verified SSN cannot be changed on Form H1000-B and Form H1000-C. If you determine the number is incorrect, send a memorandum with the correct SSN to State Office Data Integrity (SODI), to make a change:

SODI Section, Data Base Support Unit
P.O. Box 14930, MC Y92-2
Austin, TX 78714-9030

Or fax to the Data Base Support Unit at 512-706-7140.

SODI Section notifies the staff by memo when the change is made.

A blank space following the SSN indicates the SSN was entered by the advisor but is not verified.

ITEM 38: Social Security Claim Number

All Programs

Enter the benefit claim number for people enrolled in Medicare or for people who receive social security or Railroad Retirement (RR) benefits. If a person is receiving benefits under more than one number, use the number shown on the Medicare card. If there is no claim number assigned, leave blank.

Note: If entering a RR benefit claim number in Item 38, total the household's RR benefits in Item 55, not in Item 43.

Following the claim number is a code indicating whether the state is paying Medicare premiums for the individual or the individual has private medical insurance. The codes apply to all cases, but are not printed on the SNAP Form H1000-B and Form H1000-C. Reports that include biographical information have these codes. They are

0 — No insurance.

1 — Medicare premium paid by state.

2 — Private medical insurance.

3 — Private medical insurance and Medicare premium paid by state.

The presence of a code 1 or 3 indicates SSA validated the number and the number cannot be changed on Form H1000-B and Form H1000-C. If you determine a verified number is incorrect, send a memorandum with the correct number to Data Control Section, Special Programs Support Unit, State Office, Y-922, to make achange.

THIS COMPLETES THE ALLOWABLE ENTRIES ON THE NOTICE OF APPLICATION.

ITEM 39: Education/Service Code

TANF

Enter an education code for each person in the certified group who is 16 or older (including achild who will be 16 during the month of certification). Note: Do not change the code unless it was incorrect at the time the initial tier level was set or the individual has been denied for at least one complete month before reapplying.

SNAP

Enter an education code for each person with a Code 2, 3, 4, R, V, W, X, or Y in Item 41, Work Registration. **Note:** Education codes entered for TANF individuals will be printed on the next Form H1000-B that processes, whether registered for SNAP ESP or not.

TANF and SNAP

Enter a code in the first digit of Item 39 to indicate the highest educational level/grade each person has completed. Do not consider vocational/technical schools when determining education level.

Educational Level	Code
1st grade	1
2nd grade	2

3rd grade	3
4th grade	4
5th grade	5
6th grade	6
7th grade	7
8th grade	8
9th grade	9
10th grade	A
11th grade	B
High school graduate/completed general equivalency diploma	C
Attending college or completed some college but has not graduated from a four-year college	E
Graduate of a four-year college	F
No formal education	N

C—520.3 Section III, Items 40 - 50

Revision 11-3; Effective July 1, 2011

All Programs

Section III (a-k) is an extension of Section II (a-k). Each line in Section III relates to the corresponding line in Section II and is used to provide additional information about the people listed. Example: The status-in-group code for the case name in Section II, line **a**, is reported in Section III, line **a**. Items 40 and 46 for Temporary Assistance for Needy Families (TANF) and Medical Programs, and Item 41, for TANF and the Supplemental Nutrition Assistance Program (SNAP), cannot be deleted but may be updated.

If an active case is denied, all monetary amounts for the case are kept in the System for Applications, Verifications, Eligibility Reports and Referral (SAVERR) files until the case is purged. The amounts kept in SAVERR files are those budgeted for the latest month of eligibility.

The same is true for individual income amounts. The amount shown, however, is the latest amount of income budgeted in any program. If the individual is moved to another case, the individual income amounts can be updated. Staff can change individual income amounts if denying an active case. This action does not update the TANF case income but does update the SNAP case income.

TANF and Medical Programs

When a certified recipient becomes a payee or case name, medical effective date is automatically deleted. For TANF, the ESP code is also deleted.

ITEM 40: Status-in-Group

All Programs

Status-in-group (SIG) codes identify the people's relationship to the case. Enter all codes that describe the people listed on Form H1000-A, Notice of Application, Form H1000-B, Record of Case Action andForm H1000-C, Secondary Client Input. A maximum of six codes may be used for one person.

TANF and Medical Programs

Assign each person listed one primary code. Use secondary codes only in combination with a primary code. Use secondary codes when required or to provide additional information. **Note:** For TP 30 case, include only one person with an eligible primary code (SIG 8 or 4) per case.

SNAP

Always enter a code to identify the head of household. Use other codes when appropriate. Use the head of household codes with any of the other codes listed under other codes. Only one person in the case, however, may be given a code indicating head of household.

TANF

Primary Codes

2 – Disqualified/Ineligible Child or Second Parent— Identifies a child or second parent who would be a required member of the certified group but who is disqualified or ineligible for another reason, including noncompliance with the unmarried minor parent domicile requirement.

3 – Noncertified child – Identifies the only deprived child of the certified caretaker/second parent.

If the child receives ...	then enter SIG Code ...
SSI	3
Foster Care Payments	3F
Adoption Assistance payments	3A

5 – Certified Child – Identifies a child included in the certified group for TANF or refugee cash assistance (RCA) cases.

7 – Second Parent — Identifies the second parent in a TANF-SP case.

Do not use Code 7 for a Supplemental Security Income (SSI) recipient, to identify the case name, or for more than one member.

8 – Caretaker — Identifies the caretaker in TANF cases.

Do not use Code 8 for an SSI recipient or for more than one member.

9 – Payee – TANF payee only includes:

- SSI recipients (legal parents and other caretaker relatives), or
- other caretaker relatives who act as head of the TANF household and who are not eligible for TANF or do not want to be included as a caretaker (See A-222, Who is Not Included).

0 – Case Name Only — Identifies a legal parent disqualified for:

- intentional program violation;
- alien status/citizenship requirements;
- failure to comply with employment services, child support, SSN or third-party resource (TPR) requirements;
- failure to timely report the temporary absence of a certified child;
- being a fugitive;
- noncompliance with the unmarried minor parent domicile requirement; or
- a felony drug conviction (not deferred adjudication) for an offense committed on or after April 1, 2002. This disqualification is permanent. See A-222, Who is Not Included.

Secondary Codes

E – Federally Recognized Tribe or Unaccompanied Refugee Minor(URM) — Identifies individuals who are either members of a federally recognized Indian tribe or a URM. These individuals are exempt from mandatory enrollment in Medicaid managed care.

G – Reached End of State Time Limit — Identifies a person who used the maximum number of TANF months in a time limit and has a five year freeze out date on SAVERR. This code can be used with all primary SIG codes.

H – Eligible Refugee — Identifies a person identified as an eligible Amerasian, refugee, asylee, victim of severe trafficking or Cuban/Haitian entrant by the U.S. Citizenship and Immigration Services (USCIS) on Form I-94 or other USCIS document. Continue using Code H until the individual has resided in the U.S. for five years. Code H may be combined with any primary codes. **Note:** Entry of Code H requires an entry in Item 48.

I – Ineligible Child – Identifies a child who is ineligible for TANF for a reason other than being disqualified or being an SSI recipient. Use Code Ionly with Code 2.

K – Child of a Minor Child – Identifies the child of a minor parent who is also included in the TANF grant. Use Code K only with Code 5.

L – Minor Parent with a Dependent Child – Identifies a minor parent who has a dependent child on the same case. Use Code L with Codes 5, 7, 8, 9 or 0.

M – Eligible Only for Three Months Prior Medical Assistance— Identifies a person who is eligible for medical assistance during any or all of the three months before the month of application, but who is not currently eligible for medical assistance. Use Code M with Codes 5, 7 or 8.

N – Ineligible for Retroactive Medical Assistance and Current Assistance — Identifies a member of the dependent group who must be reported to certify a case for three months prior Medicaid coverage. Use this code for a member of the dependent group who is ineligible for retroactive medical assistance and current assistance. Use Code N with Codes 5, 7 or 8 to identify members of an OTTANF case. **Note:** If all people in a case are status-in-group N, the case must be Type Programs 11, 71 or 72.

O – Department of State Health Services (DSHS) Child with Special Health Care Needs— Identifies a child who is exempt from mandatory enrollment in Medicaid managed care.

P – Private Health Insurance — Identifies acertified person who has private health insurance other than Medicare or Medicaid benefits. Use Code P with Codes 5, 7 and 8.

Q – Proof of THSteps Screening — Identifies a child who the automated system indicates as delinquent in screening, but for whom the individual has provided proof of THSteps screening. This code does not remain on SAVERR. Use Code Q only with Code 5.

R – HHSC Employee — Identifies a person who is an HHSC employee. Use Code R with all primary codes.

S – Alien with Acceptable Alien Status — Identifies a noncitizen whose alien status allows him to receive TANF. Use Code S with all primary codes.**Note:** Do not use this code for refugees (SIG H).

T – Ineligible Alien — Identifies a person ineligible due to alien status. Use Code T with Codes 9, 0 and 2Y.

U – Ineligible — No U.S. Citizenship Proof— Identifies a person ineligible due to no proof of U.S. citizenship. Use Code U with Codes 0, 2I or 2Y.

V – Living in Nursing Home — Identifies aperson who is temporarily in a nursing home. Use Code V with Codes 0, 3, 5, 6, 7 and 8.

W – Disqualified Child – Identifies a child disqualified for failure to comply with employment services or SSN requirements. Also identifies a minor parent certified as a child, who is disqualified for not cooperating with child support requirements. Use Code W only with Code 2.

X – Deceased – Identifies a deceased person. Use Code X with Codes 5, 6, 7 and 8. Enter the date of death in Item 47 when using Code X.

Y – Disqualified Second Parent — Identifies a legal parent who would be required to be included as a second parent but who is disqualified. Use Code Yonly with Code 2.

Z – Migrant — Identifies members of amigrant household. Use Code Z with all primary codes.

SNAP

Head of Household Codes

A — The head of household is a household member.

G — The head of household is a nonmember.

GK — The head of household is disqualified for areason other than an intentional program violation (IPV).

GT — The head of household is disqualified for an IPV.

Other Codes

B – Student — Identifies a member who is eligible to participate even though he is a student enrolled at least half time in a curriculum that requires a high school diploma or equivalent for entrance.

C – ABAWD not meeting the work requirement — Identifies an able-bodied adult without dependents (ABAWD) who is not meeting the 18-50 work requirement.

D – ABAWD meeting the work requirement — Identifies an ABAWD who is working 20 or more hours per week or is in a work program that meets the 18-50 work requirement.

F – Treatment Facility Residents — Identifies a

- participating resident of an approved drug and alcohol treatment/group living arrangement facility; or
- resident of a public institution who jointly applies for SSI and SNAP.

H – Eligible Refugee — Identifies a person identified as an eligible Amerasian, refugee, asylee, victim of severe trafficking, or Cuban/Haitian entrant by the U.S. Citizenship and Immigration Services (USCIS) on Form I-94 or other USCIS document. Continue using

Code H until the individual has resided in the U.S. for five years. **Note:** If the Category is 8 and Aid Type is 5, all household members must be coded H.

K – Disqualified for a reason other than an IPV— Identifies a member who is disqualified for any reason other than an IPV. Even though this person is not eligible to receive SNAP, enter his biographical data.

M – Migrant, Out of Work Stream — Farm workers who travel to work in agriculture or a related industry during part of the year but who are presently residing at their permanent or home base.

R – HHSC Employee — Identifies a person who is currently an HHSC employee.

S – Eligible Alien — Identifies a noncitizen whose alien status allows him to receive SNAP. Use Code S with all primary codes. **Note:** Do not use this code for refugees.

T – Disqualified for Intentional Program Violation— Identifies a person who is disqualified for intentional program violation. This person is not eligible to receive SNAP; however, all biographical data, income, and expenses are entered. When using Code T, make an entry in Item 49, Disqualification Code and Date.

U – Seasonal Farm Worker — Farm workers who do not leave their permanent residence to work in agriculture or a related industry.

W – Migrant, in Work Stream — Farm workers who are presently employed away from their permanent residence or home base.

Medical Programs

Primary Codes

2 – Disqualified/Ineligible Child or Second Parent— Identifies a child or adult who is not eligible for Medicaid, but who is included in the budget group. Do not use SIG Code 2 for an ineligible person who is the case name. On GWS, the SIG labeled "Other Rel Spouse" also results in this SIG. The "Other Rel Spouse" label is used to identify the spouse of the "Caretaker/Other Rel." This individual is not eligible for Medicaid but is included in the budget group.

4 – Eligible child – Identifies a child who meets the Medicaid eligibility requirements for the current period and/or prior period or who would meet those requirements if still alive.

7 – Second Parent — Identifies either the

- eligible spouse of a dependent child's natural or adoptive parent, or stepparent; or
- second adult in an RMA case.

Do not use Code 7 for an SSI recipient, to identify the case name, for more than one member, or unless a caretaker is certified.

8 – Caretaker — Identifies the

- eligible pregnant woman;
- eligible caretaker in the home;
- independent child who applied for himself, and, if applicable, his siblings; or
- first adult or single adult in RMA cases.

Do not use Code 8 for an SSI recipient (see Code 9-Payee) or for more than one member.

On GWS, the SIG labels "Caretaker/Parent" and "Caretaker/Other Relative" result in this SIG if the individual is eligible for Medicaid on the case.

9 – Payee — Identifies the ineligible case name/payee only. Use SIG Code 9 when the person with the case name is not part of the budget group. Use this code when SSI recipients act as case names/payees.

0 – Case Name Only — Identifies the ineligible caretaker who is part of the budget group and is the case name. On GWS, the SIG labels"Caretaker/Parent" and "Caretaker/Other Rel" result in this SIG if the individual is not eligible for Medicaid on the case. Only one person per case may be coded 0.

Use SIG 0Y for legal parents who are disqualified for TPR, SSN or Child Support noncooperation. On GWS, the SIG label will remain "Caretaker/Parent."

Secondary Codes

E – Federally Recognized Tribe or Unaccompanied Refugee Minor(URM) — Identifies individuals who are either members of a federally recognized Indian tribe or a URM. These individuals are exempt from mandatory enrollment in Medicaid managed care.

H – Eligible Refugee — Identifies a person who is a refugee. Use Code H with all primary codes in Categories 1 through 5.

I – Ineligible Child – Identifies a child disqualified for Medical Program. Use Code I only with Code 2.

K – Child of a Minor Child – Identifies the child of a young mother who is also included in the budget group. Use Code K only with Code 4.

L – Minor Child with a Child of Her Own — Identifies a mother 18 years old or younger who has a child of her own in the same budget group. Use Code Lwith Codes 4, 7, 8 or 0.

M – Eligible Only for Three Months Prior Medical Assistance— Identifies a person who is eligible for medical assistance during any or all of the three months before the month of application, but who is not currently eligible for medical assistance. Use Code M with Codes 4, 7 or 8.

N – Ineligible for Retroactive Medical Assistance and Current Assistance — Identifies an ineligible member of the budget group who must be reported to certify a case for three months prior Medicaid coverage. Use this code for a member of the budget group who is ineligible for retroactive medical assistance and current assistance. Use Code N only with Code 2.

O – DSHS Child with Special Health Care Needs— Identifies a child who is exempt from mandatory enrollment in Medicaid managed care.

P – Private Health Insurance — Identifies acertified person who has private health insurance for hospitalization, accidental injury or sickness, other than Medicare or Medicaid benefits. Use Code P with Codes 2, 4, 7, 8 or 0.

Q – THSteps, Family Planning, or Other Service Needs— Identifies a Medicaid recipient, from birth through 18, who does not want THSteps or family planning services or who does not require assistance with other health or income-related needs. Use Code Q only on applications with Codes 4, 7 or 8.

R – HHSC Employee — Identifies a person who is an HHSC employee. Use Code R with all primary codes.

S – Alien with Acceptable Alien Status — Identifies a noncitizen whose alien status allows him to receive Medicaid. Use Code S with all primary codes. **Note:** Do not use this code for refugees (SIG H).

T – Ineligible Alien — Identifies anoncitizen whose alien status makes him ineligible for program benefits. Use Code T with Codes 2, 9 or 0.

U – No U.S. Citizenship Proof — Identifies aperson ineligible due to no proof of U.S. Citizenship. Use Code U with Codes O, 2I or 2Y.

V – Living in Nursing Home — Identifies aperson who is temporarily in a nursing home. Use Code V with Codes 4, 7 or 8.

W – Disqualified Child – Identifies a child disqualified for failure to comply with or SSN requirements, or a minor parent who is disqualified for not cooperating with child support requirements. Use Code W only with Code 2.

X – Deceased – Identifies a deceased person. If using Code X, enter the date of death in Item 47, Death/Denial Date. Use Code X with Codes 4, 7 or 8.

Y – Disqualified Caretaker or Second Parent— Identifies a legal parent who would be required to be included as a caretaker or second parent but who is disqualified for citizenship, TPR, SSN or Child Support noncooperation. Use Code Y only with Codes 2 and 0.

Z – Migrant — Identifies members of amigrant household. Use Code Z with all primary codes.

ITEM 41: (W)

TANF and SNAP

Enter an employment services code for each person listed in Item 33. The form will not process if this item is left blank.

If Form H1000-A, Form H1000-B or Form H1000-C is processed for ongoing benefits at application or complete review/recertification, SAVERR only allows a code in Item 41 that corresponds to the appropriate age, based on Item 34, Birthdate. Forms H1000-A (Form H1000-B for SNAP recertifications processed after cutoff of the last benefit month) are edited based on the date the form processes. Other Forms H1000-B are edited based on the form effective date.

For TANF, SAVERR has age edits for codes A and F.

For SNAP, SAVERR has age edits for codes 2, 3, 4, A, F, R, V and W. If Item 78, Type Review, is coded N or I, SAVERR only edits new entries in Item 41 for correctness.

TANF

Codes	Explanation
A	Child (SIG 5 or 5L).

B	A caretaker or second parent, age 18 or younger attending school.
C	Caring for an ill or disabled child in the household, even if the child is not a member of the certified group.
E	Unable to work due to a disability expected to last more than 180 days.
F	60 years of age or older.
G	Caring for a child (SIG 2, 3 or 5) under age 1. Do not use this code if another member is Code G or R.
H	Presence required in the home because of illness or incapacity of another adult member of the household and the disability is expected to last more than 180 days.
J	Not subject to participation – not a certified TANF individual. Use this code with SIG 3and 9, or with SIGs 0 or 2 who are disqualified for a reason other than ESP noncompliance.
K	Pending during appeal of denial or disqualification. Use only for currently certified TANF individuals.
L	County Hardship Exemption – Identifies an individual who has used the maximum number of TANF months allowed in the state time limit but who is certified for TANF because HHSC state office has designated the county as economically deprived.
M	Mandatory registrant.
N	Employment Hardship Exemptions – Identifies an individual who has used the maximum number of TANF months allowed in a state time limit but who is certified for TANF due to lack of employment.
P	Mandatory registrant employed or self-employed 30 or more hours per week and earning at least$700 a month. Do not use this code if the individual qualifies for exemption codes A, B, F, G, R, C, J, N, Q, W or L.
Q	Severe Personal Hardship Exemption – Identifies an individual who has used the maximum number of TANF months allowed in a state time limit but who is certified for TANF due to a disabling illness or injury of self or a close family member in the home.
R	Caring for a child under age 1 who is not listed on Form H1000-A, Form H1000-B and Form H1000-C. Do not use this code if another member is coded G or R.
T	Pregnant and unable to work.
U	A single grandparent age 50 or over caring for a child under age three.
V	An SSI recipient parent.
W	Identifies an client who noncomplies with the Choices program. There must be financial penalty of F, S or T entered on Form H1000-C.
X	A parent who has exhausted state time limits.
Y	A parent who is disqualified due to third party resource (TPR) requirements, Social Security number requirements, intentional program violation, failure to report a child's absence, being a fugitive, having a felony drug conviction, failure to cooperate with Quality Control or noncompliance with the unmarried minor parent domicile requirement.

SNAP

Codes	Explanation
A	Child age 16 years of age, or child age 16 or 17 who attends school at least half-time, or is not the head of household.
D	Three to nine-months pregnant.
E	Physically or mentally unfit for employment.
F	60 years of age or older.
G	Caring for a child under age 6.
H	Presence in home required for care of an incapacitated person.
J	Person in drug addiction or alcoholic treatment and rehabilitation program.
N	Receiving or applying for unemployment compensation.
P	Employed or self-employed 30 hours or more a week.
Q	Individual resides in a Choices county and is mandatory or has volunteered for TANF employment services.
R	Registered again, after previously serving the E&T noncompliance penalty period.
S	Student exemption (age 18 or older)/person in a training program.

T	Disqualified household member (or nonmember head of household).
U	Primary wage earner failed to comply with SNAP employment services.
2	Registered, employed less than 30 hours a week.
3	Registered, not working.
4	Registered, job attached (temporarily laid off).
5	Registration postponed, expedited service.

TP 40, TP 43, TP 44, TP 48 and TP 55

Enter a citizenship verification code for each person in the ceritified group who is a U.S. citizen. The codes specify what level of citizenship verification was used to verify citizenship, if an affidavit was used, or if good cause was allowed. When using an affidavit, a fourth level verification, enter 5 instead of 4. The levels of verification sources are found in A-358.1, Citizenship.

Codes	Explanation
1	Primary level verification source used to verify citizenship
2	Level 2 verifcation source used to verify citizenship
3	Level 3 verifcation source used to verify citizenship
4	Level 4 verifcation source used to verify citizenship
5	Affidavit used to verify citizenship
6	Good cause allowed for citizenship verification

ITEMS 42 - 45:

All Programs

Enter income information in Items 42-45, 55 and 56 as appropriate for each individual listed in Item 33. Leave an item blank if the household does not have that type income.

TANF

Do not enter income for persons whose status-in-group is

3 – an SSI child,
9 – a payee, or
2I – an ineligible child.

Note: Enter the deductible amount of any diverted income in Item 58, Deductions, for any individual whose gross income is entered on Form H1000-A, Form H1000-B and Form H1000-C. No individual's deductions should exceed his income.

SNAP

For people disqualified for citizenship, 18-50 work requirement or SSN, enter the prorated amount of income attributed to the household.

Medical Programs

Enter income information for SIG Codes 2, 4, 7, 8 and 0. For TP 45 cases, make no entry in Items 42-44, 55 and 56.

ITEM 42A: Type Income

All Programs

Enter one of the following codes to indicate the type of income entered in Item 44.

A Veterans Affairs (VA) benefits
C Unemployment Insurance benefits
P Pension benefits (other than RSDI, SSI, VA or RR)
M Combination of unemployment benefits with benefits from a pension, VA, or both
W Combined income from VA and a pension

ITEM 42B: Gross Earned

All Programs

Enter the monthly amount of countable gross earned income and net self-employment income, up to seven numeric characters. Also make an entry in Item 118, and in Items 119-122, if appropriate.

ITEM 43: RSDI

All Programs

Enter the monthly amount of Social Security (RSDI) benefits for each person whose income is considered. **Note:** If you enter an amount in this item, you must also make an entry in Item 38.

ITEM 44: VA

All Programs

Enter the monthly amount of VA benefits, unemployment insurance benefits, pension, or any combination of these.

When entering an amount in Item 44, also make entries in Item 42A and Item 118.

ITEM 45: SSI

All Programs

SAVERR will print the active penalty codes for each individual on the Form H1000-A, Form H1000-B and Form H1000-C turnaround.

SNAP

Enter the monthly SSI benefit amount.

ITEM 46: Medical Effective Date

TANF and Medical Programs

Enter the beginning date of Medicaid coverage for each person certified for cash and/or medical coverage. Leave blank for status-in-group Codes 0, 2, or 9 and 3 for TANF.

There are many edits associated with the medical effective date. If the correct medical effective date cannot be entered, submit Form H1107, Request for Forced Change of Medical Coverage, to State Office Data Integrity (SODI) Section, SDX Eligibility Unit, State Office, Y-922.

If a recipient has previous medical coverage with HHSC, enter the nine-digit client number or Code 2 in Item 32, Client Number.

TP 55 and 30

For applications with spend down, enter the earliest possible Medicaid eligibility date (MED) for each SIG 4, 7 and 8.

TP 30

Enter the date the emergency conditions started. Use the date the practitioner entered on Form H3038, Emergency Medical Services Certification.

ITEM 47: Death/Denial Date

TANF and Medical Programs

If appropriate, enter the date of denial (always the last day of the month) or date of death(always the actual date of death) for each person.

The following situations require an entry for certified group members.

- A case is released from hold to deny benefits. If the members of the certified group are not eligible for Medicaid benefits for the hold effective month, enter the last day of the month before the hold effective month.
- A case is released from hold and an eligible individual's SIG is changed to an ineligible SIG.

If the case is active and the individual's status-in-group code is changed from eligible to ineligible, do not enter a date in Item 47.

If an active case is denied, this item shows the effective date of denial of Medicaid coverage for all individuals who have medical coverage.

TP 55 and 30

Edits for cases with spend down will not allow a date in this item that is later than the application month.

TP 30

Make an entry only for the certified member (open/close code 090).

ITEM 48: FS-Med Cost; PA-Refugee

TANF and Medical Programs

Enter the code that indicates Voluntary Resettlement Agency (VOLAG), nationality, and U.S. entry date for each refugee. The first digit is the VOLAG code, the second and third digits are the nationality code, and the fourth through seventh digits are the two-digit month and the last two digits of the year of U.S. entry.

Codes	Voluntary Resettlement Agency (VOLAG)
0	Tolstoy Foundation or American Fund for Czechoslovak Refugees
1	YMCA
2	United States Catholic Conference (USCC)
3	Church World Services (CWS)
4	Lutheran Immigration Aid Society (LIRS)
5	Hebrew Immigrant Aid Society (HIAS)
6	International Rescue Committee (IRC)
7	World Relief Services
8	American Council for Nationalities Services (ACNS)
9	Persons Granted Asylum

Codes	Nationality	Codes	Nationality
01	Cuban	17	Chinese
02	Cuban/Haitian Entrant	18	Chilean
03	Soviet Jew	19	El Salvadoran
04	Romanian	20	Brazilian
05	Hungarian	21	Colombian
06	Iranian	22	Palestinian
07	Iraqi/Kurd	23	East German
08	Afghan	24	Pakistani
09	Argentinean	25	Bulgarian
10	Nicaraguan	26	Yugoslavian
11	Ethiopian	27	Armenian
12	Somali	28	Turkish
13	Other African	29	Portuguese
14	Polish	30	Peruvian
15	Czechoslovakian	99	State office use only (do not enter)
16	Indochinese — Vietnamese, Cambodian, Laotian, Khmer, Hmong	-	

Example: An Indochinese resettled by World Relief Services who entered the U.S. in June 1979 is entered 7160679.

Note: Information recorded in Item 48 cannot be changed viaForm H1000-A, Form H1000-B and Form H1000-C. To change this item, send a memorandum requesting the change to State Office Data Integrity, Special Programs Support Unit, Y-922.

SNAP

Enter the total monthly amount of medical costs of each person who is eligible for the deduction. Allowable expenses of a person who is no longer a household member are entered on line "a" of this item and credited to the head of household. Do not reduce this amount by $35. If none, leave blank.

ITEM 49: Disq. Code and Date

SNAP

Only the State Office Claims Investigation Unit (SOCIU) can enter, change or authorize deletion of entries in this item. Use this item in active or denied SNAP cases if a member has been disqualified for an intentional program violation (also see Item 40). The entry must always be six full characters. Contact the SOCIU if changes must be made in this field.

The first character SOCIU enters is:

T administrative disqualifications for offenses that occurred prior to Sept. 22, 1996;
S administrative disqualifications for offenses that occurred on or after Sept. 22, 1996, or disqualifications for convictions due to trafficking;
C court-ordered disqualifications; or
M disqualifications due to receipt of multiple benefits in one month.

The second digit SOCIU enters is:

- 1, 2 or 3 depending on whether this is the person's first, second, or third disqualification for intentional program violation (see B-912, IPV Disqualification Penalties, for lengths of penalties associated with each violation); or
- 4 if the disqualification is a permanent disqualification for trafficking in SNAP benefits or program access devices of $500 or more.

The remaining characters SOCIU enters are:

- the last month of the disqualification period entered in the MMYY format, or
- PERM if the disqualification is permanent.

SOCIU enters the same information whether the case is active or denied, and the penalty period is the same regardless of case status.

Example: For an offense that occurred after Sept. 22, 1996, a person is disqualified for an intentional program violation through May 1999. This is the person's second disqualification. SOCIU enters "S20599" to show that the disqualification is his second and that he is disqualified through May 1999. If the disqualification is his third, SOCIU enters "S3PERM" to show the disqualification is permanent.

ITEM 50: Client Number Validation

All Programs

Enter the client number if validation of the number entered in Item 32 is required. See instructions for Item 32. Use the validation only if reassigning a client number or changing individual biographical information.

Warning Messages

All Programs

SAVERR prints warning codes if the last input document is incomplete, questionable or invalid. If the head of household has had a name change because of hierarchy, the old name is printed after any warning messages in Item 50. The following format is used for all error messages: AAABBCCC

AAA — Form item number 001-191; client items 32-50 will be shown A32-K32, through K50. When a client item is shown without line indicator, 032-050, then the comparison of all entries within that item caused the error.

BB — One of the following two-digit qualifiers:

EC – ERROR CODE NUMBER "CCC"
EQ – EQUAL
GE – GREATHER THAN OR EQUAL
GT – GREATHER THAN

LE – LESS THAN OR EQUAL
LT – LESS THAN
NA – NOT ALLOWABLE WITH THE ENTRY OR LACK OF ENTRY IN"CCC"
NE – NOT EQUAL

CCC — Form item number 001-191; or error code number 300-999; or one of the following "KEY" words:

ALP – ALPHABETIC
BLK – BLANK
CUR – CURRENT PROCESS MONTH
DAT – VALID DATE
FIL – VALUE ALREADY ON FILE
N-3 – today minus 3 months
N-6 – today minus 6 months
N12 – today minus 12 months
N24 – today minus 24 months
N45 – today minus 45 days
NAM – NAME FORMAT
NOW – PROCESS DATE OF FORM
NUM – NUMERIC
NXT – NEXT PROCESS MONTH
VAL – VALID

TANF

If at application or complete review the advisor assigns a ...	SAVERR prints the message ...
three-month periodic review,	"ERRPRONE."
12-month periodic review,	"EXTENDRV."

C—520.4 Section IV, Items 51 - 59

Revision 08-4; Effective October 1, 2004

ITEM 51: Total Earned

All Programs

This computer-printed item is the sum of the entries in Column 42B, Gross Earned.

ITEM 52: Total RSDI

All Programs

This computer-printed item is the sum of the entries in Column 43, Retirement, Survivors, and Disability Insurance (RSDI).

ITEM 53: Total VA

All Programs

This computer-printed item is the sum of the entries in Column 44, VA.

ITEM 54: Total SSI

SNAP

This computer-printed item is the sum of the entries in Column 45, SSI.

ITEM 55: Total RR

All Programs

Enter the total monthly railroad retirement benefits for people whose income is considered. Include any railroad retirement benefits received by a person disqualified because of SSN or citizenship policy and attributed to the household. If none, leave blank.

ITEM 56: Other Income

All Programs

Enter the total monthly unearned income from all sources not included in other data boxes. If none, leave blank.

TANF

This may include applied income, countable child support, or alien sponsor's income.

SNAP

This includes the portion of other income of a disqualified person, or a sponsor's income, attributed to the household.

Medical Programs

This may include the TANF grant, total gross child support, and countable income from an alien'ssponsor.

ITEM 57: Total Income

All Programs

This computer-printed item is the sum of the entries in Items 51 through 56.

ITEM 58: Deductions

TANF

Enter the standard work related expense deductions for SIG 2W, 2Y, 5, 7, 8 and 0 members with earned income counted against recognized needs. The deductions cannot exceed the members' monthly earnings. Also enter any amounts diverted from the income of a:

- caretaker,
- disqualified legal parent (SIG 0), or
- disqualified second parent (SIG 2Y).

If there are no deductions, leave blank.

Note: Do not enter child care expenses or the 90% earned income deduction in this item. See instructions for Items 149-152.

SNAP

Enter the household's total monthly dependent care costs, the amount of legally obligated child support paid to or for a nonhousehold member and the remaining farm loss.

Medical Programs

Enter income deductions for everyone whose income is considered in the case, including ineligible people. Enter work-related expenses, child support disregard and any diversions for everyone. If there are no deductions, leave blank. **Note:** Do not include child care expenses (seeinstructions for Items 149-152).

ITEM 59: Adjusted Gross Income

All Programs

Enter the adjusted gross income. Enter 0 if there is no adjusted gross income.

TANF

The total case income, minus Item 58 equals Item 59, unless child care costs are entered in Item 152 or the automated 90% earned income deductions is used. For these exceptions, the total income minus Items 58, and 152 (child care and 90% earned income deduction amounts) equals Item 59.

Medical Programs

The total case income minus Items 58 and 152 (child care) must equal Item 59.

C—520.5 Section V, Items 60 - 77B

Revision 05-4; Effective August 1, 2005

ITEM 60: Shelter

SNAP

Enter the total amount of the household's monthly shelter costs. Enter zero, if there are no shelter expenses. Coordinate this item with Item 90, Utility Standard Code.

ITEM 61: Adj Gross Income

SNAP

Computer printed on Form H1000-B and Form H1000-C. Make no entry.

ITEM 62: Excess Shelter

SNAP

Computer printed on Form H1000-B and Form H1000-C. Make no entry.

ITEM 63: Net Income

SNAP

Enter the household's rounded net income. Enter zero, if there is no net income.

ITEM 64: Blank

ITEM 65: Benefits

SNAP

Computer printed on Form H1000-B and Form H1000-C. Make no entry.

ITEM 66: Total Needs

TANF

Enter the total budgetary needs figure for all members of the TANF group. Enter a new figure each time the certified group size changes.

Medical Programs

Type Program	Enter on Form H1000-A
40	185% Federal Poverty Income Limit (FPIL).
43	185% FPIL.
44	100% FPIL.

45	Leave Blank.
47	TANF budgetary needs (100%) allowance figure for all members of the budget group.
48	133% FPIL.
55	Medically Needy Income Limits for all members of the budget group.

For TP 30 cases, if Item 137 has an entry of:	Enter
40	185% FPIL
43	185% FPIL
44	100% FPIL
48	133% FPIL
55	Medically Needy Income Limits

Enter a new figure on Form H1000-B and Form H1000-C each time the household size changes. Item 66 must agree with Items 40, 125, and 126.

ITEM 67/67A: Recog/Max (Recognizable Needs/Maximum Grant)

TANF and Medical Programs

These figures are computer printed. There is no 67A entry for Medical Programs.

ITEM 68/68A: AGI (Adjusted Gross Income)

TANF and Medical Programs

These figures are computer printed. Item 68 equals the entry in Item 59. For TANF, Item 68A is the rounded down figure of Item 68. There is no Item 68A entry for Medical Programs.

ITEM 69: Unmet

TANF and Medical Programs

This figure is computer printed and is the balance of Item 68 subtracted from Item 67.

TANF

This item shows an unmet need of

- at least one cent for active TP 01, 11, and 61 cases; and
- zero cents for TP 07 and 37 cases.

Medical Programs

For ...	this item ...
TP 40, 43, 44, 47, and 48 cases,	shows an unmet need of at least one cent.
TP 55 and 30 cases that are not subject to spend down,	shows an amount greater than or equal to zero will be shown.
TP 55 and 30 cases that are subject to spend down,	shows a negative amount, which represents the monthly spend down.
TP 45	will be blank

ITEM 70: Recommended Grant Amount

TANF

This figure is computer printed and is the balance of Item 68A subtracted from Item 67A. The minimum grant of $10 is printed in Item 70 if the balance is less than $10. This item indicates benefit amount, less recoupment, if applicable. This amount is printed only for TP 01 and 61 cases.

Medical Programs

This item is computer printed. SAVERR prints a spend down amount in Item 70 if the amount in Item 69 is a negative amount. Otherwise, Item 70 will be blank.

ITEM 71 - 77-B: MAO Only

Make no entry.

C—520.6 Section VI, Items 78 - 110

Revision 10-2; Effective April 1, 2010

SNAP

Items 78, 83, 84, and 90 cannot be deleted, but may be updated. Items 86, 87, 88, 89, and 93 may be deleted with a pound sign.

ITEM 78: TR (Type Review)

SNAP

Make no entry on Form H1000-A, Notice of Case Action. SAVERR returnsForm H1000-B, Record of Case Action, and Form H1000-C, Secondary Client Input, sequence 02 with Code C. Enter one of the following codes on later Form H1000-B and Form H1000-C:

C — Complete review

I — Incomplete review

N — Non-review activity (case maintenance)

State Office Review Codes

M — SNAP "end-of-month" conversion

O — SNAP conversion that occurs at September cutoff effective October (**Example:** SNAP allotment conversion)

1 — SNAP annual RSDI/SSI conversion

ITEM 79: App. Codes (Application Codes)

SNAP

Enter the three-digit code from the list below that describes the type of application, the referral, and the number of months since the previous application or certification period.

The first digit is the type application:

1 — Eligibility Determination – individuals who are not currently certified or individuals submitting untimely reapplications.

2 — Redetermination (Reapplication) – individuals submitting timely applications for continued benefits.

3 — Application reopened after denial using the same Form H1010-B.

The second digit is always "X."

The third digit is

0 — All initial applications, reapplications within 30 days from previous application, or later applications within 30 days after the end of the previous certification period.

1-8 — For one month, enter 1, for two months, enter 2, etc.

9 — Nine months or longer.

ITEM 80: Certification Date

SNAP

Enter the month, day, and year the certification period begins. The day is always 01, even if the whole allotment is prorated.

ITEM 81: MOS. CERT. (Months Certified)

SNAP

Enter the number of months of the certification period. This must be a two-digit number.

ITEM 82: Last ATP Date (Last Benefit Month)

SNAP

Enter the month and year that the individual receives his last benefits for the current certification period. This must correspond to Items 80 and 81.

ITEM 83: HH NO. (Household Number)

SNAP

Enter the number of certified persons in the household. This is the same as the number of eligible persons listed in Section II. Do not include status-in-group Codes G, K, or T. This must be a two-digit number.

ITEM 84: AID (Aid Type)

SNAP

Enter the code that refers to the type of SNAP case.

1 — NPA only. No members receive TANF. (Category 9)

2 — NPA mixed. Some members receive TANF or RCA and others do not. (Category 9)

3 — PA. All members receive TANF or some receive SSI and other others receive TANF. (Category 6)

5 — All members are refugees, other than Cubans or Haitians, receiving TANF or RCA. (Category 8)

ITEM 85: Test

SNAP

Enter a code to indicate the household's categorical eligibility/income test/shelter deduction..

B — Gross and net income tests and capped shelter deduction.

C — Categorically eligible household with capped shelter deduction.

E — Gross and net income test and uncapped shelter deduction. Use this code only if the member who is entitled to uncapped shelter costs is disqualified for intentional program violation.

M — Net test only, uncapped shelter deduction.

T — Categorically eligible household with uncapped shelter deduction.

SNAP-CAP

S — Supplemental Nutrition Assistance Program Combined Application Project (SNAP-CAP), entered by Centralized Benefits Services.

ITEM 86: PR (Intentional Program Violation Referral)

SNAP

Make no entry. A "Y" is printed during OIG's investigation to prevent the case from being purged.

ITEM 87: NON (Non H/H Members)

SNAP

Enter the code that identifies the non-participating or non-household member(s).

A — Attendant

B — Boarders

C — Ineligible alien

D — Ineligible student

E — Any combination of two or more of A, B, C, or D

If an attendant, boarder, or roomer is an ineligible alien, code him here and in Item 88.

ITEM 88: INELIG. (Ineligible)

SNAP

Enter the total number of persons living in the SNAP household who are not eligible for participation because they are ineligible aliens.

ITEM 89: SSI

SNAP

Advisors enter an "X" if every household member receives SSI. If one or more household members do not receive SSI, leave blank.

SAVERR enters an "A" when a case transfers to Centralized Benefits Services (CBS). CBS enters an"R" when transferring a case to the field.

ITEM 90: UTIL (Utility Expense Code)

SNAP

Enter the appropriate code to describe utility and telephone costs.

Code	Description
1	Household claiming the Standard Utility Allowance.
2	Household claiming the telephone standard only.
4	Household without utility costs.
8	Households claiming the homeless shelter standard.
9	Households claiming the homeless shelter standard with one member who is disqualified for not meeting citizenship, 18-50 work and/or SSN requirements.
A	Households claiming the Basic Utility Allowance.

Do not prorate the utility and telephone standards for households with disqualified members or households sharing expenses.

ITEM 91: Action Code

SNAP

Enter the appropriate denial code. Leave blank unless the case is denied or is opened and closed on the same document. If an entry is made in Item 91, the advisor must also make an entry in Item 92. See C-221, Denial Codes, for denial codes.

ITEM 92: Action Date

SNAP

Enter the effective date of denial. If denying an application, enter the date you determine the case is ineligible. If the application is opened and closed or an active case is denied, enter the last day of the last month in which the household receives its final benefits. When making an entry in Item 92, also make an entry in Item 91.

ITEM 93: Texas Driver's License Number

SNAP

Enter the head of household's Texas driver's license number or Texas Department of Public Safety(DPS) ID number. If the head of household does not have a Texas driver's license or DPS ID, leave blank. Enter a leading zero for seven-digit license numbers.

ITEM 94: Reserved

ITEM 95: Code/Hold Date

SNAP

Enter the appropriate hold or release code under CD. Make no entry under DATE. SAVERR enters the month after cutoff as the hold effective month.

Hold Benefits

Advisor Hold Code

2 — Use to prevent SAVERR from issuing the next month's benefits. The hold is effective the first of the next SAVERR process month. Use code 2 when

- a change must be made effective the next month and the notice of adverse action expires between cutoff and the end of the month;
- an individual cannot be located;
- the second or subsequent month's benefits must be held because of expedited certification pending verification; or
- a household member receives benefits pending receipt of a social security number.

Note: Entry of Code 2 does not prevent entry of information in other sections, including Section XI, to cancel benefits or issue benefits for the current processing month.

State Office Hold Codes:

A — Form H1000-B, submitted to deny a case, contains afatal error that is not cleared by cutoff. The case remains on hold until the erroneous Form H1000-B is corrected and processed.

Z — The EBT account is dormant because the household has not accessed benefits for three consecutive months or six consecutive months when the most recent monthly issuance is less than$20.

Release Codes

O — Releases benefits effective the first of the next SAVERR process month. Release any held benefits, as necessary, by completing Section XI. **Note:** In case actions involving a hold Code A, enter a release code only if the case will not be denied.

ITEM 96: (Late Determination/Rescheduled Appointment Date)

SNAP

Make an entry if

- someone files an application, untimely reapplication or a timely application for a recertification, misses the first appointment, and schedules a subsequent appointment. Enter the date (mmddyy) of the latest appointment.
- expedited benefits are delayed because of a late determination caused by the applicant. Enter the date (mmddyy) that all the following have been completed:
  - Form H1010-B, Application for Assistance - Part B: Information We Need to Know, completed and signed,
  - individual or authorized representative interviewed, and
  - identification verified.

SSI/SNAP Prerelease Joint Application

If SSA does not notify HHSC of an individual's release until after the actual release date, enter the date (mmddyy) of notification.

ITEM 97: PASS Account Amount

SNAP

Enter PASS account amount.

ITEM 98A/B: Verification Requested/Received

SNAP

Make an entry in this item when:

- processing a timely recertification,
- the individual missed the first appointment,
- verification can be requested up to the 15th day of the month following the last benefit month, and
- Form H1020, Request for Information or Action, due date is after the last benefit month.

Use 98A to enter the date (mmddyyyy) the verification is requested.

Use 98B to enter the date (mmddyyyy) the verification is received. If no verification is received, do not enter a date.

The paper Form H1000-A, Notice of Application, Form H1000-B, Record of Case Action, orForm H1000-C, Secondary Client Input, does not correctly reflect the two separate items; however, advisors are able to enter both dates in Item 98.

Example: Item 98 09252000 10052000

ITEM 99: Ineligible Month/Combined Allotments

SNAP

Enter the appropriate code if the household is ineligible for the month of application or the second month.

1 — No benefit issued for month of application due to proration, but eligible for the second month as a combined allotment.

2 — Eligible for month of application but ineligible for the second month.

ITEM 100: PASS Account Code

SNAP

Enter the appropriate PASS account code.

E — Exempt from earned income

U — Exempt from unearned income

ITEM 101: (Prepared Meals Services Code)

SNAP

Enter the appropriate code to identify a household that qualifies to use SNAP benefits to purchase prepared meals from one of the following authorized meal providers:

C — SSI/elderly member authorized to purchase from communal dining facilities, meal delivery service, or contracted restaurant.

E — Homeless and either elderly or SSI recipient; authorized to purchase from every service(communal dining, meal delivery services, or homeless meal providers/contracted restaurants).

H — Authorized to purchase from homeless meal providers/contracted restaurants.

M — Household/disabled member authorized to purchase from meal delivery services.

ITEM 102: Reserved

ITEM 103: (Special Review Date)

SNAP

Enter the month and year for the special review (**Example:** 08-96).

ITEM 104: (Special Review Code)

SNAP

Enter the appropriate code to show the type of special review needed.

0 — State office assigned

1 — Employment Services/Work Registration

2 — School Attendance

3 — Reserved

4 — Management

5 — Income/Expense changes anticipated

6 — Living arrangement change anticipated

7 — Medical review

8 — Household change anticipated

9 — Other

To delete Items 103 and 104, enter pound (#) in 104.

ITEM 105 - 110: Reserved

C—520.7 Section VII, Items 111 - 126

Revision 02-6; Effective July 1, 2002

ITEM 111: Reserved

ITEM 112: First Case Number

All Programs

Enter the associated TANF, SNAP or Medical Programs case number.

ITEM 113: Second Case Number

All Programs

If Item 112 has an entry and there is another associated case, enter the second case number in Item 113.

ITEMS 114 - 117: Reserved

ITEMS 118 - 122

All Programs

State office uses Items 118-122 to determine discrepancies between income reported to the advisor and income reported by other agencies for the same person. Complete Items 119-122 when the earned income for a former month is not the same as the earned income entered in

Item 42B for the ongoing budget.**Note:** Do not report unearned income that differs from entries in Item 44. If entries are made in Items 119-122 for TP 30 or 55 cases, make appropriate entries in Section XI for the Spend Down history file.

ITEM 118: Mo. Earned (Month Income Is Received)

All Programs

Make an entry in Item 118 only when making or changing an entry in Item 42-B or 44.

Enter a two-digit number to identify the earliest month of certification in which the amounts entered in Items 42B and 44 were received
Example: If certification date is May 1, the ongoing budget is effective June 1, and income for May is the same as June, then enter "05."

Note: If zero is entered on Form H1000-B, Items 42B or 44, because income currently shown in these items terminates, enter the two-digit number to identify the first month the income was not received.

ITEM 119: First Budget Mo.

All Programs

Make a two-digit entry to identify the first month earned income was different than the current earned income entered in Item 42B. Make this entry even if earned income for this month totals zero.

ITEM 120: Earned Income First Month

All Programs

Enter the total amount of countable gross earnings for the household that corresponds to the month entered in Item 119. Make an entry even if the earned income for this month totals zero.

Exception: Enter the total amount of a disqualified person'searnings, even if budgeting only a prorated amount of his income.

ITEM 121: Earned Income Second Month

All Programs

Enter the total amount of countable gross earnings for all household members corresponding to the month entered in Item 122. Make an entry even if the earned income for this month totals zero.

Exception: Enter the total amount of a disqualified person'searnings, even if budgeting only a prorated amount of his income.

ITEM 122: Second Budget Mo.

All Programs

Enter the two-digit number to identify the second month in which total earned income received is different from the total of the amounts entered in Item 42-B. Make an entry even if the earned income for this month totals zero.

ITEM 123: Face-to-Face for HCO

TP 43, TP 44, TP 47 and TP 48

SAVERR enters code "N" for a caretaker required to have a Health Care Orientation (HCO). Acaretaker who does not comply with the HCO requirement must have a face-to-face interview to renew Medicaid eligibility for the child. When a caretaker has a face-to-face interview to clear non-compliance, enter code "F" in Item 123.

ITEM 124: Reserved

ITEM 125: (Adults)

Medical Programs

Enter the number of adults included in the budget group. Include a minor parent who is SIG 0 on aTP 47 case. Make no entry for TP 45.

ITEM 126: (Children)

Medical Programs

Enter the number of children included in the budget group. Make no entry for TP 45. Include the unborn child in this entry for

- TP 40 cases; and
- TP 43, 44, 47, 48, 30, and 55 cases with "01" entries in Item 128 (B.P.).

Entries in Items 125 and 126 must agree with Item 66.

C—520.8 Section VIII, Items 127 - 152

Revision 10-3; Effective July 1, 2010

TANF and Medical Programs

Section VIII shows case information for TANF, foster care, Refugee Cash Assistance (RCA), and medical programs cases.

ITEM 127: T.P. (Type Program)

TANF

Enter the appropriate code to identify the type program for certifications and denials.

01 — Cash and medical assistance.

04 — Medical Assistance Only - Deceased – Medical assistance only because the applicant(s) dies after the date of application but before certification. Do not use this type program if surviving applicants are eligible to receive cash assistance.

07 — Medical Assistance Only - 12 or 18 Months – TANF or refugee cases that are denied cash assistance because of increased earnings, but are eligible for Medicaid coverage for 12 or 18 months after the last month of TANF eligibility.

11 — Medical Assistance Only - Three Months Prior, not currently eligible or a gap in coverage– TANF individuals eligible for three months prior medical assistance, but who are ineligible in the month of application and later months, or have a gap in coverage.

20 — Medical Assistance Only - Child Support – TANF cases that are denied cash assistance because of child support, but are eligible for Medicaid for four additional months.

29 — Medical Assistance Only – 12 or 18 months post Medicaid following the end of TANF state time limit.

37 — Medical Assistance Only - 12 or 18 Months – TANF cases that are denied cash assistance because of the loss of the 90% earned income deduction, but are eligible for Medicaid coverage for 12 or 18 consecutive months after the last month of TANF eligibility.

61 — TANF-SP cash and medical assistance.

71 — OTTANF – One parent household is eligible to receive OTTANF benefits.

72 — OTTANF – Two parent household is eligible to receive OTTANF benefits.

Note: To change the type program and case name, two transactions must be processed.

Category 05 is the RCA program. TP 08, 09, and 10 are foster care programs.

Medical Programs

Enter the appropriate code to identify the type medical program for certifications and denials.

40 — Pregnant woman

43 — Children under age one

44 — Children age six through 18

45 — Newborn children

47 — Dependent children ineligible for TANF because of applied income

48 — Children ages one through five

55 — Medically Needy (with or without spend down)

30 — Nonimmigrants and undocumented aliens

ITEM 128: B.P. (Base Plan)

Medical Programs except TP 40

Enter 01 to identify cases with a pregnant woman in the budget group.

ITEM 129: Grant Eff. Date

TANF

Enter the first day of the earliest month and year the individual is eligible for and is authorized to receive benefits in the same amount as shown in the ongoing budget. Use this item to authorize benefits for the current and previous months.

ITEM 130: RSDI Increase Reserved

ITEM 131: T.R. (Type Review)

TANF and Medical Programs

Enter one of the following codes on Form H1000-A, Form H1000-B and Form H1000-C.

C — Complete

I — Incomplete

N — Nonreview activity (case maintenance)

ITEM 132: Action Code

TANF and Medical Programs

Enter the code that describes the reason for the action taken on the case. See C-200 for Item 132 codes.

ITEM 133: 3 MO. I (Three Months Prior Indicator)

TANF and Medical Programs

Enter the total number of unduplicated calendar months of three months prior Medicaid eligibility. Not applicable for TP 45.

ITEM 134: 3 MOS. PRIOR APP. DATE (Three Months Prior Application Date)

TANF and Medical Programs

When providing prior coverage enter the month and year of the original file date. This date cannot be later than the medical effective date (Item 46) by more than three calendar months. Not applicable for TP 45.

TANF

Use Form H1000-B and Form H1000-C when the requested medical effective date (Item 46) is within six months of the current process month.

ITEM 135: Reserved

ITEM 136: 4 MOS. POST/End Date

TANF

Enter the last month and year for TP 07/20 Medicaid coverage.

TP 40

Enter the second month and year following the expected delivery date.

TP 45

State Office Data Control enters the last month of forced coverage.

TP 43, TP 44, TP 47 and TP 48

Make no entry. This is a computer-calculated end date. If a one or two-month Medicaid extension is needed, update the end date for two months or less in this item, and enter "I" in Item 131.

ITEM 137: SAV (Budget TP)

TP 30

Enter the Budget TP indicator used to determine income eligibility. This is a required entry when processing three months prior or simultaneous open and close situations. Do not make an entry when processing denials.

Enter	For cases that include a
40	pregnant woman who meets the 185% FPIL income criteria.
43	child under age one who meets the 185% FPIL income criteria.
48	child age one through five who meets the 133% FPIL income criteria.
44	child age six through 18 who meets the 100% FPIL income criteria.
55	caretaker/second parent who meets MNIL income criteria.

If the income exceeds the limits and the case is eligible based on TP 55 income criteria with spenddown, enter 55.

ITEM 138: (Child Support Cooperation/Reason for Transfer to TP 07/20)

Enter the appropriate code to indicate child support cooperation or noncooperation.

R — Refusal without good cause to cooperate with child support for one or more absent parents.

C — Cooperation. Enter this code if Code R does not apply.

T — No proration when reinstating TANF after PRA cooperation.

Enter Code	If the case transfers to TP 07/20 because ...
E	of new or increased earned income or earnings of a returning absent parent who is added to the certified group.
S	of new or increased child support collections.
B	TANF denial results from a reason listed under Code E, and new or increased child support collections.
P	of PRA noncooperation.

ITEM 139: SPECIAL REVIEW

TANF and Medical Programs (except TP 40, TP 30 and TP 55 with Spend Down)

Enter the date of any contact planned before the date of the next periodic review, or the end of the budget period. For cases with a pregnant woman, enter the first day of the month following the month the pregnancy is anticipated to terminate.

ITEM 140: CODE

TANF and Medical Programs (except TP 40, TP 30 and TP 55 with Spend Down)

Enter the code for the type of special review needed.

1 — Employment Services/Work Registration (TANF only)

2 — School attendance

3 — (Reserved)

4 — Management

5 — Income/Expense changes anticipated

6 — Living arrangement change anticipated

7 — Medical review

8 — Household change anticipated. Note: Use to designate a review for cases with a pregnant woman

9 — Other

Q — Disability Hardship Exemption (TANF only)

To delete a special review date in Item 139, enter a pound sign in Item 140. This entry deletes the information in Items 139 and 140.

ITEM 141: PERIODIC REVIEW

TANF and TP 07, TP 20, TP 37 and TP 55 without Spend Down

Make no entry. This is a computer calculated and printed date of the next periodic review date. If incorrect, enter a new periodic review date in this item and "N" in Item 131.

TP 43, TP 44, TP 47 and TP 48

Make no entry. This is a computer-calculated date that reflects the next required periodic review. If the date is incorrect, enter a periodic review date in this item and "N" in item 131.

ITEM 142: HOLD CD: DATE

TANF and Medical Programs

Enter the appropriate hold or release code under CD. Make no entry under DATE. SAVERR enters the month after cutoff as the hold effective month.

Hold/Release Codes

Advisor

Hold Code 1

Use when the advisor cannot locate the individual and an investigation of the individual's location is pending. This code automatically denies the grant and Medicaid at cutoff of the hold month effective the first day of the hold month. Fiscal cancels any returned warrants and SODI cancels returned Form H3087, Medicaid Identification.

Release: Use Code 8 if the household does not have a new address. Use Code 9 if the household has a new address. Enter the new address on Form H1000-B.

Hold Code 2

Use when appointment of guardian is pending. SAVERR does not produce TANF benefits and Form H3087 until the advisor submits Form H1000-B releasing the hold.

Release: 9 – Enter the name of the guardian on Form H1000-B.

Hold Code 3

Use if changing the payee. SAVERR does not produce TANF benefits and Form H3087 until the advisor submits Form H1000-B releasing the hold.

Release: 0 – Enter the new payee information and complete Section XI on Form H1000-B to issue benefits for hold months.

Hold Code 4

Use when lowering benefits and the adverse action notice period expires between cutoff and the end of the month. SAVERR does not produce TANF benefits and Form H3087 until the advisor submits Form H1000-B releasing the hold.

Release: 0 – Use to release the hold after the adverse action expires. Enter the new budget and/or household composition and complete Section XI on Form H1000-Bto issue benefits for hold months.

Hold Code 5

Use when denying a case or transferring a case to TP 07 or TP 20 and Form H1000-B cannot be submitted because the adverse action period expires between cutoff and the end of the month.

When denying a case, SAVERR does not issue TANF benefits or Form H3087. SAVERR automatically denies the benefit and Medicaid at cutoff of the hold month effective the first day of that month. Fiscal cancels returned warrants and Data Control cancels returned Form H3087.

SAVERR automatically transfers a TP 01 case to TP 07 or TP 20 effective the first day of the next month. SAVERR produces Form H3087 when a case pending transfer is placed on Hold Code 5.

Release: Use Code 8 if the household does not have a new address, responds during the adverse action period, and qualifies for continued benefits. Use Code 9 if the household has a new address, responds during the adverse action period, and qualifies for continued benefits. Enter the new address on Form H1000-B.

State Office Use Only:

Computer-generated Codes

Hold Code A

Form H1000-B submitted to deny a case contains a fatal error not cleared by cutoff. The case remains on hold until the fataled Form H1000-B is corrected and processed. When the form is corrected and the case is denied, enter the correct Death/Denial Date in Item 47.

Release: Use Codes 8, 9 or 0 if the case is not denied.

Data Control Codes

Hold Code C

Form H3087 is returned with postal message: individual moved out of state. State office sends the advisor an RP-24B and sends the individual Form H1029, Notice of Case Action. Automatic denial of the grant occurs at cutoff of the hold month, effective the first day of the hold month. Automatic denial of Medicaid occurs effective the last day of the month before the hold. Apply this hold only when the message on the returned form H3087 indicates the individual has moved out of state.

Release: Use same release procedures described for Hold Code 1.

Hold Code D

Form H3087 is returned with postal message: deceased. State office sends the advisor RP-24B and holds returned warrants and Form H3087 until the advisor takes action to deny assistance or select a new payee.

Release: Use same release procedures described for advisor Hold Code 3.

Hold Code E

RESERVED

Formerly used when Form H3087 returned with postal message: unclaimed.

TANF

Advisor Codes

Hold Code 2

Use when appointment of a guardian is pending. SAVERR does not produce TANF benefits and Form H3087 until the advisor submits Form H1000-B releasing the hold.

Release: 9 – Enter the name of the guardian on Form H1000-B.

Hold Code 4

Use when lowering benefits and the adverse action notice period expires between cutoff and the end of the month. SAVERR does not produce TANF benefits and Form H3087 until the advisor submits Form H1000-Breleasing the hold.

Release: 0 – Use to release the hold after the adverse action period expires. Enter the new budget and/or household composition and complete Section XI on Form H1000-B to issue benefits for hold months.

State Office Use Only:

Computer-generated Codes

Hold Code 3

At least one refugee in a Category 05 case entered the United States more than eight months ago.

State office sends the advisor a RP-24B and holds warrants and Form H3087 until the advisor takes action to deny the case or delete the person(s) over the eight-month limit.

Release: 0 – Release benefits when deleting all people over the eight-month limit. Deny the case if all members are over the eight-month limit.

Hold Code 6

Case is automatically being denied or transferred to TP 20 because of receipt of child support.

Release: 0 – Use to release and make required entries in Section XI.

Hold Code H

Status-in-group Code 5 individual is age 19 or older. The effect is the same as Hold Code C.

Release: The release procedures are the same as Hold Code 1.

Hold Code L

Individual's state time limit is expiring and SAVERR cannot rebudget the TANF case. Advisor action to rebudget the case is required.

Release: 0 – Release hold and make required budget and Section XI entries.

Hold Code Z

The EBT account is dormant because the household has not accessed it for three consecutive months or six consecutive months when the most recent monthly issuance is less than $20.

Release: The release procedures are the same as Hold Code 1.

Fiscal Codes

Hold Code F

Warrant returned as undeliverable. The effect is the same as Hold Code C.

Release: The release procedures are the same as Hold Code 1.

Hold Code G

Warrant returned with message: deceased. The effect is the same as Hold Code D.

Release: The release procedures as the same as for advisor Hold Code 3.

Hold Code J

Warrant charged back.

Release: Hold is released only by Fiscal Division.

Data Control Codes

Code R

SDX Hold

SDX Release Codes

Code S

Mail benefits using address on SDX.

Code T

Denied

Code X

Deceased

Medical Programs

Advisor Codes

Hold Code 4

Pending assignment of protective payee.

Release: 0 – Release hold and enter protective payee information.

State Office Use Only

Computer-generated Codes

Code 3

Occurs at cutoff in the month:

- a SIG Code 4 child on a TP 44 case becomes age 19, and each following month until the advisor denies TP 44 coverage for the child;
- a SIG Code 4 child on a TP 47 or 55 case becomes age 19; or
- the corresponding case for the mother of the TP 45 child is placed on hold.

Release: Use Code 0.

TP 40

State Office Use Only

Computer-generated Codes

Code H

Occurs at cutoff in the month entered in Item 136. If the advisor does not take action, automatic denial will occur at the cutoff in the following month.

ITEM 143: F. ACT (Future Action)

TANF and Medical Programs

Enter the appropriate action code if placing the case on hold with Code 5.

ITEM 144 - 148: Reserved

ITEM 149: CODE

TANF and Medical Programs

Use on earned income cases only. Enter C for a child care deduction. This entry requires an entry on the same line in Item 152.

To delete this entry, enter "C" in Item 149 and 0 in Item 152 on the appropriate line.

TANF

Enter 9 for

- a 90% earned income deduction up to $1400 per employed member. This entry requires entries on the same line in Items 151 and 152.

- 12 or 18 months additional Medicaid coverage. This entry requires an entry on the same line in Item 151.

ITEM 150: FROM Reserved

ITEM 151: THRU

TANF

Enter the last month of the four-month period of the 90% earned income deduction on the line with Code 9. This also contains the TP 37 end date.

ITEM 152: AMOUNT

TANF and Medical Programs

Enter the last month of the four-month period of the 90% earned income deduction on the line with Code 9. This also contains the TP 37 end date.

TANF

Enter the allowable amount of actual child care costs on the Code C line.

SNAP

Complete only for cases in which an individual receives or anticipates receiving a TANF child support disregard payment from the Office of the Attorney General (OAG). Enter an amount anytime you

- certify these cases for ongoing benefits, or
- make a change to Form H1000-B that will affect the budget, including disqualifications, changes in household composition, or shelter costs.

Enter six numbers indicating the amount of child support received from the OAG to be budgeted.(**Example:** $25 as 002500.) Enter 000000 if payments were previously reported and have now terminated.

These entries are no longer required if, for the two previous months, the OAG has not reported payments to the individual.

Always enter an amount in Item 56 if you enter an amount in this item.

C—520.9 Section IX, Items 153 - 160

Revision 02-3; Effective April 1, 2002

ITEM 153 - 160

All Programs

Make no entries in these items.

C—520.10 Section X, Items 161 - 178

Revision 02-3; Effective April 1, 2002

CC (Case Classification)

All Programs

The codes in Section X are not stored in the computer file. They are kept for individual transactions only and are used to complete management reports.

ITEM 161 - 163: Reserved

ITEM 164: Case County/Home Telephone No.

All Programs

Enter the three-digit code for the individual's residence county, followed by a space. After the space, enter the individual's ten-digit telephone number, including the area code.

Notes:

- See C-350 for the county codes.
- Enter the county associated with the worker's BJN in Item 25.
- Enter only the individual's home telephone number. If the individual has no home telephone number, leave blank.

ITEM 165 - 167: Reserved

ITEM 168 - 170: Program Combination Code(s)

All Programs

Use program codes to indicate whether the case action associated with the Form H1000-A, Form H1000-B and Form H1000-C is worked alone or generically with other programs.

PROGRAMS	PROGRAM CODE
TANF only	A
TANF-SP only	U
FS only	F
MP only	M
TANF/FS	AF
TANF-SP/FS	UF
FS/MP	FM
TANF/MP	AM
TANF-SP/MP	UM
TANF/FS/MP	AFM
TANF-SP/FS/MP	UFM

ITEMS 171 - 178: Reserved

C—520.11 Section XI, Items 179 - 187

Revision 04-3; Effective April 1, 2004

TANF

Use this section instead of Form H1008, Authorization for Cancellation or Issuance of Public Assistance Warrants, to request benefits in situations described in the instructions for Item 180. Use Form H1008 to process all other requests for warrant actions. Use this section only for Category 2, TP 01 or 61 cases, or cases being transferred to TP 01 or 61.

Recoupment cannot be done on a benefit requested in Section XI.

SNAP

Use this section to request the issuance and cancellation of benefits.

When reporting a SAVERR or ATA issuance timely on Form H1000-A, Form H1000-B andForm H1000-C, complete Items 118-122 (if appropriate), 179, 180, 183, 184, 185, 186 (if appropriate), and 187.

When reporting an ATA issuance untimely, complete Items 118-122 (if appropriate), 179, 180, 181, 182, 183, 184, 185, 186 (if appropriate), and 187.

TP 55 and 30

Use this section on Form H1000-A with Item 46 to identify any eligible (non-spend down) or potentially eligible (spend down) prior coverage month(s). Use one line for each prior month. Use this section only for consecutive months, with or without spend down. A separate Form H1000-A will be required for any prior coverage months followed by a gap in eligibility. For this section, months with spend down are not considered gaps in eligibility.

Entries in this section for prior coverage cannot precede:

- the third month before the month in Item 08;
- the earliest month of medical coverage entered in Item 46 for any person.

ITEM 179: ISS/CAN (Issue/Cancel)

TANF

Enter one of the following codes to indicate the type of benefit being requested:

1 — Full month's amounts

2 — Additional benefits for a month; Form H1000-B use only

SNAP

Enter one of the following codes to indicate the method of issuance or to request a cancellation:

S — Untimely reporting EBT issuance via ATA to clear a discrepancy report RF-07E-1. This code can only be used with Code 1 or 3 in Item 180.

E — Requesting EBT issuance or timely reporting EBT benefits issued via the ATA.

N — Requesting cancellation of benefits.

5 — Historical Information: State-office entered. Used to identify a CCDMI as a certified mail issuance. No longer in use effective April 1, 2004.

C — Historical Information: State-office entered. Used to identify a CCDMI that was cancelled. No longer in use effective April 1, 2004.

TP 55 and 30

Enter the appropriate code for each prior month in which a case is eligible or potentially eligible.

N — Not eligible for Medicaid until spend down is met

E — Eligible for Medicaid without spend down

Make no entry for ineligible months. The months reported in this section must be consecutive months of eligibility, with or without spend down.

ITEM 180: TYPE ISS.

TANF

Enter the reason for authorization:

9 — Action Code 090, simultaneous open and close on Form H1000-A only. Use to request allowable warrants from Item 129, Grant Effective Date, through Item 47, Denial Date, if the amount equals Item 70, Recommended Grant.

B — Change in both household composition and money reflected in the budget

F — Additional benefits issued due penalty imposed in error

H — Change in household composition

M — Change in money reflected in the budget

Note: Use B, H, and M for certifications and reinstatements, action Codes 57 or lower, to request allowable benefits for the month(s) before the Item 129 entry. These codes identify why the prior amount is different from Item 70, Recommended Grant, amount.

Also use B, F, H, and M to issue additional amounts for months in which benefits have already been produced. These codes identify why the additional amount is requested.

Use these codes to issue a benefit for the current or previous month when releasing hold with Code 0 or 7 in Item 142.

O — Retroactive and/or current month's benefit when releasing a case from hold with release Code 0or 7 in Item 142. Use for a benefit amount equal to the grant amount to be printed in Item 70.

P — Budgeting process requires different payment month benefits. Enter Code 1 in Item 179. Use for a benefit amount different than the amount to be printed in Item 70.

R — (State office use only.) Identifies on the history file benefits produced when release Code 8or 9 is used to release a case from hold. These benefits will always be for the recommended grant amount previously on file, not a recommended grant amount changed at the time the hold is released on Form H1000-B andForm H1000-C.

T — Transfer from TP 07, 20 , 29, or 37 to TP 01 or 61 (Form H1000-B and Form H1000-C use only).Use to issue a benefit of the same amount for the previous month, if needed. The advisor must ensure that the benefit amount requested is equal to the new grant amount that is printed in Item 70. Use Form H1008 to request a benefit for a different amount or an earlier month.

SNAP

Enter one of the following codes to indicate the type of benefit requested:

Full Regular Ongoing Benefits or Replacement of These Benefits

A — Initial benefit (regular ongoing benefit).

E — Initial expedited benefit issued through

- SAVERR to meet timeliness requirements, or
- the ATA and reported timely in Section XI.

Also use for the second month on an expedited case when issuing the second month's benefits as a combined allotment and the first month's benefit cannot be issued because it prorates to less than$10.

H — Use to issue a benefit through SAVERR as a priority issuance to meet timeliness for a hearing officer decision. Do not use when timeliness can be met using another applicable code.

L — Restored full month's benefit for a past month.

1 — Use only to clear discrepancy report RF-07E-1, generated because the benefit was issued via the ATA and was not reported timely in Section XI. On inquiry, an issuance coded E by the advisor displays as a Code 1 if the benefit was issued via the ATA.

2 — Priority benefits issued through

- SAVERR to meet non-expedited application timeline requirements, or
- the ATA to meet non-expedited application timeliness requirements and reported timely in Section XI.

3 — Use only to clear discrepancy report RF-07E-1, generated because the benefit was issued via the ATA and was not reported timely in Section XI. On inquiry, an issuance coded 2 by the advisor displays as Code 3 if the benefit was issued via the ATA.

All issuances coded A, E, 2, or L in Item 180 must balance using Items 184, 185, 186 (if applicable), and 187.

Potential Item 180 code combinations for applicants receiving combined allotments are:

First Month Code	Second Month Code
E (Expedited)	2
2 (Timely)	2
No issuance*	E

A (Regular)	A
No issuance*	2
No issuance*	A
1 (Expedited-ATA; reported untimely)	3
3 (Expedited-ATA; reported untimely)	3
No issuance*	1
No issuance	3

*1st month not issued due to proration

Additional Benefits for a Month

C — Supplemental benefits. Use when providing benefits in addition to initial benefits for the current month or following month if submitting Form H1000-A,Form H1000-B andForm H1000-C after cutoff.

D — Restoration benefits. Use when restoring partial benefits for a past month.

F — Supplemental or restoration benefits. Use when providing additional benefits for a month in which the household has already received one issuance coded C and/or one coded D.

P — Restore an erroneously expunged EBT benefit.

Destroyed Food

T — Replacement of destroyed food, that was purchased with SNAP benefits.

Historical Information: State office also uses this code to replace CCDMIs that are lost/stolen within the postal system. No longer in use effective April 1, 2004.

Every month must have an uncanceled A, E, 1, 2, 3, or L before an issuance coded C, D, F, P, or Tin Item 180 can be processed. To replace a canceled issuance, always use the same code in Item 180.

Only one type issuance Code C or D is allowed per month. Codes C and D issuances are allowed for the same month. Code C cannot be used for month already having a type code L issuance. Code F cannot be used unless type code C or D has been issued for the month.

Advisor entered cancellation

G — Use to cancel EBT benefit because the household has moved out of state. Use code N in Item 179.

State Office-entered

4 — Historical Information: CCDMI mailed out of state as a result of converting EBT benefits to coupons. No longer in use effective April 1, 2004.

5 — Historical Information: Benefits placed back in an EBT account after a CCDMI was returned and cancelled. No longer in use effective April 1, 2004.

These codes do not appear on Form H1000-B. These are in the benefit history file that is available through inquiry.

ITEM 181: ATP/BENEFIT NUMBER

TANF and SNAP

Issuance numbers issued via EBT have two leading alpha characters (**Example:** AA12345).

TANF

Make no entry. SAVERR assigns issuance numbers.

SNAP

Make no entry if requesting an issuance or reporting an ATA issuance timely.

SAVERR assigns an issuance number when authorizing an issuance or when the EBT system reports an issuance.

Priority Issuance Numbers:

- Issuance numbers beginning with ZX indicate priority issuances processed via the ATA that were not reported on Form H1000-A, Form H1000-B andForm H1000-C within five days.
- A code X after an issuance number indicates SAVERR sent the benefit record to the vendor system as a priority issuance. SAVERR sends benefits as priority issuances only if the advisor uses code E in Item 179 and code E, H, or 2 in Item 180.

ITEM 182: ISSUE DATE

TANF

Enter only on Form H1000-B and Form H1000-C when requesting a prorated benefit resulting from the transfer of a case from TP 07, 20, 29, or 37 to TP 01 or 61.

SNAP

Enter the date benefits were issued if canceling an issuance.

Enter the issue date if reporting an ATA issuance untimely to clear an RF-07/37E-1.

In the Issue Date (ISSUE DT) column, SAVERR inquiry displays an asterisk (*) for the second month's benefit of a combined allotment if it is issued before cutoff of the application month. This information does not appear on Form H1000-B. It is in the benefit history file that is available through inquiry.

ITEM 183: BENEFIT MONTH

TANF and SNAP

Enter the month and year for which the benefits are requested. Use a separate line for each benefit month entered.

SNAP

Historical Information: In the EFF column, SAVERR inquiry displays the date a CCDMI was processed instead of the benefit month. This information does not appear on Form H1000-B. It is in the benefit history file that is available through inquiry. No longer in use effective April 1, 2004.

TP 55 and 30

Enter the month and year for the prior coverage month in which a case is eligible or potentially eligible.

ITEM 184: NET INCOME

TANF, SNAP, TP 55 and 30

Enter the whole dollar amount of net income that applies to the benefit month in Item 183.

ITEM 185: BENEFIT AMOUNT

TANF

Enter the benefit amount requested.

SNAP

Enter the amount of the benefit being issued. If recouping $8 from a $10 allotment, enter $2.00

TP 55 and 30

Enter the spend down amount for that month. Enter 0 if there is no spend down.

ITEM 186: OTHER DATA (Initial Month and Code)

TANF

When issuing a benefit (prorated, full, or supplemental) in Section XI that is reduced because of a financial penalty, enter the penalty amount and penalty code in Item 186. If the benefit is reduced because of multiple penalties, enter the amount and Code U (multiple penalties). Enter the adjusted benefit amount (the benefit amount minus the penalty amount) in Item 185.

If a supplement is issued because a penalty was imposed in error, enter Code F in Item 180 and code (supplemental restored benefit) in Item 179.

SNAP

Do not recoup on a Section XI issuance or a prorated initial month's benefits. Enter the appropriate initial month code in this item and record the dollar amount.

If you are not prorating the initial month's benefits, leave this item blank. Make the following entries if you are prorating benefits:

Issuance Type	Cents Field	Dollar Field
SAVERR or ATA issuance reported timely on Form H1000-A, Form H1000-B and Form H1000-C.	P	No entry.
ATA issuance reported untimely (code S entered in Item 179).	P	Enter the amount subtracted from the whole monthly benefit because of proration. **Example:** A $100 allotment prorates to $60. Enter $60 in Item 185, P in Item 186 cents field, and $40 in the dollar field.

For all issuances coded C, D, F, H, P, or T in Item 180, enter in the cents field the range code below that corresponds to the issuance amount in Item 185. Do not make an entry in the dollar field.

Range Code	Issuance Dollar Amount	Range Code	Issuance Dollar Amount
A	$1 - 49	H	$350 - 399
B	50 - 99	J	400 - 449
C	100 - 149	K	450 - 499
D	150 - 199	L	500 - 549
E	200 - 249	M	550 - 599
F	250 - 299	X	600 or over
G	300 - 349	-	

These codes are not needed for benefits coded A, E, L, or 2 since these type of benefits must correspond to entries in Item 184, Net Income and Item 187, Household Size.

ITEM 187: H.H. NO. (Household Number)

TANF

Enter the household composition for the benefit requested.

Digit	Number of individuals with status in group Code
1st	7 and 8. The maximum number is two. If none, enter 0.
2nd and 3rd	5. If none, enter 00. If there are less than ten members with SIG 5, enter 0 for the 2nd digit and number SIGs 5 in the 3rd digit.

Example: One adult and three children – 103.

SNAP

Enter the number of people in the SNAP household whose benefits are included in the issuance reported.

TP 55 and 30

Enter the household composition for the month.

Digit	Number of
1st	adults in the budget group.
2nd and 3rd	children in the budget group. Include the unborn child in this entry for cases with an 01 entry in Item 128, base plan.

For budget group with less than 10 children, enter 0 for the second digit.

These entries must correspond with Items 184 and 185.

C—520.12 Section XII

Revision 02-3; Effective April 1, 2002

All Programs

SAVERR completes this section to report the status of a denied application, the case status and the form effective date.

ITEM: (App. Code) (Action Code) (Action Date)

SNAP

SAVERR prints the denied application information in this section. This information appears only in Section XII, and not in Items 79, 91, and 92.

ITEM: CASE STATUS

All Programs

This item shows the current status of the case: active, denied, or hold.

ITEM: FORM EFF. DATE

All Programs

This item shows the form effective date of the previously submitted Form H1000-A, Form H1000-B andForm H1000-C.

On Form H1000-B and H1000-C with Sequence 02, the form effective date is the first of the month that the input document was entered on SAVERR.

On Form H1000-B and Form H1000-C with sequences 03 and above, the form effective date is the date the action reported on the previous Forms H1000-B and Form H1000-C becomes effective according the SAVERR cutoff cycles.

C—520.13 Section XIII

Revision 02-3; Effective April 1, 2002

TANF and SNAP

SAVERR records on the Form H1000-B turnaround the monthly benefit issuance history for the current and past 11 months.

TP 55 and 30 with Base Plan of 55

SAVERR prints the three months prior spend down on Form H1000-B turnaround.

ITEM: ISS./CAN./RESULTS

TANF

This item records the authorization code from Item 180 and the benefit amount from Item 185.

SNAP

This item records the advisor entries from Items 179 and 185.

ITEM: DATE

TANF

This item lists the month of eligibility for which the benefit was issued.

SNAP

This item records the month and year for which benefits are authorized (benefit month).

ITEM: ISSUED/NO.

TANF

This item lists the number of issuances for the month of eligibility.

SNAP

This item records the number of issuances the household is issued for the month.

ITEM: ISSUED/PERSONS

SNAP

This item records the household size listed on the last benefit issued for the month.

ITEM: ISSUED/AMOUNTS

TANF

This item lists the amount of benefits issued for the month.

SNAP

This item records the household's cumulative benefit allotment, including supplemental benefits and replacement issuances, less any cancelled benefits.

ITEM: REDEEMED/NO.

SNAP

This item records the cumulative number of issuances for the household.

ITEM: REDEEMED/PERSONS

SNAP

This item is not used.

ITEM: REDEEMED/AMOUNT

SNAP

This item is a record of the amount of benefits issued monthly.

ITEM: CD

TANF

The code in this column indicates deductions made from recognizable needs. (R = Recoupment deduction)

SNAP

This item records the type of the last issuance processed in the month.

C—520.14 Section XIV, Items 188 - 191

Revision 02-3; Effective April 1, 2002

ITEM 188: SIGNATURE

All Programs

The advisor completing Form H1000-A, Form H1000-B andForm H1000-C signs and enters his unit number in this space.

ITEM 189: DATE SIGNED

All Programs

Enter the date Form H1000-A, Form H1000-B or Form H1000-C is signed.

TANF

Exception: When certifying a TANF application, enter the certification date. This should be the date entered on the TANF worksheet. SAVERR prorates benefits for the first month of eligibility from this date or the 30th day after the file date, whichever is earlier.

ITEM 190: EMP NO

All Programs

Enter the employee number of staff signing Form H1000-A, Form H1000-B and Form H1000-C.

ITEM 191: TP ONLY

All Programs

Data Communications Unit use only. Make no entry.

Medical Programs

When the record of case action is received, the advisor or clerical reviewer edits, initials, and dates the form. If the turnaround document contains an error or warning message, the clerical reviewer must not initial and file it, but must immediately send it to the advisor.

C—530 Form H1000-C, Secondary Client Input Instructions

Revision 05-4; Effective August 1, 2005

TANF and SNAP

UseForm H1000-C to enter start and end dates for PRA penalties and good cause. Form H1000-A and Form H1000-B must be submitted with Form H1000-C, but Form H1000-C is not always required when submitting Form H1000-A and Form H1000-B. SAVERR does not produce a turnaround for Form H1000-C.

C—530.1 Section I, Items 01 - 07

Revision 08-4; Effective October 1, 2008

ITEM 01: App./Case No.

TANF and SNAP

Enter the application or case number.

ITEM 03: Seq. No.

TANF and SNAP

Enter the same sequence number from Form H1000-A andForm H1000-B.

ITEM 04: Pg. No.

TANF and SNAP

Enter the same page number the individual is listed on Form H1000-A and Form H1000-B.

ITEM 06: BJN

TANF and SNAP

Enter the employee's BJN.

ITEM 07: Mail Code

TANF and SNAP

Enter the office mail code.

ITEM 09: Case Name

TANF and SNAP

Enter the same case name from Form H1000-A and Form H1000-B.

C—530.2 Section II, Items 201 - 213

Revision 05-5; Effective October 1, 2005

ITEM 201: PAR. SKILLS

TANF

When an individual is referred or has completed Parenting Skills training, enter code

R — Eligibility referred the individual to parenting skills training, or

C — Eligibility verified that the individual completed parenting skills training.

SAVERR stores Code R or C on Client Screen A, Welfare Reform Data, under Parenting Skills status. In addition, the status of J appears in this SAVERR field when the Choices system verified that the individual completed parenting skills training as a Choices component.

ITEMS 202, 205, 208, and 211: TYPE

TANF

When starting or ending a penalty or good cause, enter the following codes in these items

- Penalty Codes

  T — Third or subsequent noncooperation with Choices

  S — Second noncooperation with Choices

  F — First Noncooperation with Choices

  C — Child Support

  V — Voluntary Quit

  E — Texas Health Steps

  G — Immunizations

  A — School Attendance - child

  M — School Attendance - minor parent

  P — Parenting Skills Training

  D — Alcohol or Drugs

  U — Unidentifiable penalty - Use this code when making Section XI entries only and the benefit is being reduced by more than one penalty.

- Good Cause Codes

  1 — Individual is on an alternate schedule for immunizations

  2 — Good cause for immunizations due to medical reasons

  3 — Good cause for immunizations due to conscientious objection

  4 — Grace period

  6 — Good cause for noncooperation with Texas Health Steps

  7 — Good cause for noncooperation with Parenting Skills Training

  Note: Good cause Code 5 is sent through the Choices automated system.

ITEMS 203, 206, 209, and 212: Start

TANF

Enter the month and year the penalty starts. At application, start a child support or voluntary quit penalty beginning the application month.

On incomplete and complete reviews, the start date cannot be earlier than three months before the current cutoff month or later than the next SAVERR effective month.

ITEMS 204, 207, 210, and 213: End

TANF

Enter the month and year the penalty ends.

SAVERR does not allow entry of future end date. The end date cannot be later than the SAVERR effective month.

C—530.3 Section III, Items 214 - 215

Revision 09-4; Effective October 1, 2009

ITEM 214: FIC (R/E) (Finger Image Code)

TANF and SNAP

Enter finger image codes for required individuals at application and at complete review/recertification, including simultaneous open and close transactions. Finger image codes are not required on denials or Temporary Assistance for Needy Families (TANF) complete reviews with a future action code of a denial.

If the correct finger image code is not already on the System for Applications, Verifications, Eligibility Reports and Referral (SAVERR), enter a finger image code for each household member who is:

- age 18 or older as of the interview date;
- a minor parent (secondary SIG L) on a TANF case with a dependent child on the same case; or
- a minor head of household (SIG A) on a Supplemental Nutrition Assistance Program (SNAP) case.

Enter one of the following finger imaging codes:

- **Y** — all available images have been taken

- **Z** — one image has been taken (**Note:** This includes a finger image that Lone Star Image System (LSIS) determines to be temporarily unavailable because of low quality.) or

- one of the following exemption codes:

  A — appeal pending (TANF related)

  B — low quality image/physically unable to image/equipment failure

  C — certified out of office or unable to travel to the LSIS site to be imaged

  D — undue burden for disabled individual

  E — undue burden for elderly individual

  F — disqualified (SNAP only) **Note:** If SAVERR has no finger imaging code andForm H1000-C, Secondary Client Input, has no entry, the finger imaging code defaults to F for individuals with SIG G, or SIG K or T when the individual is over 18.

On expedited SNAP cases for required members:

- present at the interview, enter the appropriate
  - finger image code and vendor unique number (VUN); or
  - finger imaging exemption code.
- not present at the interview, allow Code C until the next recertification or reapplication.

Automated Changes

The advisor cannot change Codes I or Y on Form H1000-C. SAVERR performs this automated conversion as described in the following chart.

If the individual's status changes from ...	and SAVERR has code ...	then SAVERR ...
inactive to active	I	• changes the code to Y, and • sends a message to LSIS to remove the archive date.
active to inactive	Y	• changes the code to I, and

- sends a message to LSIS to set the archive date.

SAVERR also sends a message to LSIS to set the archive date on inactive individual records with Code Z, but does not change the code.

SAVERR automatically deletes the finger Code I or Z when LSIS notifies SAVERR that it purged the finger image record. The LSIS purges the finger image record after the individual is inactive for 12 months.

Changing, Correcting or Deleting Finger Image Codes

Finger image exemption codes remain on SAVERR until it purges the individual record.

If the advisor needs to change ...	to ...	then ...
Code Z	Code Y,	enter the new code on Form H1000-C.
an exemption code	Code Y,	enter the new code and VUN, on Form H1000-C.
an exemption code	another exemption code,	enter the new code on Form H1000-C.
Codes Y or Z	an exemption code,	• deletes the Y or Z through the force change process using Form H1075, Welfare Reform Force Change Request, for TANF individuals or Form H1074, SNAP Force Change Request, for food benefit individuals, and • enter the new code on Form H1000-C after the forced change processes.
Code I	an exemption code	• follow the procedures listed above for Codes Y and Z, or • allow the vendor's automated purge process to delete the code if the LSIS record is approaching its archive date.

ITEM 215: Vendor's Unique Number

TANF and SNAP

If the entry in Item 214 is Y or Z, enter the nine-digit VUN.

The VUN contains a "check digit," an automated aid for validating data. If the check digit indicates the advisor did not enter the VUN correctly, Form H1000-C will not process.

SAVERR does not store the VUN, but uses it to associate the SAVERR client number with the finger image record on the vendor's system.

C—530.4 Section IV, Items 216 - 223

Revision 07-4; Effective October 1, 2007

ITEM 216: ADD

SNAP

Enter the code(s) to indicate that an individual is being disqualified for one or more of the following reasons, even if the disqualification results in case denial. Once entered, these codes remain on the System for Applications, Verifications, Eligibility Reports and Referral (SAVERR) until removed by an entry in Item 217.

B — Ineligible alien without a U.S. Citizenship and Immigration Services (USCIS) document

C — Ineligible aliens with USCIS document

D — Felony drug conviction

F — First offense failure to comply with Employment Services Program (ESP) requirements (employment and training/voluntary quit/reducing work hours to less than 30)

J — Fugitive

N — Failure to meet the Social Security number (SSN) requirement

S — Second offense failure to comply with ESP requirements

T — Third or subsequent offense failure to comply with ESP requirements

W — Failure to comply with the 18-50 work requirement

Note: Send Form H1074, SNAP Force Change Request, to correct SAVERR information on:

- active individuals to delete the drug disqualification code; or
- denied individuals to add or delete a disqualification code or change the employment and training/voluntary quit counter.

ITEM 217: Remove

SNAP

Enter a code below to remove a code, end a specific type of disqualification or change a Supplemental Nutrition Assistance Program (SNAP) time-limited benefit code. Enter one of the following codes to indicate the action needed.

1 — Delete the first countable month

2 — Delete the second countable month

3 — Delete the third countable month

4 — Delete the fourth countable month (first month of second three month period)

B — End the ineligible alien (undoc) disqualification

C — End the ineligible alien (doc) disqualification

F — End the first offense SNAP ESP disqualification

J — End the fugitive disqualification

L — Subtract one offense from the ESP offense counter (when entering code L, do not enter Code F, S or T in Item 216 on the same Form H1000-A, Notice of Application, Form H1000-B, Record of Case Action andForm H1000-C, Secondary Client Input, transaction)

N — End of the SSN disqualification

S — End the second offense SNAP ESP disqualification

T — End the third offense SNAP ESP disqualification

W — End the 18-50 work requirement disqualification

ITEMS 218 - 223

SNAP

Make entries in these fields to report that HHSC has authorized a SNAP benefit for acountable month of the initial or second three-month period of time-limited benefits in a 36-month period for an individual age 18-50. Make entries of Code(s) 1-4 in Items 218 and the corresponding month(s) in Item 219.

Items 220-223 can be used on the same Form H1000-A,Form H1000-B andForm H1000-C transaction when necessary to simultaneously report up to three months of countable issuances. If the advisor needs to report four months simultaneously, the fourth month (first month of second three-month period) must be reported on a subsequent Form H1000-C.

SAVERR does not automatically update the months of countable time-limited SNAP benefits received by an individual age 18-50. The advisor must update SAVERR each time when submitting Form H1000-A, Form H1000-B and Form H1000-C.

Staff do not have to enter the last month of the 36-month period. SAVERR computes it based on the months entered by the advisor as the first countable month of the initial three-month period of time-limited benefits, and displays it on inquiry.

On the same Form H1000-C, staff can delete months using Item 217 and enter corrected months in Items 218-223.

ITEM 218: CODE (Countable Month Code)

SNAP

Enter one of the following codes and a corresponding month in Item 219:

1 — Benefit authorized for the first month of the initial three-month period

2 — Benefit authorized for the second month of the initial three-month period

3 — Benefit authorized for the third month of the initial three-month period

4 — Benefit authorized for the first month of the second three-month period

ITEM 219: MONTH (Countable Month MMYYYY)

SNAP

Enter the month and year corresponding to the code entered in Item 218. The month cannot be greater than the SAVERR effective month.

ITEM 220: CODE (Countable Month Code)

SNAP

If more than one month needs to be reported on the same Form H1000-A, Form H1000-B amdForm H1000-C, enter the appropriate code (2, 3 or 4) to indicate that HHSC has authorized a SNAP benefit for a second, third, or fourth (first month of second three-month period) countable month. Enter a corresponding code in Item 221.

ITEM 221: MONTH (Countable Month MMYYYY)

SNAP

Enter the month and year corresponding to the code entered in Item 220. The month cannot be greater than the SAVERR effective month.

ITEM 222: CODE (Countable Month Code)

SNAP

If more than two months needs to be reported on the same Form H1000-A, Form H1000-B, Form H1000-C, enter the appropriate Code 3 or 4, to indicate that HHSC has authorized a SNAP benefit for a third or fourth countable month. Enter the corresponding month in Item 223.

ITEM 223: MONTH (Countable Month MMYYYY)

SNAP

Enter the month and year corresponding to the code entered in Item 222. The month cannot be greater than the SAVERR effective month.

C—530.5 Section V

Revision 02-3; Effective April 1, 2002

ITEM 190: Emp. No.

TANF and SNAP

Enter employee number of staff member completing form.

C—540 Code Summary

Revision 08-4; Effective October 1, 2008

TANF and SNAP

This section contains a Form H1000-A, Notice of Application, Form H1000-B, Record of Case Action, andForm H1000-C, Secondary Client Input, instructions code summary.

ITEM 02: Category

TANF

2 — TANF

5 — Refugee Cash Assistance (RCA)

SNAP

6 — Public Assistance (PA) SNAP Case

8 — Refugee, PA SNAP

9 — Non-PA SNAP Case

ITEM 03: Sequence No. (SEQ)

TANF and SNAP

Y — Yes

Item 27: Modifier (M)

TANF

P — Protective Payee

R — Representative Payee

SNAP

I — Authorized representative (AR) is a member of household (under the same roof).

O — AR is not a member of household (not under the same roof).

F — AR is an employee of a drug and alcohol treatment/group living arrangement facility.

ITEM 28: Indicator Code

TANF

M — Incapacity

TANF-UP

U — (system entered when TP 61 transfers to TP 07, 20 or 37)

SNAP

1 — Streamlined reporting (SR) household with total gross monthly income that is less than or equal to 130% of the Federal Poverty Income Limits (FPIL).

2 — SR household with total gross monthly income that is greater than 130% FPIL.

3 — Non-SR household.

ITEM 32: Client Number

TANF and SNAP

2 — Check for an existing number.

ITEM 35: Sex

TANF and SNAP

M — Male

F — Female

ITEM 36: Race

TANF and SNAP

1 — White

2 — Black

3 — Hispanic

4 — American Indian or Alaskan Native

5 — Asian or Pacific Islander (includes Indochinese)

6 — Computer entered code indicating inappropriate or omitted code. Must be corrected.

ITEM 39: Education/Service Code

TANF and SNAP

1 — First Grade

2 — Second Grade

3 — Third Grade

4 — Fourth Grade

5 — Fifth Grade

6 — Sixth Grade

7 — Seventh Grade

8 — Eighth Grade

9 — Ninth Grade

A — Tenth Grade

B — Eleventh Grade

C — High School Graduate/completed general equivalency diploma

E — Attending college or completed some college but has not graduated from a four-year college

F — Graduate of a four-year college

N — No formal education

ITEM 40: Status in Group

TANF

Primary Codes

2 — Disqualified/ineligible child or second parent

3 — Noncertified child: Identifies the only deprived child of the certified caretaker/second parent

If the child receives ...	then enter SIG Code
SSI	3
Foster Care Payments	3F
Adoption Assistance payments	3A

5 — Certified Child

7 — Second Parent

8 — Caretaker

9 — Payee

0 — Case Name Only:

Secondary Codes

G — Reached End of Time Limit

H — Eligible Refugee

I — Ineligible Child

K — Child of a Minor Child

L — Minor Parent with a Dependent Child

M — Eligible Only for Three Months Prior Medical Assistance

N — Ineligible for Retroactive Medical Assistance and Current Assistance

P — Private Health Insurance

Q — Proof of THSteps Screening

R — HHSC Employee

S — Alien with Acceptable Alien Status

T — Ineligible Alien

U — Ineligible - No Citizenship Proof

V — Living in Nursing Home

W — Disqualified Child

X — Deceased

Y — Disqualified Second Parent

Z — Migrant

SNAP

Head of Household Codes

A — Household head

G — Household head is nonmember

GK — Head of household disqualified for a reason other than an IPV

GT — Head of household is disqualified for intentional program violation (IPV)

Other Codes

B — Student

C — ABAWD not meeting 18-50 work requirement

D — ABAWD meeting 18-50 work requirement

F — Resident of drug and alcohol treatment/group living arrangement facility

H — Eligible Refugee

K — Disqualified for a reason other than IPV

M — Migrant, out of work stream

R — HHSC Employee

S — Eligible Alien (not a refugee)

T — Disqualified for Intentional Program Violation

U — Seasonal Farm Worker

W — Migrant, in work stream

ITEM 41: Employment Services/Work Registration

TANF

Codes	Explanation
A	Child (SIG 5 or 5L)
B	Caretaker or second parent, age 18 or younger attending school
C	Caring for an ill or disabled child in the household, even if the child is not a member of the certified group
E	Unable to work due to a disability expected to last more than 180 days
F	60 years of age or older
G	Caring for a child (SIG 2, 3, or 5) under age 1
H	Presence required in home due to illness or incapacity of another adult household member and the disability is expected to last more than 180 days
J	Not subject to participation – not a certified TANF individual
K	Pending during appeal of denial or disqualification
L	County Hardship Exemption
M	Mandatory registrant
N	Employment Hardship Exemptions
P	Mandatory registrant employed or self-employed 30 or more hours per week and earning at least $700 a month
Q	Severe Personal Hardship Exemption
R	Caring for child under age 1 who is not listed on Form H1000-A, Form H1000-B andForm H1000-C
T	Pregnant and unable to work

U	A single grandparent age 50 or over caring for a child under age three
V	An SSI recipient parent.
W	Identifies a individual who noncomplies with the Choices program
X	A parent who has exhausted state time limits.
Y	A parent who is disqualified due to third party resource (TPR) requirements, Social Security number requirements, intentional program violation, failure to report a child's absence, being a fugitive, having a felony drug conviction, failure to cooperate with Quality Control or noncompliance with the unmarried minor parent domicile requirement.

SNAP

Codes	Explanation
A	Child age 16 years of age or child age 16 or 17 who attends school at least half-time, or is not the head of household
D	Three to nine-months pregnant
E	Physically or mentally unfit for employment
F	60 years of age or older
G	Caring for a child under age six
H	Presence in home required for care of an incapacitated person
J	Person in drug addiction or alcoholic treatment and rehabilitation program
N	Receiving or applying for unemployment compensation
P	Employed or self-employed 30 hours or more a week
Q	Individual resides in a Choices county and is mandatory or has volunteered for TANF employment services
R	Registered again, after previously serving the E&T noncompliance penalty period
S	Student exemption (age 18 or older/in a training program)
T	Disqualified household member or nonmember head of household
U	Primary wage earner failed to comply with SNAP employment services
2	Registered, employed less than 30 hours a week
3	Registered, not working
4	Registered, job attached (temporarily laid off)
5	Registration postponed, expedited service

ITEM 42A: Type Income

TANF and SNAP

A — Veteran's Administration (VA) benefits

C — Unemployment Insurance benefits

P — Pension benefits (other than RSDI, SSI, VA, or RR)

M — Combination of unemployment benefits with benefits from a pension, VA, or both

W — Combined income from VA and a pension

ITEM 49: Disqualification Code (Intentional Program Violation)

SNAP

1st digit	**T** – Administrative disqualification for offense which occurred prior to September 22, 1996

	S – Administrative disqualification for offense which occurred on or after September 22, 1996, or disqualification for conviction due to trafficking **C** – Court-ordered disqualification **M** – Disqualification due to receipt of multiple benefits in one month.
2nd digit	**1** – 1st disqualification **2** – 2nd disqualification **3** – 3rd disqualification **4** – permanent disqualification for trafficking in SNAP benefits or program access devices of $500 or more.
3rd – 6th digits	**MMYY** – last month of disqualification **PERM** – disqualification permanent

ITEM 50: Error Messages

TANF and SNAP

The following format is used for all error messages: AAABBCCC

AAA — Form item number 001-191; client items 32-50 will be shown A32-K32, through K50. When a client item is shown without line indicator, 032-050, then the comparison of all entries within that item caused the error.

BB — One of the following two-digit qualifiers:

EC – ERROR CODE NUMBER"CCC"
EQ – EQUAL
GE – GREATER THAN OR EQUAL
GT– GREATER THAN
LE – LESS THAN OR EQUAL
LT – LESS THAN
NA – NOT ALLOWABLE WITH THE ENTRY OR LACK OF ENTRY IN "CCC"
NE– NOT EQUAL

CCC — Form item number 001-191; or error code number 300-999; or one of the following "KEY" words:

ALP – ALPHABETIC
BLK – BLANK
CUR – CURRENT PROCESS MONTH
DAT – VALID DATE
FIL – VALUE ALREADY ON FILE
N-3 – today minus 3 months
N-6 – today minus 6months
N12 – today minus 12 months
N24 – today minus 24 months
N45 – today minus 45 days
NAM – NAME FORMAT
NOW – PROCESS DATE OF FORM
NUM – NUMERIC
NXT – NEXT PROCESS MONTH
VAL – VALID

Error Codes

300 — Either the first digit of application number is not A or the last eight digits are not numeric

301 — By changing the A of the application number to zero, it was found that a case already on file has been assigned that number.

304 — Application already disposed

305 — BJN was incorrect

307 — The case or individual indicated is already active in the same program area for the benefit period requested.

308 — The client number entered cannot be reassigned due to a mismatch of client information.

309 — Multiple entries for this item contained the same value.

320 — A SNAP denial cannot precede a benefit issuance month.

321 — The ATA issuance exceeded the maximum allotment for household size.

400 — The individual's SSI coverage was changed to SUSPENSE

402 — Hierarchy of individual information prevented the use of the client entries on the transaction.

403 — The entry made in Adjusted Gross Income is zero. Determine if the correct income was entered.

404 — Valid entries for case number reassignment are required.

500 — The rejection of this attempted denial caused the case to be placed on hold.

ITEM 78: Type of Review

SNAP

C — Complete review

I — Incomplete review

N — Non-review activity (case maintenance)

ITEM 79: Application Codes

SNAP

First Digit – Application Type	**1** – Eligibility Determination **2** – Redetermination **3** — Application reopened after denial
Second digit	Enter X
Third digit – Number of Months	**0** – All initial applications, reapplications within 30 days from previous application, or later applications within 30 days after the end of the previous certification period. **1-8** – Enter the number of months, as appropriate, since the last application or certification period. **9** – Nine months or longer since the last application or certification period.

ITEM 84: AID

SNAP

1 — NPA Only

2 — NPA Mixed

3 — TANF-PA

5 — Refugee, PA

ITEM 85: Test (Income Test/Shelter Deduction Identifier)

SNAP

B — Gross and net income tests with capped shelter deduction.

C — Categorically eligible household with capped shelter deduction.

E — Gross and net income test and uncapped shelter deduction. Use this code only if the member who is entitled to uncapped shelter costs is disqualified for intentional program violation.

M — Net test only, uncapped shelter deduction.

T — Categorically eligible household with uncapped shelter deduction. **Note:** This code is also used in situations where a household member, disqualified for any reason, is the only elderly or disabled member.

ITEM 87: NON (Non H/H Members)

SNAP

A — Attendant

B — Boarders

C — Ineligible alien

D — Ineligible student

E — Any combination of two or more of A, B, C, or D

ITEM 89: SSI

SNAP

X — Every household member receives SSI

ITEM 90: Util (Utility Expense Code)

SNAP

Code	Description
1	Household claiming the Standard Utility Allowance.
2	Household claiming telephone standard only, or telephone standard plus actual utilities.
3	Household claiming actual utility costs only (even if some members are disqualified).
4	Household without utility costs.
5	Two households live together and share the standard utility allowance.
6	Households claiming the standard utility allowance with member(s) disqualified for not meeting the citizenship, 18-50 work, and and/or SSN requirements.
7	All other proration situations. A combination of households described in Codes 5, 6, B, and C, aprorated telephone standard, and all other situations in which the utility allowance is prorated (such as a proration involving three or more households, or more than one disqualified member).
8	Household claiming the homeless shelter standard
9	Household claiming the homeless shelter standard with one member who is disqualified for not meeting the citizenship, 18-50 work and/or SSN requirements
A	Households claiming the basic utility allowance.
B	Two households live together and share the basic utility allowance.
C	Households claiming the basic utility allowance with member(s) disqualified for not meeting the citizenship, 18-50 work, and/or SSN requirement.

Codes 1, 2, 3, 4, 5, 7, A, and B are allowed for household containing member(s) disqualified for an intentional program violation, felony drug conviction, E&T non-compliance, and/or being a fugitive.

Codes 3, 4, 6, 7, 9, and C are allowed for households containing member(s) disqualified for not meeting the citizenship requirement, 18-50 work requirement, or SSN requirement. Also, these codes are allowed for household containing member(s) disqualified for an intentional program violation, felony drug conviction, E&T non-compliance, and/or being afugitive **and** member(s) disqualified for citizenship, 18-50 work requirement, and/or SSN requirements. **Note:** Utility, homeless, and telephone standards, if used, are prorated for these kinds of disqualifications.

ITEM 91: Action Code

SNAP

See C-221, Denial Codes.

ITEM 95: Code/Hold Date

SNAP

Hold Codes

2 — Hold benefits

A — Form H1000-B has fatal error not cleared by cutoff

Z — Dormant EBT account (state office use)

Release Codes

0 — Do not hold future benefits.

ITEM 101: Prepared Meals Services Code

SNAP

C — SSI/elderly member authorized to purchase from communal dining facilities, meal delivery service, or contracted restaurant

E — Homeless and either elderly or SSI recipient; authorized to purchase from every service (communal dining, meal delivery services, or homeless meal providers/contracted restaurants)

H — Authorized to purchase from homeless meal providers/contracted restaurants

M — Household/disabled member authorized to purchase from meal delivery services

ITEM 104: Special Review Code

SNAP

Enter the appropriate code to show the type of special review needed

0 — State office assigned

1 — Employment Services/Work Registration

2 — School Attendance

3 — Reserved

4 — Management

5 — Income/Expense changes anticipated

6 — Living arrangement change anticipated

7 — Medical review

8 — Household change anticipated

9 — Other

ITEM 127 Type Program

TANF

01 — Cash and medical assistance

04 — Medical Assistance Only – Deceased

07 — 12 or 18 months medical assistance only

11 — Three months prior medical assistance only not currently eligible

20 — Medical assistance only – Child Support

37 — 12 or 18 months medical assistance only

61 — TANF-UP cash and medical assistance

71 — OTTANF – One parent household

72 — OTTANF – Two parent household

ITEM 131: Type Review

TANF

C — Complete review

I — Incomplete review

N — Non-review activity (case maintenance)

ITEM 132: Action Code

TANF

See C-200 for Item 132 Codes.

ITEM 138: (Child Support Cooperation/Reason for Transfer to TP 07/20)

TANF

R — Refusal without good cause to cooperate with child support for one or more APs

X — Exempt from child support requirements, or claiming good cause for all APs

C — Cooperation. Enter this code if Codes R or X do not apply

E — new or increased earned income or earnings of a returning absent parent who is added to the certified group

S — new or increased child support collections

B — TANF denial results from a reason listed under Code E and new or increased child support collections

ITEM 140: CODE

TANF

1 — Employment Services/Work Registration (TANF only)

2 — School attendance

3 — (Reserved)

4 — Management

5 — Income/Expense changes anticipated

6 — Living arrangement change anticipated

7 — Medical review

8 — Household change anticipated

9 — Other

Q — Disability Hardship Exemption (TANF only)

ITEM 142: HOLD CD: DATE

TANF

Advisor Hold Codes

1 — Unable to locate

2 — Guardianship pending

3 — New payee pending

4 — Notice of adverse action to lower benefits that expires between cutoff and the end of the month

5 — Notice of adverse action expires between cutoff and end of month (case denial or transfer to TP 07 or TP 20)

State Office Hold Codes

A — Hold, Form H1000-B has fatal error not cleared by cutoff

C — Form H3087 returned, moved

D — Form H3087 returned, deceased

E — Form H3087 returned, unclaimed

F — Warrant Undeliverable and returned by post office

G — Warrant undeliverable because individual is deceased

H — TANF case has SIG 5 member age 19 or over

L — State time limit expiring and SAVERR cannot rebudget TANF

J — Warrant charged back

R — SDX hold

Z — Dormant EBT account

3 — RCA case has a member who entered the United States eight months ago

6 — TANF case pending denial or transfer to TP 20

Advisor Release Codes

8 — Release benefits as originally authorized

9 — Release benefits as originally authorized using the new address on this Form H1000-B

0 — Release future benefits. Use Form H1008 to release any returned benefits. Use Section XI to issue benefits for months on hold.

ITEM 149: Code

TANF

C — Dependent care deduction

9 — A 90% earned income deduction up to $1400 per employed member or 12 or 18 months additional Medicaid coverage. This entry requires an entry on the same line in Item 151.

Item 179 - Type of Warrant Requested

TANF

1 — Full months amount

2 — Additional amount for a month; Form H1000-B use only

SNAP

S — Reporting ATA issuance untimely

E — Requesting issuance or timely reporting benefits issued via the ATA

N — Requesting cancellation of benefits

ITEM 180: Type Issuance

TANF

Reason for authorization of benefits

9 — Action Code 090, simultaneous open and close on Form H1000-A only

B — Change in both household composition and money reflected in the budget

H — Change in household composition

M — Change in money reflected in the budget

O — Retroactive and/or current month's benefit when releasing a case from hold with release Code 0 or 7 in Item 142

P — Budgeting process requires different payment month benefits. Enter Code 1 in Item 179

R — (State office use only) Identifies on the history file benefits produced when release Code 8 or 9is used to release a case from hold

T — Transfer from TP 07, 20, 29, or 37 to TP 01/ 61 (Form H1000-B andForm H1000-C use only)

SNAP

Full Regular Ongoing Benefits or Their Replacements

A — Initial benefit (regular ongoing benefit)

E — Initial expedited benefit issued*

H — Priority benefits issued to meet hearing officer decision timeliness

L — Restoring benefits for a past month

1 — Initial expedited benefits issued through ATA*

2 — Priority benefits issued through SAVERR or ATA to meet timeliness

3 — Initial priority benefits issued through ATA*

4 — Historical Information: CCDMI mailed out of state as a result of converting EBT benefits to coupons (state office use only). No longer in use effective April 1, 2004.

5 — Historical Information: Benefits replaced in EBT account when CCDMI was returned (state office use only). No longer in use effective April 1, 2004.

*See details in C-500, Item 180 instructions.

Additional Benefits for a Month

C — Supplemental benefits. Use when providing benefits in addition to initial benefits for the current month, or following month if submitting Form H1000-A,Form H1000-B andForm H1000-C after cutoff.

D — Restoration benefits. Use when restoring partial benefits for a past month.

F — Supplemental or restoration benefits. Use when providing additional benefits for a month in which the household has already received one issuance coded C and/or D.

P — Restore an erroneously expunged EBT benefit.

Destroyed Food

T — Replacement of destroyed food, which was purchased with SNAP benefits

Advisor enter cancellation

G — Use to cancel EBT benefit because the household has moved out of state

ITEM 186: OTHER DATA (Range Code)

SNAP

P — Initial month benefit prorated

Benefit Range Code for all issuances coded C, D, F, H, P, or T in Item 180

Range Code	Issuance Dollar Amount	Range Code	Issuance Dollar Amount
A	1 - 49	H	350 - 399
B	50 - 99	J	400 - 449
C	100 - 149	K	450 - 499
D	150 - 199	L	500 - 549
E	200 - 249	M	550 - 599
F	250 - 299	X	600 or over
G	300 - 349	-	

ITEM 187: Household Composition for Benefit Requested

TANF

1st digit	Number of individuals with status-in-group (SIG) code 7 and 8 (maximum of two). If none, enter 0.
2nd and 3rd digits	Number of individuals with status-in-group Code 5 (maximum of nine). Always enter as two-digit number. If none, enter 00. If there are more than nine Code 5s, use Form H1008.

Note: See C-500 for additional codes and instructions toForm H1000-C. A Form H1000-C cannot be submitted without Form H1000-A or Form H1000-B.

ITEM 214: FIC (R/E) (Finger Image Code)

TANF and SNAP

Enter individual's finger image enrollment or exemption code

Y — If all available images have been taken

Z — If one image has been taken

A — Appeal pending (TANF related)

B — Low quality image/physically unable to image/equipment failure

C — Certified out of office or unable to come to office

D — Undue burden for disabled individual

E — Undue burden for elderly individual

F — Disqualified (FS only)

ITEM 215: LSIS Vendor's Unique Number (VUN)

TANF and SNAP

If the entry in Item 214 is Y or Z, enter the nine-digit VUN.

ITEM 216: Disqualification Type

SNAP

Enter the code(s) to indicate that an individual is being disqualified for one or more the following reasons.

B — ineligible alien without BCIS document

C — ineligible aliens with BCIS document

D — felony drug conviction

F — first offense failure to comply with ESP requirements (E&T /voluntary quit/reducing work hours to less than 30)

J — fugitive

N — failure to meet SSN requirement

S — second offense failure to comply with ESP requirements

T — third or subsequent offense failure to comply with ESP requirements

W — failure to comply with the 18-50 work requirement

ITEM 217: Remove

SNAP

Enter a code below to end a disqualification or change a time-limited benefit code.

1 — delete the first countable month

2 — delete the second countable month

3 — delete the third countable month

4 — delete the fourth countable month (first month of second three month period)

B — end the ineligible alien (undoc) disqualification

C — end the ineligible alien (doc) disqualification

F — end the first offense SNAP ESP disqualification

J — end the fugitive disqualification

L — subtract one offense from the ESP offense counter (when entering Code L, do not enter Code F, S, or T in Item 216 on the same Form H1000-A, Form H1000-B andForm H1000-C transaction)

N — end of the SSN disqualification

S — end the second offense SNAP ESP disqualification

T — end the third offense SNAP ESP disqualification

W — end the 18 - 50 work requirement disqualification

ITEMS 218-223

SNAP

Make entries in these fields to report that HHSC has authorized a SNAP benefit for a countable month of the initial or second three-month period of time-limited benefits in a 36 month period for an individual age 18-50. Make entries of Code(s) 1-4 in Items 218 and the corresponding month(s) in Item 219.

ITEMS 218, 220, and 222 - Countable Month Code

SNAP

Enter one of the following codes and a corresponding month in Item 219, 221, and 223:

1 — benefit authorized for the first month of the initial three-month period

2 — benefit authorized for the second month of the initial three-month period

3 — benefit authorized for the third month of the initial three-month period

4 — benefit authorized for the first month of the second three-month period

Additional Codes

TANF

Benefit History Codes

A — Mailed warrant/EBT benefit issued

C — Warrant held

D — Warrant or EBT issuance cancelled

E — Warrant charged back

P — Warrant paid by state treasure

R — Warrant returned

S — Warrant stop payment in effect

L — Warrant stop payment lifted

Y — Duplicate EBT benefit or warrant issued

Z — Duplicate warrant returned

Read benefit history codes on inquiry from right to left. The most recent code/action appears on the far left.

TWH, C-600, Form H1000-A and Form H1000-B Entries (Retired as of July 1, 2013)

Revision 10-1; Effective January 1, 2010

C—610 General Information

Revision 02-3; Effective April 1, 2002

All Programs

This section contains Form H1000-A, Notice of Application, and Form H1000-B, Record of Case Action, entries for certifications, actions taken during certification periods, and denials. For transfer entries, refer to C-700, Transfer Guidelines.

C—620 Certification Entries

Revision 02-3; Effective April 1, 2002

C—621 Minimum Entries for Certification

Revision 02-3; Effective April 1, 2002

C—621.1 TANF Minimum Entries

Revision 02-3; Effective April 1, 2002

TANF

Section I

Item 02	Category
Item 07	Mail Code
Item 08	Date Filed
Item 09	Case Name
Item 13	Mailing Address
Item 15	City
Item 16	State
Item 17	ZIP Code
Item 25	County

Section II

Item 32	Client Number
Item 33	Client Name
Item 34	Birth Date
Item 35	Sex
Item 37	Social Security Number (if known)
Item 38	Social Security Claim Number (if enrolled in Medicare or receiving benefits)

Section III

Item 40	Status in Group
Item 41	ESP Code (unless Category 5)
Items 42-44	Individual Income, if applicable
Item 46	Medical Effective Date

Section IV

Item 55	Total Railroad Retirement (if appropriate)
Item 56	Total Other (Income) (if appropriate)
Item 58	Dependent Care Deductions (if appropriate)
Item 59	Adjusted Gross Income

Note: Total income minus deductions must equal adjusted gross income

Section V

Item 66	Total Needs

Section VIII

Item 127	Type Program
Item 129	Grant Effective Date
Item 132	Action Code
Item 133	Three Months Prior Indicator (only if eligible for three months prior medical assistance)
Item 134	Three Months Prior Application Date (if entry made in Item 133)
Item 138	Child Support Cooperation
Items 149, 151, and 152	For cases with earned income, enter dependent care and 90% earned income deduction information if these deductions are used in determining the adjusted gross

Section XIV

Section I

Item 188	Signature
Item 189	Date Signed
Item 190	Employee Number

C—621.2 SNAP Minimum Entries

Revision 02-3; Effective April 1, 2002

SNAP

Section I

Item 02	Category
Item 04	Page number and the number of pages if there are more than 11 individuals
Item 06	Budgeted Job Number
Item 07	Mail Code
Item 08	Date Filed
Item 09	Case Name
Item 13	Mailing Address – first line
Item 15	City
Item 16	State
Item 17	ZIP Code
Item 25	County

Section II

Item 32	Client Number
Item 33	Client Name
Item 34	Birth Date
Item 35	Sex (if known)
Item 36	Race (if known)
Item 37	Social Security Number
Item 38	Social Security Claim Number (if visually verified)
Item 39	Education Level (if Item 41 is 1, 2, 3, or 4)

Section III

Item 40	Status in Group
Item 41	Work Registration
Items 42-45	Individual Income, if applicable
Item 48	Medical Cost of eligible members as appropriate
Item 49	Disqualification Code and Date, if applicable

Section IV

Item 55	Total Railroad Retirement (if appropriate)
Item 56	Total Other (Income) (if appropriate)
Item 58	Dependent Care Deduction (if any)
Item 59	Adjusted Gross Income

Section V

Item 60	Shelter
Item 63	Net Income

Section VI

Item 78	Type Review
Item 79	Application Codes
Item 80	Certification Date
Item 81	Months Certified
Item 82	Last Benefit Month
Item 83	Household Number
Item 84	Aid Type
Item 85	Test (Gross/net income eligibility test identifier codes)
Item 89	SSI Code (if applicable)
Item 90	Utility Code

Item 91	Action Code (if case is opened and closed on same document)
Item 92	Action date (if entry made in Item 91)
Item 96	Late Determination/Rescheduled Appointment Date, if applicable
Items 103 and 104	(if appropriate)

Section VII

Items 112 and 113	Associated TANF case numbers, if appropriate
Items 118-122	(if appropriate)

Section VIII

Item 152	Child Support Disregard, if applicable

Section XI

Items 179-187	As appropriate to request or report benefits

Section XIV

Item 188	Signature
Item 189	Date Signed
Item 190	Employee Number

C—621.3 Minimum Entries for Medical Programs

Revision 02-3; Effective April 1, 2002

Medical Programs except TP 45

NOA Entries

Section I

Item 01	Case Number
Item 02	Category
Item 03	Prior Recipient
Item 06	Budgeted Job Number
Item 07	Mail Code
Item 09	Case Name
Item 12	Employee Number
Item 13	Mailing Address
Item 15	City
Item 16	State
Item 17	ZIP Code
Item 25	County
Item 31	Medical Programs Application Number

Section II

Items 33-38	Client Names and Biographical Data

Certification Entries

Section I

Item 02	Category
Item 07	Mail Code
Item 08	Date Filed
Item 09	Case Name
Item 13	Mailing Address
Item 15	City
Item 16	State
Item 17	ZIP Code
Item 25	County
Item 29	Notice Date
Item 30	Medical Delay (if appropriate)

Section II

Item 32	Client Number
Item 33	Client Name

Item 34	Birth Date
Item 35	Sex
Item 37	Social Security Account Number (if known)
Item 38	Social Security Claim Number (if enrolled in Medicare or receiving benefits)

Section III

Item 40	Status in Group
Items 42-44	Individual Income, if applicable
Item 46	Medical Effective Date

Section IV

Items 55, 56, and 58	Case Income, if applicable
Item 59	Adjusted Gross Income

Note: Total income minus deductions must equal adjusted gross income.

Section V

Item 66	Total Needs

Section VII

Item 125	Number of Adults
Item 126	Number of Children

Section VIII

Item 127	Type Program
Item 132	Action Code
Item 133	Three Months Prior Indicator only if eligible for three months prior medical assistance
Item 134	Three Months Prior Application Date (if entry is made in Item 133)
Item 136	Medicaid Termination Date

Section XIV

Item 188	Signature
Item 189	Date Signed
Item 190	Employee Number

C—621.3.1 TP 45 Minimum Entries

Revision 02-3; Effective April 1, 2002

TP 45

Section I

Item 02	Category
Item 07	Mail Code
Item 08	Date Filed
Item 09	Case Name
Item 13	Mailing Address
Item 15	City
Item 16	State
Item 17	ZIP Code
Item 25	County
Item 29	Notice Date

Section II

Item 32	Client Number
Item 33	Client Name
Item 34	Birth Date
Item 35	Sex
Item 37	Social Security Account Number (if known)

Section III

Item 40 Status in Group
Item 46 Medical Effective Date

Section VIII

Item 127 Type Program
Item 132 Action Code

Section XIV

Item 188 Signature
Item 189 Date Signed
Item 190 Employee Number

C—622 Entries for Three Months Prior

Revision 02-3; Effective April 1, 2002

C—622.1 Three Months Prior Medicaid – Currently Eligible – No Gap in Coverage

Revision 02-3; Effective April 1, 2002

TANF

Complete Form H1000-A, Notice of Application, using TANF entry requirements.

Item 46 – Enter prior medical effective dates for applicants eligible for three months prior medical coverage.

Item 133 – Enter the number of months of prior eligibility.

Item 134 – Enter three months of prior application date.

Note: For three months prior with a gap in coverage, see C-623.2.

C—622.2 Three Months Prior Entries for a Medically Needy Case

Revision 02-3; Effective April 1, 2002

TP 55 and 30

Make minimum certification entries for a case with or without spend down. For a TP 30 case, do not make entries in Items 179-187 if Item 137 has an entry of 40, 43, 44, or 48. Refer to Form H1000-A and Form H1000-B instructions for Items 133 and 137.

Make the following entries in Section XI when there is no gap in eligibility during the prior period:

Item 179 – Enter N if the prior month has spend down or E if the prior month does not have spend down. This code corresponds with the month entered in Item 183.

Item 183 – Enter the month to correspond with the code in Item 179.

Item 184 – Enter the net income to correspond with the month in Item 183. Round down to the whole dollar amount.

Item 185 – Enter the spend down amount to correspond with the month entered in Item 183. Enter 0 if there is no spend down.

Item 187 – Enter the household size to correspond with the month entered in Item 183. Enter the number of adults in the budget group in the first digit and the number of children in the budget group in the second digit.

If there is a gap in eligibility during the three-month prior period, process a separate Form H1000-A for the eligible months.

C—623 Entries for Open and Close Certifications

Revision 02-3; Effective April 1, 2002

C—623.1 TP 04, Medical Assistance Only – Deceased

Revision 02-3; Effective April 1, 2002

TANF

Make TANF minimum entries except for Items 41 and 129

Item 40 – Enter X with status in group code for deceased individual.

Item 46 – Enter the medical effective date for each eligible person.

tem 47 – Enter the appropriate dates.

Item 132 – Enter action code 090.

Item 133 – Enter three months prior indicator, if eligible.

C—623.2 TP 11, Three Months Prior Medical Assistance – Not Currently Eligible; Gap in Coverage; or Reopened Applications

Revision 02-3; Effective April 1, 2002

TANF

Make all TANF minimum entries except Items 41 and 129.

For reopened applications,

Item 08 – Enter the date the applicant requests the application be reopened.

Item 134 – Enter the month and year the original application was filed.

Item 140 – Enter M with primary Codes 5, 6, 7, or 8 for applicants eligible for retroactive coverage. Enter N with primary Codes 5, 7, or 8 for applicants who are not eligible for retroactive coverage but are included to show need.

Item 47 – Enter last day of medical coverage for all applicants with Code M in Item 40.

Item 132 – Enter Code 090.

Notes:

- Enter MX with primary codes for an applicant who dies during the three month prior period or if the person died before the application was made on his behalf.
- For Three Months Prior Currently Active – In addition to the above entries, enter the existing case number in Item 01 and the existing client number in Item 32.

C—623.3 Simultaneous Open and Close for TANF

Revision 02-3; Effective April 1, 2002

TANF

Use this procedure to process applications for

- denied households eligible for restored benefits (See B-800, Restored Benefits),
- applicants eligible for TANF for the current month but ineligible for future months,
- applicants eligible for OTTANF, or
- applicants eligible for TANF Medicaid for the application month but ineligible for the months following the application month.**Note:** Form H1000-A, Notice of Application, can be processed only if the month after the application month is entered in Item 129.

Make all minimum entries for the appropriate type program.

Note: Do not reassign an old case number.

Item 40 – Enter secondary status in group Code N for OTTANF applicants.

Item 47 – Enter last month of eligibility for each certified person. If an applicant is deceased, enter date of death.

Item 127 – enter Type Program 71 or 72 for OTTANF cases.

Item 132 – Enter Code 090.

Items 179, 180, 183, 184, 185 and 187 (Section XI) – Enter information to authorize benefits for Type Program 01 and 61 certifications. **Exceptions:** Do not make entries in Section XI for OTTANF cases. When the form processes, benefits are automatically issued.

C—623.4 Simultaneous Open and Close for Medical Programs

Revision 02-3; Effective April 1, 2002

Medical Programs

Use this procedure to process applications for

- TP 55 and 30 with spend down in the application month;
- TP 30 when the applicant is a caretaker or a second parent with an emergency condition; or
- three months prior only including
  - TPs 30 and 55 with or without spend down, and
  - applications for TPs 30, 40, 43, 47, 48, and 55 reopened within two years after the original application was filed.

Make minimum certification entries for a case (with or without spend down) including the file date of the application. **Note:** Do not reassign an old case number.

Item 40 – Enter the appropriate SIG codes. For three months prior, only include in the certified group members who have Title XIX-reimbursable bills for the prior period. For TP 30, include only one member in the certified group.

Item 46 – Enter the Medical Effective Date (MED) or earliest possible MED. For TP 30 cases, enter the start date of the emergency condition taken from Form H3038, Emergency Medical Services Certification.

Item 47 – Enter the last day of medical coverage. For TP 30 cases enter the earliest of either

- the end date of the emergency condition, or
- the last day of the application month.

Note: For TP 55 cases with spend down, computer edits will not allow a date later than the last day of the application month.

Item 66 – Enter the correct needs allowance for the month(s) entered in Items 46 and 47.

Item 127 – Enter the correct type program (30, 40, 43, 44, 47, 48, or 55).

Item 132 – Enter code 090.

Item 133 – For three months prior only, enter the total number of unduplicated calendar months of three months prior.

Item 137 – For TP 30 cases, enter the appropriate TP. Refer to Form H1000-A and Form H1000-B instructions for this entry.

Section XI – For three months prior only, make appropriate entries for each of the prior months. For TP 30 cases, do not make these entries if Item 137 has an entry of 40, 43, 44, or 48.

For reopened three months prior applications,

Item 08 – Enter the date the applicant requests the application be reopened.

Item 134 – Enter the month and year the original application was filed.

C—624 Entries for Reinstatements

Revision 02-6; Effective July 1, 2002

C—624.1 TANF

Revision 10-1; Effective January 1, 2010

Make all Form H1000-A minimum entries.

Item 01 – Enter the previous case number.

Item 08 – Enter first day of the month of reinstatement.

Item 46 – Enter each individual's medical effective date.

Item 131 – Enter type review Code C.

Item 132 – Enter Code 054 or 055.

Item 164 – Enter the three-digit code for the individual's county of residence. See C-350.

Note: SAVERR edits prevent household additions when Code 054 is used in Item 132. Use Form H1000-B turnaround to make this change.

C—624.2 SNAP

Revision 10-1; Effective January 1, 2010

SNAP

Item 08 – Enter the original file date.

Item 79 – Enter 3X0.

Item 80-82 – Reenter the information from the certification period when the case was denied.

Section XI – Make entries as appropriate to order benefits.

C—624.3 TP 07/20 (Four, 12, or 18 Months Medicaid) for a Case Previously Denied in Error

Revision 10-1; Effective January 1, 2010

TANF

Make all TANF minimum entries except Items 41 and 129.

Item 01 – Enter case number of the case denied in error.

Item 32 – Enter each individual's previous client number.

Item 46 – Enter each individual's medical effective date as the day after the date the erroneous denial became effective.

Item 132 – Enter

- Code 090 if the Medicaid end date is before the current process month, or
- Code 055 if the Medicaid end date is during or after the current process month.

Item 136 – Enter the Medicaid end date.

Item 138 – Enter the reason for transfer to TP 07 or TP 20.

Item 164 – Enter the three-digit code for the individual's county of residence. See C-350.

C—624.4 TP 37 (12 or 18 Months Medicaid) for a Case Previously Denied in Error

Revision 10-1; Effective January 1, 2010

TANF

Make all TANF minimum entries except Items 41 and 129.

Item 01 – Enter case number of the case denied in error.

Item 32 – Enter each individual's previous client number.

Item 46 – Enter each individual's medical effective date as the day after the date the erroneous denial became effective.

Item 132 – Enter

- Code 090 if the Medicaid end date is before the current process month, or
- Code 050 if the Medicaid end date is during or after the current process month, or
- Code 054 to reinstate a denied household that meets the requirements in A-800.

Item 149 – Enter Code 9 for the 90% Earned Income Deduction (EID).

Item 151 – Enter the original date of the 90% EID. Do not enter a dollar amount in Item 152.

Item 164 – Enter the three-digit code for the individual's county of residence. See C-350.

C—624.5 Reinstatement for Post Medicaid (TP 20), Transitional Medicaid (TP 07 or 37), or TP 29

Revision 10-1; Effective January 1, 2010

TANF

Make all TANF minimum entries.

Item 01 – Enter the previous case number.

Item 08 – Enter the first day of the month of reinstatement.

Item 46 – Enter each individual's medical effective date.

Item 131 – Enter Type Review Code C.

Item 132 – Enter Code 054 or Code 090.

Item 136 – TP 07, TP 20, or TP 29: Enter

- the original end date as shown on SAVERR, or
- an earlier end date, when applicable, when using Code 090.

Item 138 – Enter

- S for TP 20, or
- E or B for TP 07.

Item 151 – Enter the original date of the 90% EID. Do not enter a dollar amount in Item 152.

Item 164 – Enter the three-digit code for the individual's county of residence. See C-350.

Note: SAVERR edits prevent the actions listed below when Code 054 is used in Item 132. Therefore, use Form H1000-B turnaround to

- add a person.
- correct the end date of the original TP 07, TP 29, or TP 37 period. Change the end date only if it was incorrect when the case originally transferred to transitional Medicaid.

C—625 Miscellaneous Certification Entries

Revision 02-3; Effective April 1, 2002

C—625.1 Certifying Benefits for the Month After Certification

Revision 02-3; Effective April 1, 2002

TANF

Make all minimum TANF entries.

Item 46 – Enter first calendar day of the month after the application month.

Item 129 – Enter first calendar day of the month after the application month.

Note: Do not make future grant or medical effective dates for TANF more than one month past the future cutoff month.

C—625.2 Certifying a TP 29 Case

Revision 02-3; Effective April 1, 2002

TANF

Certify only one individual on each TP 29 case.

Item 40

- For the individual being certified on TP 29 enter
  - SIG 8G if the individual was SIG 8 on the TANF case, or
  - SIG 7G if the individual was SIG 7 on the TANF case.
- For other household members listed on the case enter
  - SIG 0 or 2Y for an adult, or
  - SIG 2, 2I, 2IT, 2IU, 2W, or 3 for a child.

Note: The case must be include a SIG 2, 2W, or 3 for the caretaker or second parent to be certified.

Item 127 – Enter Type Program 29.

Item 132 – Enter opening Code 057 on Form H1000-A, Notice of Application, or code 121 on Form H1000-B, Record of Case Action.

Item 136 – Enter the Medicaid end date.

C—625.3 Independent Child as the Case Name When a Representative from a Child Care Facility Applies for the Child

Revision 02-3; Effective April 1, 2002

Medical Programs

Make all minimum entries for the appropriate type program.

Item 13 – Enter the child's residence or, upon request, the address of the child care facility located near the child.

Item 25 – Enter the BJN's county code.

Item 26 – Enter the name of the child care representative as representative payee.

Item 271 – Enter Code R.

Item 40 – Enter SIG Code 8 to designate the child as case name.

Item 164 – Enter the child's residence county code.

C—630 Entries for Actions Taken During the Certification Period

Revision 02-3; Effective April 1, 2002

C—631 Entries for Case Name Changes

Revision 02-3; Effective April 1, 2002

C—631.1 Case Name Changes with Same Household Members

Revision 02-3; Effective April 1, 2002

SNAP

Item 10 – Enter new case name.

Item 40 – Enter # to remove former head of household status.

Item 40 – Enter A for new head of household.

Item 78 – Enter type review.

C—631.2 Case Name Changes When Head of Household Leaves

Revision 02-3; Effective April 1, 2002

SNAP

Item 10 – Enter new case name.

Item 33 – Enter # to remove former head of household.

Item 40 – Enter A for new head of household.

Item 78 – Enter type review.

Item 83 – Enter new household number, if applicable.

C—632 Entries for Households Becoming Eligible for SSI

Revision 02-3; Effective April 1, 2002

C—632.1 TANF Caretaker Becomes Eligible for SSI

Revision 08-4; Effective October 1, 2008

TANF

Item 40 – Enter Code 9.

Item 41 – Enter Code V.

Item 66 – Enter new needs amount.

Item 131 – Enter type review code.

Item 132 – Enter Code 105.

Remove any income entries for the caretaker.

C—632.2 TANF Child Becomes Eligible for SSI

Revision 02-3; Effective April 1, 2002

TANF

Item 40 – Enter Code 3.

Item 41 – Enter Code J.

Item 66 – Enter updated budget entries.

Item 131 – Enter type review.

Item 132 – Enter action code.

Note: SAVERR will not allow a SIG 5 child on the same case a SIG 3 child.

C—633 Entries for Adjusting Certification Periods

Revision 02-3; Effective April 1, 2002

C—633.1 Extending the Certification Period of an Active SNAP Case

Revision 02-3; Effective April 1, 2002

SNAP

Item 78 – Enter Code I.

Item 81 – Enter the new number of months certified.

Item 82 – Enter the new last benefit month.

C—633.2 Shortening the Certification Period of an Active SNAP Case

Revision 02-3; Effective April 1, 2002

SNAP

Item 78 – Enter type review Code I.

Item 81 – Enter the new number corresponding to the original certification date in Item 80 and the new last benefit month in Item 82.
Example: If the certification date was 06/01/01, and the new last benefit month is 9/01, enter 04 in this item.

Item 82 – Enter the new last benefit month.

C—634 Miscellaneous Action Entries

Revision 02-3; Effective April 1, 2002

C—634.1 Death of an Active Client

Revision 02-3; Effective April 1, 2002

TANF

Item 40 – Reenter the original status in group codes for the deceased individual plus code X.

Item 47 – Enter the individual's date of death.

Item 131 – Enter the type review code.

Item 132 – If the case is also being denied because of death, enter Code 058 or 059.

C—634.2 Canceling a Previous SNAP Issuance

Revision 02-3; Effective April 1, 2002

SNAP

Item 179 – Enter Code N.

Item 180 – Enter cancellation Code G.

Item 181 – Enter number of the issuance being cancelled.

Item 182 – Enter the issuance date of the benefit being cancelled.

Item 183 – Enter the benefit month of the issuance being cancelled.

Item 185 – Enter the benefit value of the issuance being cancelled.

Item 186 – Enter the recoupment amount (if appropriate).

C—634.3 Households with Disqualified Members

Revision 02-3; Effective April 1, 2002

C—634.3.1 Households with Members Disqualified for Citizenship, or 18-50 Work Requirement, or Noncompliance with SSN Requirements

Revision 02-3; Effective April 1, 2002

SNAP

Make the following entries for the disqualified person:

Item 40 – Enter status in group Code K.

Item 41 – Enter Code T.

Items 42B-45 – Enter prorated income of disqualified person.

Item 60 – Enter appropriate shelter expenses.

Item 83 – Enter number of household members not disqualified.

Item 87 – Enter Code C if household has member disqualified as ineligible alien.

Item 88 – Enter number of household members disqualified as ineligible aliens.

Item 90 – Enter code for prorated shelter expense, if applicable.

Also make corresponding entries onForm H1000-C, Secondary Client Input, in Item 216 to identify the reason for disqualification.

C—634.3.2 Households with Members Disqualified for SNAP Employment Services Noncompliances, Felony Drug Convictions, Refusing to Cooperate with the Quality Control Process, or Being a Fugitive

Revision 08-3; Effective July 1, 2008

SNAP

Make the following entries for the disqualified person:

Item 40 – Enter status in group Code K.

Item 41 – Enter Code T.

Items 42B-45 – Enter total income of disqualified person.

Item 60 – Enter total shelter expenses.

Item 83 – Enter number of household members not disqualified.

Item 90 – Enter appropriate code for shelter expense.

Also make corresponding entries onForm H1000-C, Secondary Client Input, in Item 216 to identify the reason for disqualification.

C—634.4 Reinstating a Person Disqualified for Intentional Program Violation When the Disqualification Expires

Revision 02-3; Effective April 1, 2002

SNAP

Make minimum entries for certification or changes.

Item 40 – Enter the appropriate code.

Item 41 – Enter the appropriate code.

Item 49 – Make no entry.

Item 83 – Enter number of eligible household members including the person who is no longer disqualified.

C—634.5 Reporting Increases in Household Composition with More than 11 Persons

Revision 02-3; Effective April 1, 2002

All Programs

Use more than one set of forms. In addition to the standard entries on the first Input document, complete Item 04, page 1.

Use a Form H1000-A, Notice of Application, packet. Separate the NOA and the Case Index Card from the packet and destroy, leaving the H1000-A Input and case record copy intact. White out the preprinted application number, enter the case number in Item 01, and make the following entries:

Item 03 – Sequence Number

Item 04 – Page

Item 06 – Budgeted Job Number

Item 07 – Mail Code

Item 09 – Case Name

Items 32-50 – Begin with line "b"

Staple the Input document together and batch as one.

C—634.6 Change of Payee or Caretaker

Revision 02-3; Effective April 1, 2002

TANF

Item 10 – Enter new case name.

Items 32-37 – Enter information about case name if the person was not previously included in the case.

Items 40-41 – Enter code for new case name.

Item 46 – Enter medical effective date for new case name if the person is certified as a caretaker and was not previously included in the case.

Item 33 – Enter # to remove previous individual if the individual is to be removed from the case.

Items 40-41 – Enter new codes if the previous case name is to remain in the case.

Item 131 – Enter type review code.

Item 132 – Enter Code 120.

Enter budget and Item 66 entries for situations with these changes.

C—634.7 Three Months Prior Medicaid – No Gap in Coverage on an Active Case

Revision 05-4; Effective August 1, 2005

TANF

Item 46 – Enter new medical effective date.

Item 131 – Enter the type review code.

Item 132 – Enter reinvestigation Code 107 if sustaining or other codes if raising or lowering.

Item 133 – Enter number of months of prior eligibility.

Item 134 – Enter three months prior application date.

To change a medical effective date for more than six months before the current process month, send a memo with supervisor'sapproval to State Office Data Integrity (SODI) Section, Systems Control Division, State Office, Y-922, explaining why the information needs to be processed.

C—634.8 Entering the 90% Earned Income Deduction and Child Care to Ensure Automatic Removal of the Deduction

Revision 05-4; Effective August 1, 2005

TANF

Item 42B – Enter gross earned income.

Item 58 – Enter standard work expense deduction. Do not enter childcare or 90% deduction.

To report child care deduction:

Item 149, line 1 – Enter C.

Item 152, line 1 – Enter total child care deduction.

To report the 90% earned income deduction:

Item 149, line 2 – Enter 9.

Item 151, line 2 – Enter the last month of the four month eligibility period.

Item 152, line 2 – Enter the total allowable 90% earned income deduction.

Item 59 – Enter the remainder of Item 57 minus Items 58 and 152.

SAVERR automatically removes the 90% deduction after cutoff in the month before the month entered in Item 151. If the case is denied, SAVERR transfers assistance to Type Program 37 and adds 12 or 18 months to the month in Item 151.

When processing the automatic removal of the 90% deduction, SAVERR notifies the individual and sends the advisor an updated H1000-Bsequence.

SAVERR will not automatically remove the 90% deduction or transfer the case to TP 37 when a case is on hold. If a Form H1000-B, Record of Case Action, is submitted to remove the hold, remove the 90% deduction by entering

- 9 in Item 149, and
- 0 in Item 152.

If denying the case, process a transfer to TP 37.

C—640 Denial Entries

Revision 02-3; Effective April 1, 2002

C—641 Denial of a TANF/Medical Programs Application

Revision 02-3; Effective April 1, 2002

TANF and Medical Programs

Item 29 – Action Notice

Item 127 – Type Program

Item 132 – Action Code

C—642 Denial of a SNAP Application

Revision 02-3; Effective April 1, 2002

SNAP

To deny an application of Form H1000-A, Notice of Application, make the following entries:

Item 29 – Enter date Form H1017, Notice of Benefit Denial or Reduction, is sent to applicant.

Item 79 – Enter application code.

Item 91 – Enter denial code.

Item 92 – Enter date of denial.

To deny an application on Form H1000-B, Record of Case Action, make these additional entries:

Item 08 – Enter date applied.

Item 78 – Enter C.

C—643 Hold Code 5 Actions Pending Automatic Grant Denial

Revision 02-3; Effective April 1, 2002

TANF

Item 131 – Enter the type review code.

Item 132 – Enter Code 107. Use Code 110 for Type Program 07 cases.

Item 142 – Enter hold Code 5.

Item 143 – Enter denial code.

Do not enter any budgetary changes

If the hold is not released in the hold effective month, an updated sequence Form H1000-B, Record of Case Action, is produced at cutoff of the hold effective month showing the grant denial.

C—644 Denial of an Active Case Because of Failure to Comply with Employment Services

Revision 02-3; Effective April 1, 2002

SNAP

Item 41 – Enter U for the primary wage earner who did not comply.

Item 78 – Enter type review.

Item 91 – Enter Code 610.

Item 92 – Enter last day of month the denial is effective.

TWH, C-700, Reserved for Future Use

TWH, C-800, Automated Support Systems

Revision 17-2; Effective April 1, 2017

C—810 Texas Integrated Eligibility Redesign System (TIERS)

Revision 14-1; Effective January 1, 2014

C—811 Case Number and Eligibility Determination Group (EDG) Number

Revision 15-4; Effective October 1, 2015

All Programs

A case is defined as a group of persons who are seeking benefits together for at least some, if not all, of the members of the group. Members included on the case may or may not be certified to receive benefits. Each case is identified by a 10-digit case number. A TIERS case can include multiple EDGs. An EDG is defined as members of a household whose needs, resources, income, and deductions, as applicable by program, are considered in determining eligibility for benefits. Each EDG is identified by a nine-digit EDG number.

Example: If a household is approved for Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP), assign one EDG number for TANF and another EDG number for SNAP.

Case numbers are kept indefinitely and should be reassigned when the household reapplies for any program.

Note: There may be instances when a new case number may be required, such as for a person leaving a drug treatment facility or for foster care cases.

Related Policy
Supplemental Nutrition Assistance Program Combined Application Project (SNAP-CAP), B-475

C—812 Individual Number

Revision 15-4; Effective October 1, 2015

All Programs

The first time a person is approved for Texas Health and Human Services Commission (HHSC) services or benefits, TIERS assigns an individual a unique number. Advisors use the same number, called the individual number, for that person for all programs.

Individual numbers are kept indefinitely and should be reassigned when the individual reapplies for any program.

C—813 Hierarchy of Individual Identification Data

Revision 15-4; Effective October 1, 2015

All Programs

Before approving an applicant who already has an individual number, advisors must compare information in TIERS inquiry to the information in the case record. Advisors should note and clear any discrepancies with the individual.

TIERS retains only one set of identification information for each individual. The advisor must make changes according to the hierarchy. The following priority applies:

- A program area providing benefits to an individual takes precedence over a program area not providing benefits. For example, TANF caretaker information takes precedence over TANF payee information, and an active case takes precedence over a denied case.
- For name and birth date identification data:

Priority is given to ...	over ...
Medical Programs	TANF
TANF	Supplemental Security Income (SSI), SNAP, SAS*
SNAP	SAS*

- For sex and race identification data:

Priority is given to ...	over ...
Medical Programs	TANF, SSI, SNAP, SAS*
TANF	SSI, SNAP, SAS*
SNAP	SSI, SAS*
SSI	SAS*

* SAS is Long Term Care's Service Authorization System. Long Term Care authorizes payments to its service providers using this system.

Note: If the Social Security Administration (SSA) validates the Social Security number (SSN) or claim number, the advisor cannot change the number in TIERS. Document the incorrect SSN in the Request Merge/Separate record, if requesting a merge/separate. Use the existing number on file and report the correct number by memorandum to State Office Data Integrity (SODI) Section, Long Term Care, State Office, Y-922.

Before approving an applicant in another program area, check TIERS for accuracy of identifying information. If the identifying information is incorrect, enter the correct information in the **Individual Household** Logical Unit of Work (LUW) or other applicable LUW in TIERS.

C—814 Merge and Separate

Revision 14-1; Effective January 1, 2014

All Programs

Advisors use the functional area on the left navigation bar titled **Merge/Separate** to request a merge or a separate.

Select **Request Merge** if an individual has been assigned more than one individual number. Follow the steps below.

- Enter a minimum of two and up to 10 individual numbers to be merged. Enter mandatory comments explaining the reason for the merge request.
- Click the **Add** button. The demographic information associated with that individual number will be displayed in the **Selected Individuals** section. If it is not the correct person, delete the entry using the **Delete** icon or use the **Binoculars** icon to search for the individual using the demographic data, similar to the individual search in **Inquiry**.
- Once the individual numbers and mandatory comments are entered, click the **Submit** button to send the request to State Office Data Integrity.

Select **Request Separate** when more than one person is assigned to a single individual number. Follow the steps below.

- Enter one shared individual number and up to three individual numbers to be separated. Enter mandatory comments explaining the reason for the separate request.
- Enter the individual number or demographic information and click **Add**. The demographic information associated with the individual number will be displayed in the **Selected Shared Individuals** and **Shared ID above is to be separated to these individuals** sections. If it is not the correct person, delete that entry using the **Delete** icon or use the **Binoculars** icon to search for the individual using demographic data, similar to the individual search in **Inquiry**.
- Once all the individual numbers and mandatory comments are entered, click the **Submit** button to send the request to State Office Data Integrity.

TIERS will not allow a merge or separate request to be submitted for an individual number when a merge or separate request already exists and will display a validation message. When TIERS displays a validation message, correct the information if entered incorrectly or use the **Search Merge/Separate** to determine if the individual numbers requested are associated with the same individual number.

Use **Search Merge/Separate** to track the progress of the request. Some requests will take longer than others. Some individual numbers have to age off of an EDG due to the denial effective date. State Office Data Integrity staff can mark an individual number as a Potential Duplicate (PD) when a merge or separate request is made. Staff cannot select an individual number for addition to new cases if it is marked as PD, which limits the potential for the wrong individual number to be awarded benefits or coverage in error.

Questions concerning a merge or separate request should be sent to the State Office Data Integrity mailbox at tiers_statepaidmedicaid@hhsc.state.tx.us.

C—815 TIERS Case Modes

Revision 14-1; Effective January 1, 2014

A TIERS case mode is a particular mode that TIERS uses to determine the sequence of LUWs it presents during Data Collection. The case mode is typically determined by the type of action being taken on the case, for example, *Intake* (new application), *Complete Action* (redetermination), *Change Action* (processing a change), and so on. Staff set the case mode in the **Data Collection – Initiate Interview** page. Staff should check the case mode prior to starting a case by performing inquiry. Inquiry displays the current case mode and the employee number of the advisor currently assigned the case. The current case mode is also displayed at the top of each page in Data Collection.

C—815.1 Case Mode Definitions

Revision 15-4; Effective October 1, 2015

All Programs

There are 16 case modes.

Mode	Definition
Case Reading	Authorized staff use this mode to examine certain information for a case and record results online.
Change Action	Used to make changes to a case when no application is required.
Complete Action	Used for redeterminations and reviews or applications for a new program for an individual in an existing case.

Mode	Definition
Continue Previously Selected Mode	Allows staff to access Data Collection in the mode previously used.
Conversion	The case mode that System for Application, Verification, Eligibility, Referrals, and Reports (SAVERR) cases and Children's Health Insurance Program (CHIP) cases were converted to if there was mismatched data. This mode is utilized by authorized staff.
Intake	Used when the household is requesting assistance for the very first time or for an existing case when all of the EDGs are denied.
Ongoing	Ongoing mode provides read-only access to all LUWs. **Exception:** Changes can be made in Ongoing mode to the **Household Address – Details** page and the **Initiate Interview – Initiate Review** page. In these two areas, updates can be made without running Eligibility Determination Benefit Calculation (EDBC) and then having to dispose all EDGs. Used with start date and end date fields on the Initiate Interview page to view historical records for a specific time period.
Periodic Income Check (PIC)	Used when a client returns information requested in a missing information request during a PIC.
Reopen	Used when an advisor reopens a case (no active EDGs) and it has been more than 30 days since the last denial action.
Reopen-Left Navigation	Used when the advisor reopens a case (no active EDGs) and it has been 30 days or less since the last denial action.
SSI Certification	This mode is used by State Office Data Integrity staff to approve SSI Medicaid.
SSI Manual Create	Allows authorized staff to establish SSI eligibility in TIERS for an individual when the individual is newly eligible for SSI, or when an SSI-eligible individual has moved from another state and the record is not yet available through the TIERS interface with State Data Exchange (SDX).
Second Level Review	Used when a second level review is required. The staff member must be authorized to perform second level reviews on TIERS cases.
Special Review	Used when a case or EDG requires a review or reauthorization of services that falls outside the normal redetermination time frames.
Spousal PRA	Allows authorized staff to record information and determine the Spousal Protected Resource Amount (SPRA) for institutional and waiver programs.

C—816 Case Mode Hierarchy

Revision 14-1; Effective January 1, 2014

All Programs

Complete Action and Intake modes have hierarchy over all other modes. When an advisor is working on a case in Complete Action or Intake mode, other staff can enter information in TIERS, but they cannot send notices or dispose the case. Their actions are disposed only when the advisor working in Complete Action or Intake mode disposes the case. If an advisor has the case in Change Action mode and subsequently a different advisor accesses the case in Complete Action mode, the Change Action advisor can continue to enter information in the case, but the Complete Action advisor is the only one who can dispose the case and send notices.

Once an advisor accesses a case in Complete Action mode, all individual-initiated changes go to that advisor until the case is disposed. In addition, once an advisor begins an individual-initiated change, all subsequent individual-initiated changes will go to that advisor until the case is disposed. However, outstanding alerts assigned to someone else do not automatically transfer to an advisor who begins a new action on a case.

Note: TIERS routes agency-generated changes based on the office profile.

C—817 Electronic Data Sources (ELDS)

Revision 15-4; Effective October 1, 2015

All Programs

Information from ELDS, such as State Online Query (SOLQ), is presented to advisors in TIERS during Data Collection to allow the advisor to use it as verification. If verification is not available through ELDS in Data Collection, advisors must attempt to verify using other electronic sources (i.e., Data Broker) before requesting additional information or documentation from the applicant.

Advisors must receive written or verbal consent for any adult age 19 or older that is included on an application or renewal and whose information is needed to make an eligibility determination before:

- requesting information from electronic data sources, such as Data Broker or SOLQ; or
- using the individual's information from TIERS, if that adult has a case with HHSC (SNAP, TANF, Medicaid or CHIP).

When consent is given, advisors may use ELDS, a Data Broker report, and/or information from a known case.

If the advisors cannot obtain consent to use ELDS, Data Broker, or existing HHSC data, advisors must deny the application for the individual whose eligibility is being determined.

SNAP and TANF

The signature of the person submitting the application or renewal provides permission for all household members.

Medical Programs

The signature of the person submitting the application or renewal provides permission for any adult listed in A-121, Receipt of Application. For individuals not listed in A-121, advisors must attempt to contact the individual whose permission is needed by phone or via Form H1213, Children's Health-Care Benefits: More Facts Needed from the Parent Who Has Custody.

Example: If a non-custodial parent applies on behalf of a child, information, such as income from the custodial parent, may be needed from the custodial parent to determine that child's eligibility. Advisors must call and obtain verbal consent from the custodial parent before pulling electronic data on that individual, even if the custodial parent's information is available in the system. If the advisor cannot get consent from the custodial parent, the advisor must request the missing information needed from the custodial parent using Form H1213. If the custodial parent does not provide consent to use electronic data, the advisor must deny the child's application.

Related Policy
Verification Requirements, A-1370
How to Use Texas Workforce Commission (TWC) Quarterly Wage Information to Budget Earned Income, A-1355.2

C—820 Data Broker

Revision 15-4; Effective October 1, 2015

All Programs

HHSC contracts with a Data Broker vendor to provide financial and other background information about SNAP, TANF, and Medical Programs applicants and recipients. The vendor collects and combines information from several sources into one report. The report includes information such as residence address, individuals living at that address, vehicle and real property ownership, credit, employment, income verification, and other information reported to other sources.

Follow policy in C-920, Questionable Information, to resolve discrepancies between Data Broker information and information the applicant/recipient provides. In this situation:

- contact the household and allow the individual the chance to explain the discrepancy; or
- send the household Form H1020, Request for Information or Action, asking for information or proof to resolve the discrepancy.

Federal law limits the use of credit reports. See C-824, Permissible Purpose, for information about these limits. Permissible purpose means the individual whose credit report is requested must be:

- an applicant or a certified TANF, SNAP or Medical Program household member (or a member who would be certified but is disqualified); or
- a Medical Program Modified Adjusted Gross Income (MAGI) household member.

Note: For programs that require an interview, do not request a credit report before the initial interview on the individual who signed the application or on individuals for whom assistance is requested on the application.

Use the charts below to find out when to request a Data Broker Combined Report, with or without credit information, when the needed information is not in ELDS:

Request a Data Broker Combined Report *Without* a Credit Report

For TANF, SNAP, One-Time TANF Applications, Redeterminations	Request a Data Broker Combined Report **without** a credit report for household members age 16 and up.
For TP 08, TP 33, TP 34, TP 35, TP 43, TP 44, and TP 48 Applications	Request a Data Broker Combined Report **without** a credit report for household members age 16 and up.
For TP 08, TP 33, TP 34, TP 35, TP 43, TP 44, and TP 48 or CHIP Redetermination	Do not request a Data Broker Combined Report with or without a credit report unless a report is needed to: • provide required verification, • verify identity, or • help clear questionable or discrepant information as explained below.
For SNAP, When Adding an Adult Household Member	Request a Data Broker Combined Report **without** a credit report for household members age 16 and up.

Request a Data Broker Combined Report *With* a Credit Report

All Programs Applications, Redeterminations, Changes – New Household Members	Request a Data Broker Combined Report **with** a credit report for household members age 16 and up on **any** EDG when permissible purpose exists (see C-824, Permissible Purpose) and a credit report is needed to: • authenticate a caller; • help clear questionable information; or • clear discrepant information in the EDG, for example, when an individual has more than two months of negative management. Use the prudent person principle in deciding the need for a Data Broker report or credit report in these instances.

Notes:

- Data Broker Combined Reports with or without credit reports are not required for households that apply for or receive SNAP-CAP or SNAP-SSI. However, staff may request a Data Broker Combined Report if needed for verification or a Combined Report with a credit report if needed to resolve discrepancies in reported information (such as negative management, as in the chart above).
- For independent children or child-only EDGs, request a Data Broker report on the child only if the advisor believes there are unreported assets (as applicable by program), income or other information that would affect the child's eligibility.
- For reported changes, use the interactive search feature in the Data Broker stand-alone system to request a specific type of report according to the change (for example, earned income — The Work Number/Texas Workforce Commission [TWC], child support — Office of the Attorney General [OAG]).

Staff can use Data Broker to access acceptable verification sources, such as TWC Wages/Benefits and The Work Number. Staff can also verify vehicle valuation and property taxes (SNAP) through other sources in the Data Broker report.

Staff must view the Data Broker report to accurately determine eligibility and clear any found discrepancies. Failure to view the report may result in eligibility errors that can lead to quality control errors.

C—821 Access Permission

Revision 15-3; Effective July 1, 2015

All Programs

New Users — Through the Security Access System (SAS), supervisors/managers complete and submit Form 4743, Request for Applications and System Access, for each employee who needs access to the Data Broker system. Managers get signed Data Broker Security Agreement, TWC Security Agreement and OAG Security Agreement forms for each employee who needs access. In the comment field of Form 4743, the supervisor/manager notes the dates all three Security Agreements were signed. Once added to the system, the user gets an email with a temporary password link and further instructions.

Note: New users must access the system within 45 days of the account creation, or the system automatically deactivates the account.

Inactive Users — All provisioned staff must access the system at least every 90 days, or the system deactivates access. Once the system has deactivated access, staff must ask for reactivation through the Regional IT Help Desk. Once access has been reactivated, the user will get an email with a temporary password link and further instructions.

C—822 Data Broker Passwords

Revision 15-3; Effective July 1, 2015

All Programs

Users are directed to the User Options page to create a unique password. Staff can change their password at any time. To change a password, click on the User Options field on the Dallas Computer Services (DCS) Search Options Menu. Enter a new password, confirmation of the password and the user's email address in the appropriate fields. The user then clicks Update My Options to save the changes. The user must log out and then log back in to the system to keep the changes.

Forgotten Passwords — Staff who have forgotten their password can use the **Forgot your Password?** link, and the system will send a temporary password link to the email address associated with the user’s account.

C—823 Login Procedures — Stand-alone System

Revision 15-3; Effective July 1, 2015

All Programs

To access the Data Broker stand-alone system, go to https://nofraud.hhsc.state.tx.us/. To log on, the user enters a User ID (11-digit employee identification number) and a unique password and then clicks Login.

Note: By checking the **Remember Login?** box, the system will store only the user’s employee identification number (which is the same as the User ID). The system will not store the password.

The first time a user logs on, two screens appear. The first screen is the Application for Password — HHSC Office of Social Services. The user must read the screen and click "I understand and agree" to show the user understands that Data Broker information can be used only for business purposes and is confidential. If the user clicks "I disagree," Data Broker does not allow access to the system.

The second screen is the Additional Authorization for Access to Request Credit Reports screen. The user must first read the screen. If the user has completed Data Broker training, the user should click "I understand the above and agree" to acknowledge that the individual:

- has been adequately trained on the Fair Credit Reporting Act (FCRA), and
- agrees to only order a credit report when permissible purpose exists.

If the user is unsure or has not completed training regarding the FCRA, the user should click "I disagree" and contact a supervisor. By clicking "I disagree," the user cannot access credit reports. If this should occur, the page can only be redisplayed if the user contacts the Regional IT Help Desk. The Regional IT Help Desk will reset the page. If the page is not reset, the user may request all reports, but will not get a credit report.

C—823.1 Online Help Feature

Revision 12-4; Effective October 1, 2012

The Online Help feature is available in the Data Broker stand-alone system and includes instructions and sample screens to assist staff with understanding the different types of reports available in the Data Broker system. This feature is located on the left navigational bar in the Data Broker stand-alone system. To activate this feature, click the Help link, and a pop-up window will display.

C—824 Permissible Purpose

Revision 15-4; Effective October 1, 2015

All Programs

Federal law in FCRA covers access to and use of credit reports. FCRA permits HHSC to request credit information on individuals in the course of determining eligibility for programs it administers. HHSC may not request credit information for purposes other than eligibility determination. The law requires permissible purpose before HHSC may legally request a credit report. Permissible purpose means the individual whose credit report is requested must be:

- an applicant or a certified TANF, SNAP or Medical Program household member (or a member who would be certified but is disqualified); or
- a Medical Program MAGI household member.

Note: Do not request a:

- credit report on a payee EDG unless the responsible relative is the child's parent.
- credit report using an invalid Social Security number.

The FCRA makes a clear distinction between requesting credit reports and other types of inquiries made through Data Broker. Under legal statutes, HHSC may request identifying information such as address, employment and vehicle registration on any individual.

Permissible purpose is not required when requesting non-credit identifying information. For example, if an advisor suspects an absent parent is in the home, the advisor does not have permissible purpose to request a credit report on the absent parent. However, it is appropriate to request identifying information available through the Data Broker system.

Note: Those who request information without permissible purpose are in violation of federal law and are subject to fines, imprisonment of up to two years, or both.

C—825 Reports Not Subject to Permissible Purpose

Revision 15-4; Effective October 1, 2015

All Programs

This section describes the various data sources in Data Broker that are not subjected to permissible purpose requirements noted in C-824, Permissible Purpose.

C—825.1 Driver License Information

Revision 13-3; Effective July 1, 2013

All Programs

Data Broker matches information from the Combined Report Search screen against Department of Public Safety (DPS) data. When a match is found, DPS data is pulled into the report. Information in this report may identify discrepancies in the identity and residence address of the individual. While DPS still collects information on height, weight, eye and hair color, this information is no longer sold to Data Brokers. DPS continues to carry information previously collected in these categories.

This report includes a Previous Name/Address sub-section. Since DPS re-issues driverlicense/ID numbers, approximately two years after the license/ID number expires, previous names/addresses associated with that number are listed in this section.

The Validated field is the date the driver license or ID information was last updated with DPS.

Note: DPS updates information on this report only when the individual with the Texas driver license (TDL) or DPS ID provides updated information to DPS. When an individual changes their address or name with DPS, DPS sends the Data Broker vendor this information. Even though DPS does not retain an old address on its files, the Data Broker does. If the individual moves or has a name change and does not notify DPS, that information on the DPS database will be obsolete. Always review the date the information was last updated.

C—825.2 Persons at Entered Address

Revision 12-4; Effective October 1, 2012

All Programs

Data Broker searches the DPS database and pulls records for all persons listed at the address entered on the Combined Report Search screen. The information pulled includes each person's name, address, date of birth (DOB) and the last date DPS updated this particular record. Previous residents may appear if they have not changed their address with DPS.

Information on this report is useful in providing case clues about household composition and exploring parental absence for deprivation.

The Validation field shows the date the individual on that line last updated information with DPS. All other entries are self-explanatory.

C—825.3 Neighborhood Address Search

Revision 13-3; Effective July 1, 2013

All Programs

This report lists residents of the 20 addresses nearest to the address entered on the Combined Report Search screen. Information may be useful for locating absent parents or for other case-related activities. Data Broker pulls this information from the DPS database. The information is only as current as DPS' most recent update.

The Validation field shows the date the individual on that line last updated the information with DPS. The asterisk (*) indicates that the individual has a Texas ID in lieu of a TDL. Some individuals may have both a Texas ID and a TDL. These individuals appear on two lines.

Note: The advisor may contact a neighbor on the Data Broker report only when:

- instructed by the individual to do so; or
- staff receives information from another source that contradicts the client's statements.

See C-920, Questionable Information, and C-930, Providing Verification, for information regarding contacting a collateral source not designated by the individual.

C—825.4 Out-of-State Shopping (OSS) Report

Revision 15-4; Effective October 1, 2015

TANF and SNAP

The OSS Report lists households receiving SNAP and/or TANF benefits in Texas that:

- shopped out of state in the last 60 days;
- did not shop in Texas during that period; and
- have active EDGs.

OSS Report information is included on the combined Data Broker report and is considered a case clue that Texas residency may be questionable. The advisor must address OSS information at the time of the interview/desk review.

Clearing Non-Border OSS Report Activity at a Complete Action

The household must provide verification of their address if:

- the most recent OSS occurred within six months before the interview/desk review month, and
- the OSS occurrence listed in the report was not previously cleared.

Note: Some non-border OSS Reports are also sent to the Customer Care Center (CCC) as potential change actions, as explained in B-353, Out-of-State Shopping (OSS) Reports.

Clearing Border OSS Report Activity at a Complete Action

This report must be cleared at a complete action when a household submits an application or redetermination and the OSS activity in the report makes the household's address questionable. **Example:** A household living in Texas near the Arkansas border and shopping in Arkansas may not cause residency to be questionable. A household living in Austin and listed as shopping only in Arkansas in the past 60 days would cause residency to be considered questionable.

Note: Take action on any associated Medical Program EDG when clearing any OSS report activity.

Related Policy
Out-of-State Shopping (OSS) Reports, B-353
Verification Requirements, A-760
Verification Sources, A-761

C—825.5 Texas Vehicle

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32, and Children on TP 56

Data Broker searches the Texas Department of Transportation (TxDOT) database and pulls information for all vehicles listed at the address entered on the Combined Report Search screen. Information pulled includes the:

- owner of each vehicle;
- Texas vehicle license tag number;
- year, make and model of each vehicle;
- average wholesale value of the vehicle; and
- vehicle's lien holder (when applicable).

This information is useful when exploring a household's resources. The information provides case clues on vehicle ownership and value and on household composition. Explore and clear any discrepancies.

Except for vehicle values, Data Broker receives updated information weekly from the TxDOT database. Data Broker updates the vehicle value twice per year to coincide with the release of the *National Auto Research (NAR) Black Book*.

TxDOT updates its database when an individual renews a vehicle's registration, retitles a vehicle, or reports a change of address to TxDOT. It is possible for vehicles not owned by the household to appear on this report. This can happen when an individual does not complete atitle transfer or does not update an address with TxDOT.

Vehicles registered at an address other than where the individual lives do not appear on this report. When an individual has a vehicle not shown on the report, staff can use the owner's name or the vehicle tag number to obtain information by using the Texas Vehicle report listed under the DCS Search Options menu.

The Value field lists the average wholesale value of the vehicle and can be used as verification to determine the countable value of the vehicle. See A-1251, Verification Sources, for other acceptable methods of verification.

C—825.6 Social Security Administration (SSA) Death Index

Revision 15-4; Effective October 1, 2015

All Programs

This report is only available via an interactive inquiry on the Data Broker Search Options menu. Information from this report is not included on the combined report. The Death Master File contains approximately 50 million records of deceased individuals dating back to 1937. Approximately 98 percent of the file consists of individuals who died after 1962. The Death Master File contains only decedents whose deaths were reported to the SSA. While a majority of individuals who die are contained in the file, it is not a complete file of all deaths that occur in the U.S. Data Broker matches a last known address with approximately 30 percent of the death records. Most of these addresses are associated with individuals who died more recently (during the 1970s or later).

C—825.7 Property Value

Revision 15-4; Effective October 1, 2015

TANF, SNAP, Children on TP 32, and Children on TP 56

This report contains information regarding real property owned in Texas according to the address listed on the Combined Report Search screen. The combined report provides information on ownership of the property at the address entered regardless of who owns the property. If an individual owns other property in Texas, the report lists the property only if the individual receives the tax bill at the address entered.

Individuals may report owning property in Texas that is not listed on the report. Staff can obtain information on this property (if it is in one of the counties whose records are on the Data Broker system) by accessing the property report listed on the DCS Search Options menus.

The Data Broker system currently lists property records for the following 43 counties:

Bell	Ector	Harris	Lubbock	Rockwall
Bexar	Ellis	Harrison	McLennan	San Patricio
Brazoria	El Paso	Hays	Midland	Smith
Brazos	Fort Bend	Hidalgo	Montgomery	Tarrant
Cameron	Galveston	Jefferson	Nueces	Travis
Collin	Grayson	Johnson	Orange	Webb
Comal	Gregg	Kaufman	Parker	Williamson
Dallas	Guadalupe	Kendall	Potter	-
Denton	Hardin	Liberty	Randall	-

Note: Frequency of information updates on this report varies according to the county.

The total value of real property consists of the value of the land plus the value of any improvements. See A-1200, Resources, for policy regarding property.

Explore any discrepancies between information on the application and this report. Information on this report is taken directly from taxing authorities and can be used as a verification source. If an individual states the information on the report is incorrect, request verification to clear the discrepancy. See A-1251, Verification Sources, for other acceptable methods of verification. Use a method other than Data Broker to determine the value of rural land that may have an agricultural exemption. **Note:** Before taking action on an EDG based on property information, ensure that the property is not exempt (such as homestead, income producing, etc.).

C—825.8 Telephone Number

Revision 13-1; Effective January 1, 2013

All Programs

This report is only available via an interactive inquiry on the DCS Search Options Menu. Information from this report is not included on the combined report. The telephone number search locates the address associated with the telephone number listed on the Combined Report Search Screen. The system then searches the address and lists all people at the address associated with the telephone number.

C—825.9 Texas Marriage and Divorce

Revision 13-1; Effective January 1, 2013

All Programs

This report is only available via an interactive inquiry on the DCS Search Options menu. Information from this report is not included on the combined report. This report is pulled from marriage and divorce records from the Department of State Health Services Texas Vital Statistics Unit. These records, updated annually, provide the dates and names of individuals married and divorced in Texas.

C—825.10 Texas Criminal Convictions

Revision 16-3; Effective July 1, 2016

TANF, SNAP and One-Time TANF

The Texas Criminal Conviction report contains a list of all convictions and felony deferred adjudications that are contained in the computerized criminal history system maintained by DPS. This report is updated monthly; however, since it contains records reported to DPS by various Texas courts, the report may not be complete. The information included in the report depends on the authority reporting the offense and is considered a case clue only. DPS does not guarantee that the records obtained relate to the person about whom you are requesting information. In most cases, the report includes the classification of the offense (felony, misdemeanor, deferred adjudication, etc.). When it does not, staff must investigate further.

Note: The report only gives the conviction date. Disqualifications for TANF are based on offense dates. See A-2128.1, When the Individual Signs Form H1073.

The report lists several pieces of identifying information including DOB, sex, race, hair and eye color, height, and weight. When a criminal record is found, check each factor to ensure the individual on the report is the individual on the EDG.

When the report reveals information that indicates the individual may have committed an offense subject to action by HHSC, explore the situation with the individual. If the individual acknowledges she or he is the person on the report, take the appropriate action.

If the advisor has reason to believe that the individual is the person indicated on the report but the individual disagrees or disagrees with other information contained within the report (such as the type of conviction or whether it was a felony or misdemeanor), the advisor must:

- document the individual's response in the case comments;
- proceed with the appropriate EDG action without acting on the criminal history report;
- contact the Office of Inspector General (OIG) by emailing the HHSC OIG General Investigations Policy and Quality Control Unit at oig_gi@hhsc.state.tx.us; and
- document the reason for contacting OIG in the case comments. Once OIG obtains information to clear the discrepancy, the assigned OIG investigator provides the response/finding by creating a task within the Task List Manager (TLM). The assigned advisor clearing the task documents the results of the OIG's findings in case comments and, if applicable, enters information in the Individual Demographic Conviction/Rehabilitation Tab. Make an overpayment referral if appropriate. (See B-770, Filing an Overpayment Referral.)

Related Policy
SNAP — Budgeting for Persons Disqualified for Intentional Program Violations, SNAP Employment Services Noncompliances, Felony Drug Convictions or Being a Fugitive, A-1362.4
Alcohol or Drugs, A-2128

C—825.11 The Work Number

Revision 15-3; Effective July 1, 2015

All Programs

DCS is the authorized agent for HHSC to get income verification reports from The Work Number, which provides an automated employment and income verification service. More than 1,000 employers give their employees' salary data to The Work Number database each payroll period. Employers represent all industries, including fast food chains, retail stores, health care organizations, temporary staffing agencies and others. Employer lists are available online when The Work Number is selected from the left navigational bar of the Data Broker application.

If the employer's records are part of The Work Number database, the system returns the applicable payroll information in the requested combined search or the interactive inquiry search. Some of the following payroll information is returned by the system:

- Employee name and address
- Social Security number
- Employment status
- Most recent start date and/or end date
- Total time with employer
- Job title
- Rate of pay
- Average hours per pay period
- Year-to-date (YTD) wages
- Most recent pay periods of gross earnings for the period of time selected from the interactive search drop-down list (i.e., two months, four months, six months, one year, two years, three years or all available)

  Note: Combined reports default to three months of income. If the user needs more than three months of income, the user must perform an interactive inquiry.
- Basic medical information

The Work Number also may provide, on behalf of employers:

- up to three years of income broken down by pay period;
- payroll deductions; and
- comprehensive medical information, including:
  - carrier name;
  - policy and group number;
  - premiums; and
  - dependent care benefits.

Note: The individual employer decides the information reported to The Work Number. Staff may see blank areas of information if that particular employer chooses not to report the data.

C—825.11.1 Using The Work Number as Verification

Revision 15-3; Effective July 1, 2015

All Programs

The Work Number is an acceptable source of verification. Staff must attempt to verify wage information using Data Broker before asking for verification from the individual. If the Data Broker report does not provide wage verification or the verification is not sufficient to prove current eligibility, use an alternate source to get the verification. See A-1371, Verification Sources, for other sources of acceptable wage verification.

C—825.12 Employer New Hire Report (ENHR) and National Directory of New Hires (NDNH) Report

Revision 16-1; Effective January 1, 2016

All Programs

The ENHR and NDNH contain information used as an indicator for unreported earned income. The ENHR contains employer information for individuals whose employers are based in Texas. The NDNH contains employer information from all 50 states, four territories, and all federal agencies. These reports list information such as hire date, employer name/address, and employee name, date of birth and address.

These reports are assigned to CCC staff when a change action is needed on an active EDG. The information also is made available through Data Broker to ensure staff has access to this information for applications and redeterminations. Staff should treat this information as a case clue and take appropriate action to verify the information in accordance with existing policy. See C-920, Questionable Information.

The new hire data listed in Data Broker will display from the beginning of the calendar year. Once the information is included as part of the TWC Wage Report, it will no longer display separately under the New Hire Report.

The ENHR and NDNH may list the corporate name and address instead of the local business name and address. Before taking adverse action related to this report, consider that the commonly known name of a business may be different from the corporate name.

Related Policy
Changes, B-600
Verification and Documentation, C-900

C—825.13 Texas Workforce Commission (TWC) Wages/Benefits

Revision 13-3; Effective July 1, 2013

All Programs

TWC Wages/Benefits information is available through the interactive and combined Data Broker report options and includes information on wages, claimants and unemployment benefit records. Claimant and unemployment benefit payments will display only if the individual has applied, is receiving or has received unemployment with TWC.

The TWC information is obtained in Data Broker using one of two methods.

1. **Interactive Search** (individual reports) will allow the user to search TWC information using the TWC Wages/Benefits link from the left navigation bar. Four search criteria are identified:

- Claimant Status
- Wage Details
- Benefits
- Combined Wages, Status, Benefits Report

Individual searches can be done using any of the first three criteria. Selecting the fourth search criteria will return a combined report of all three TWC inquiries.

The date filter option is available for the user to request TWC inquiries for any of the four search criteria. Date filter options include two months, four months, six months, one year, twoyears, three years or all available.

2. **The Standard Combined Report** includes the TWC information along with all other reports available. See C-827, Data Broker Combined Reports, for other sources.

TWC information returned on the standard combined report will default to the last four months of data available for wage detail, claimant and benefit payments. If the user needs more than four months of data, the interactive search criteria can be used.

The following codes appear within the Claimant Status Search and the Combined Wages, Status, Benefits Report:

- **Clm Sta —** the current status of the claim
  - COMPLETE = is valid and complete
  - INCOMPLETE = is missing required information
  - VOID = is voided
  - BATCH = claimant must complete and activate the claim
- **Clm Sta DT —** date the claim status last changed
- **Pgm —** the program under which this claim is filed
  - EUC = Emergency Unemployment
  - EXB = Extended Benefits
  - REG = Regular Unemployment Insurance
  - TRA = Trade Affected Unemployment Insurance
  - TRX = Extended Trade Affected
  - TUC = Temporary Unemployment
- **Clm Dt —** the Sunday effective date of this claim
- **Pay St —** the two initials of paying state
- **File Dt —** the date the claimant filed his/her claim
- Last employer's name and address
- **WBA —** the weekly benefit amount
- **MBA —** the maximum benefit amount
- **Balnc —** the current benefits remaining
- **PaiD –** the total amount of benefits paid
- **Disqual —** the amount of benefits deducted from the balance due to disqualification
- **Overpmt —** the amount of any overpayment of benefits on this claim
- **RecovrD –** the amount of money recovered by TWC to offset an overpayment of benefits
- **Opbalnc —** the amount of overpayment still remaining to be paid
- **Pend Invstn —** whether or not TWC is investigating this claim. If yes, the person's benefits may be delayed. Y = Yes, N = No
- **BWE —** ending date of this benefit week (will always be a Saturday because TWC begins a new week on Sunday)
- **OP —** the amount overpaid that week
- **Status —** the status code of each certification
  - AA = BAD ADDRESS
  - AG = AGENT STATE CERTIFICATION
  - AR = SYSTEM ERROR - NOTIFY TE
  - CV = CONVERTED BENEFIT WEEK
  - DQ = DISQUALIFIED
  - EE = EXCESSIVE EARNINGS
  - EH = EXCESSIVE HOURS
  - FP = FIRST PAYMENT
  - FR = FRAUD
  - FV = FRAUD VOIDED BY APPEALS
  - GM = GOOD MONEY/ACCOUNTING
  - IC = OPEN INVESTIGATION
  - IE = INELIGIBLE
  - IN = INCOMPLETE INVESTIGATION
  - IW = WAITING WEEK IDENTIFIED
  - NC = RESPONSE NOT CERTIFIED
  - OP = OVERPAID
  - OR = OVERPAYMENT REVERSED
  - OV = OVERPAYMENT VOIDED
  - PD = PROCESSED
  - PP = PENDING PROCESSING
  - PR = PENDING EMPLOYER RESPONSE
  - RC = RECOVERED
  - RP = PARTIAL RECOVERY
  - SP = SUPPRESSION PERIOD
  - VC = VOIDED CLAIM
  - WW = SERVED WAITING WEEK
  - XX = FORCED PAY
  - YY = OFFLINE PAY

    - ZZ = PAY OLD CLAIM
- **TotDist —** the sum of any recovered overpayments, Child Support payments and all other distributions for that week
- **TotDedc —** the sum of any Child Support deductions and all other deductions for that week
- **PmtAmt —** the amount of benefits issued to the claimant after any withheld for an overpayment recovery, Child Support or income tax. This amount may be less than the WBA.

The following codes appear within the Benefit Payments Search:

- **BWE —** ending date of this benefit week (will always be a Saturday because TWC begins a new week on Sunday.)
- **File Date —** the date the claimant filed his/her claim
    - V = filed by telephone
    - P = filed by paper
- **Week Sts —** the status code of each certification
    - CV = convert benefit week
    - DQ = disqualified
    - EE = earning adjustment
    - FP = first pay
    - IC = payment flag is "NO"
    - IE = ineligible (will not receive benefits)
    - IN = investigation pending, no payment
    - IW = identified waiting week; will not be paid until claimant receives three times the weekly benefit amount
    - NC = not certified
    - PD = paid
    - PP = pending payment
    - PR = pending for employer's response
    - PROCESSED = this claim is processed
    - WW = waiting week served and paid
- **Op Amt —** the amount UI overpayment, if any
- **Erngs —** amount of wages the claimant earned during this week, if any
- **Pgm —** the program under which this claim is filed
    - EUC = Emergency Unemployment
    - EXB = Extended Benefits
    - REG = Regular Unemployment Insurance
    - TRA = Trade Affected Unemployment Insurance
    - TRX = Extended Trade Affected
    - TUC = Temporary Unemployment
- **Ddct —** The sum of any Child Support deductions and all other deductions for that week. A deduction is a reduction in the weekly entitlement or amount benefiting the claimant. An example would be a reduction in benefit payment because the claimant receives retirement payment from a qualifying employer.
- **Dist —** The sum of any recovered overpayments, Child Support payments and all other distributions for that week. A distribution is a benefit to the claimant but distributed to an entity other than the claimant. Examples of a distribution would include Child Support payments, IRS withholdings or overpayment absorption.
- **Amt —** The amount of benefits issued to the claimant, after any withheld for an overpayment recovery, Child Support or income tax. This amount may be less than the WBA. **Note:** There are periods when payment is supplemented. An example is Federal Augmented Compensation (FAC). FAC payments increased weekly entitlement by $25. A weekly benefit payment with no deductions or distributions may be greater than the WBA.
- **Date —** the date the benefits were issued to the claimant.
- **ID –** the warrant number of this benefit payment. Payment is made by warrant, direct deposit and debit card. The method of payment is indicated by the first character of the payment ID. Codes include:
    - B = DIRECT DEPOSIT
    - D = DEBIT CARD
    - W = TWC WARRANT

If no information is available for an individual, **NO CURRENT MATCHES** will display.

C—825.13.1 TWC Error Messages

Revision 13-3; Effective July 1, 2013

Error messages may appear when a request is made and the TWC database is experiencing heavy volume. When the TWC inquiry is retrieved, a feature in the Table of Contents of the Standard Combined Report will display the following message:

TWC Error: CLICK TO RETRY

By clicking on this link, the user can re-request the report without re-entering all of the individual's information. Users should continue to retry until the information becomes available.

C—825.14 Office of the Attorney General (OAG) Child Support

Revision 13-3; Effective July 1, 2013

All Programs

This report contains child support data from the OAG's database. Data Broker searches the OAG database and pulls records for the HHSC client entered on the Combined Report Search screen and displays all persons receiving and/or paying support payments associated with that individual.

This report also is available via an interactive inquiry on the Data Broker Search Options menu to conduct a member or financial search. A member search is used when the case name or adult household member's SSN is not available. A financial search can be done for specific financial information for a period of time not found on the Combined Report Search.

The OAG information available through Data Broker allows staff to more easily obtain child support income that may not be listed on Form H1010, Texas Works Application For Assistance – Your Texas Benefits, or otherwise reported, thus reducing risk of fraud and Quality Control payment errors. Additionally, Data Broker offers household composition case clues by listing an address for each member, if available, on the combined report associated to a particular OAG case.

Note: The Texas Child Support Enforcement System (TXCSES) web-based system is available for limited use if needed to obtain any information not found within the Data Broker system.

C—825.14.1 OAG Child Support Data

Revision 13-3; Effective July 1, 2013

All Programs

The child support data is displayed in five types of fields and each section of data is displayed in the order shown below for each report:

- **Collections –** current child support, medical support and arrears from the HHSC client for which Data Broker was requested.
- **Disbursements –** current child support and medical support to the HHSC client for which Data Broker was requested.
- **Arrears –** disbursements to the HHSC client for which Data Broker was requested.
- **Obligated Support –** reported for both collections and disbursements.
- **Member Details –** includes all members associated with the child support case.

Notes:

- Anytime a Show Section link is displayed in the report, staff should click the link for more detailed information on each applicable member.
- Sections that have no data will not be displayed within the report. If there are payments that are discovered by staff or by an individual's statement that are not available in Data Broker, staff will need to access TXCSES to verify any payments and obligations. If all information is not available in TXCSES, staff will need to pend for verification.

Example: Registry Only cases are not collected and disbursed by the OAG and are only recorded in the OAG system and will not be displayed in Data Broker. When Data Broker inquiry is conducted on these cases, the message displays:

Case is a 'registry-only' case which means that not all obligations nor dependents may be listed.

The Data Broker OAG screens contain a detailed breakdown of the following information.

- **The reports are member-oriented instead of case-oriented.** The report contains details from all child support cases associated with the HHSC client (member), including both collections and disbursements. If the individual receives disbursements from multiple absent parents (AP), the payments from each AP are displayed separately within each report.

  Disbursements for arrears are displayed separately within the report as income to the custodial party. Collections for arrears are not displayed separately from other types of support payments since both types of payments can potentially be allowed as a deduction.

- **The report displays collections and disbursements in payment date order, starting with the most recent payment**. Payments from all child support cases associated with a particular HHSC client will be displayed in the report.
- **Support order obligations are sorted per dependent.** Legal obligations typically reflect a monthly amount. The Obligated Support section is displayed to inform the advisor of the **legally** obligated amount. For SNAP, the policy in A-1421, Child Support Deductions, allows a deduction only for legally obligated support.

  The Per Period Amount column under the Obligated Support section displays the total obligated amount for all children of a particular absent parent. The Per Child Amount displays each child's portion of legally obligated support. If there is only one child, then the amounts in the Per Child Amount and Per Period Amount columns will be the same.

  The Duration column displays the time period for which the legal obligation applies. The child support order establishes the begin date and end date of the legal obligation. Orders normally end once the child turns 18, or graduates from high school if later; although obligations may continue past this date due to a child's disability. When the obligation includes more than one child of a different age and the obligation ends for a child, a new duration period will be reflected in the duration field. If at any time the AP becomes delinquent in payments, child support and medical arrears can be ordered in addition to the amount the AP is originally ordered to pay, and this may prolong the AP's obligation duration period.

Note: Payments (collections and disbursements) are sorted by support type (e.g., child support vs. medical support).

- **Disbursement Payments are sorted by dependent.** The Data Broker child support function automatically calculates and sorts the payment information for each dependent on the case when a single payment is made for more than one dependent. Advisors no longer have to calculate the correct portion of the payments for each dependent.

  The Per Child Amount column displays the amount to be entered into TIERS for each dependent listed in the Dependents column. Data Broker reports payments disbursed for a child under the dependent's name even if the child is not in the household. If a caretaker receives current child support for a non-member (or a member who is no longer in the home) but uses the money for personal or household needs, count it as unearned income as required by policy in A-1326.2, Child Support. Do not count the amount actually used for or provided to the nonmember for whom it is intended to cover. Verify what the individual is doing with the payments and what amount must be counted, as explained in A-1370, Verification Requirements.

Note: Legal obligations are typically established as a monthly obligation. Wages are typically garnished based on the pay frequency of the AP's job; therefore, the amounts shown on the screens for collections and disbursements reflect the frequency for which the OAG receives the payments, which is usually other than monthly.

For additional policy information on child support payments and how they are allocated for members and non-members, refer to A-1326.2, Child Support.

- **Disbursement Received dates are calculated by Data Broker and displayed in the report.** Data Broker automatically applies the policy in A-1326.2.1, Counting Child Support, to estimate the date a child support payment is received by adding five days from the date a warrant was mailed or by adding two business days from the date an electronic transfer was initiated, excluding weekends and bank holidays. Therefore, when using Data Broker to verify child support, the advisor must use the Receive Date as the estimated date the individual receives a child support payment disbursed by the OAG.
- **Only payments actually disbursed to the individual will be displayed to assist in reduction of calculation and payment errors.** All collections will be displayed in the Collections screen. Since all collections are potentially a deductible expense, only payments that were actually disbursed to the individual will be displayed in the Disbursements screen to help reduce errors (e.g., payments given to HHSC as repayment services will not be displayed). If the OAG disbursed additional payments to an entity other than the HHSC client, the message "Additional payments were made on this case to non-member recipients: CHILD SUPPORT ENFORCEMENT DIVISION: HHSC" will be displayed for informational purposes only.

Note: If an individual reports receiving child support via the Texas OAG and those payments are not being reflected on the Data Broker system, the advisor must check the TXCSES Web portal for verification of the payment(s). Infrequently, the advisor may also be unable to verify using the TXCSES web portal. In this situation, the advisor must pend the individual for proof of the child support payment because the payments are not currently available in the Data Broker system.

Example: An individual is receiving child support payments for a dependent from an out-of-state order and the Texas OAG does not yet have the child support order but is receiving payments on behalf of the individual.

- **Arrears payments are separated in the report to help ensure advisors count them properly.** Advisors must enter arrears payments as income for the person to whom the payments are disbursed, not for the dependent. Enter arrears payments into TIERS as unearned income for the custodial party. See A-1326.2, Child Support, for more policy information.
- **Member addresses are displayed as a case clue to determine household composition and to aid in determining if an absent parent has moved back into the same home as the custodial party.** The Member Details section will display all members associated with the individual for whom the report was requested. The report will display the individual and all members associated with that particular OAG case.

Note: If an absent parent is making child support payments but moves back into the home of the caretaker and child, do not count the child support. Count the earnings and/or other income as a regular household member as stated in A-1326.2.

Related Policy
Medical Support Payments, A-1326.2.3
Reimbursements, A-1332
Child Support Deductions, A-1421

C—825.14.2 OAG Error Messages

Revision 13-3; Effective July 1, 2013

Error messages may appear when a request is made and the OAG database is experiencing heavy volume. When the OAG information is retrieved, a feature in the table of contents of the Standard Combined Report may display one of the following messages:

The OAG Child Support portal has temporarily exceeded capacity. Please retry this request in a moment using the link below.
Child Support Portal Retry

or

A 505 error has occurred in the CSD request.
CSD Error: CLICK TO RETRY

By clicking on these links, the user can re-request the report without reentering all of the individual's information. Users should continue to retry until the information becomes available.

C—825.15 SNAP Out-of-State IPV Disqualifications

Revision 15-4; Effective October 1, 2015

This report lists household members who have a current intentional program violation (IPV) disqualification from another state. Advisors must follow policy in B-941, Disqualifying a Household Member with a Current SNAP Out-of-State IPV Disqualification, when this is reported.

C—825.16 Alien Status/Systematic Alien Verification for Entitlements (SAVE)

Revision 15-3; Effective July 1, 2015

All Programs

Data Broker in TIERS includes information about alien status. Once staff select Individual ID, an Alien Status option appears at the top of the Data Broker TIERS Report page with two options:

- Verify SAVE Status — Staff can send a Request for Initial Verification and a Request for Additional Verification to the Department of Homeland Security (DHS).
- Verification History — Displays prior SAVE inquiry responses.

By clicking on the Verification SAVE Status option, the last name, first name and birthdate fields are prepopulated based on the information in TIERS Data Collection. Enter the alien registration number per the U.S. Citizenship and Immigration Services (USCIS) document. Staff should only access Data Broker reports for individuals age 16 and older. Staff must continue to use the stand-alone SAVE Web-based system for individuals under age 16.

HHSC must use the SAVE Web-based system operated by DHS to verify the immigration status of each noncitizen applying for SNAP, TANF, Medicaid and CHIP. Staff must verify alien status:

- at application;
- when adding a new person identified as a noncitizen; or
- when the USCIS document of a SNAP, TANF, Medicaid (except Emergency Medicaid) or CHIP recipient has expired.

Do not reverify the noncitizen's USCIS documents if they were previously verified and documented and the documents have not expired.

For sponsored aliens, use the Request for Additional Verification option on the Alien Status page if the household states there is a sponsor, but does not provide the name and address of the sponsor.

Note: When copying the USCIS document for imaging, be sure the document is clear and copied at 200%. Be sure to copy any pertinent information on the back of the card.

The SAVE stand-alone system is available for limited use, if needed, to get any information not found within the Data Broker system or for individuals under age 16. Follow the steps in A-355.2, How to Request an Initial Verification.

C—825.16.1 Alien Status Historical Data

Revision 14-2; Effective April 1, 2014

This feature will search alien status history for up to the last 24 months to determine if there is a previously submitted inquiry available. A new alien status inquiry will not display if any inquiry has been completed within the last 24 months. A message will display along with the historical record when this occurs. If the document on file is expired and an inquiry was completed within 24 months, staff will have an option to continue with the inquiry by selecting the **perform a new initial verification** link.

C—825.16.2 Alien Status Initial Verification

Revision 15-3; Effective July 1, 2015

Staff must choose from a drop-down menu the document type that the person provided and enter the alien number and card number. The Document Type drop-down menu lists the most common types of documents. If the document type is not listed, choose "Other."

The card number from the I-551, Permanent Resident Card, that must be entered in SAVE is 13 digits and begins with three letters. I-551s issued between May 2004 and May 2010 have the card number on the front, whereas I-551s issued beginning in May 2010 have the card number on the back.

Note: To verify whether SAVE was completed, staff (such as case readers) should use Data Broker > Case History in the stand-alone system.

C—825.17 Inmate/Parolee Match

Revision 16-3; Effective July 1, 2016

All Programs

The Inmate/Parolee Match displays prisoner information for individuals who are incarcerated for more than 30 days. The following identifying information is displayed, if applicable, for the incarcerated individual:

- name;
- SSN;
- DOB;
- last known address;
- incarceration sentence date (first day of incarceration);
- earliest release date;
- prison unit;
- offense; and
- date of offense.

Staff must treat prisoner match information as a case clue when Data Broker shows the individual is currently incarcerated and the current date is more than 30 days from the incarceration sentence date.

For applications and renewals with an interview (and at a change when applicable), staff must ask whether the individual is still incarcerated (if the individual is not present, by phone or in the office, during the interview or report of change).

- If the household agrees that the individual is not in the home, staff must remove the individual from the EDG and process the case action.
- If the household disagrees and states that the individual is in the home, staff must pend for verification of household composition. Staff may use existing verification sources to verify household composition as listed in A-251, Verification Sources. In addition to the sources listed in A-251, individuals may provide records from the court or incarceration facility as verification.

For applications, renewals, and changes that do not require an interview, staff must attempt to contact the household to inquire about the individual shown as incarcerated on Data Broker.

- If contact can be made, staff must follow the appropriate steps above for households who agree or disagree with the report of incarceration.
- If contact cannot be made, staff must pend for verification of household composition using the sources explained above.

Staff must document the following information in case comments:

- the household's response regarding whether they agreed or disagreed with the incarceration information in Data Broker;
- when a household member is not included as a result of incarceration information in Data Broker;
- if applicable, attempts to verify and how questionable information was cleared (C-940, Documentation); and
- if applicable, when a fraud referral is sent to OIG (B-720, When to File an Overpayment Referral).

Related Policy
Questionable Information, C-920

C—826 Entry Instructions

Revision 12-4; Effective October 1, 2012

C—826.1 Requesting Data Broker Reports in the Stand-alone System

Revision 15-3; Effective July 1, 2015

Staff can use the Data Broker stand-alone system to pull specific data element searches, such as TWC, OAG, etc. Staff can also use the stand-alone system on a limited basis if TIERS is experiencing technical issues.

All Programs

DL Number: Enter the TDL number or DPS identification card number. This is not a mandatory entry, but when staff enter this number and click the Lookup button, the system automatically pulls data for all fields except SSN and Case Number. If DPS data is incorrect or obsolete, enter the correct data over the incorrect data. This pulls data from both the old and new addresses.

Inquire On: Click on the appropriate description for the person on whom you are making the inquiry.

- Applicant — New applicants or household additions.
- Recipient — Currently active recipients.
- None of the Above — Anyone who is not an applicant or recipient. No credit report is pulled if this choice is made; instead, a Credit Header report is included, which does not require permissible purpose.

SSN: Enter the SSN of the person for whom you need Data Broker information. Do not enter an incorrect or false SSN. If an incorrect SSN is entered, an erroneous file may be created or information for the wrong person may be pulled.

Case Number: Enter the TIERS application/case number. Never enter a false TIERS application/case number or one belonging to another person.

Staff must enter information in the remaining fields marked with an asterisk when the DPS identification or TDL number is unknown. These fields are self-explanatory.

C—826.2 Requesting Data Broker Reports in TIERS

Revision 15-3; Effective July 1, 2015

TIERS lets eligibility staff request information from Data Broker online. Staff must request and view the Data Broker Combined Report for applicable household members to accurately determine eligibility and clear any found discrepancies. Failure to view this report may result in eligibility errors that can lead to quality control errors.

In Regular or Customized Redetermination modes, TIERS automatically makes a Data Broker request for each individual household member age 16 and older, including members without an SSN. However, TIERS does **not** automatically pull a credit report.

In the Redetermination Summary logical unit of work, each page has a DB icon. Click the DB icon at the top of the page to access the Data Broker window. The Data Broker Combined Report link will display. Click on the **Report link** to view the Data Broker Combined Report for the person. Follow the same process for each additional household member for whom a Data Broker Combined Report is needed.

Data Broker in TIERS cannot do interactive searches on specific data; it only produces the Combined Report. For example, if the user only needs OAG information, the user would go to the Data Broker stand-alone system.

Requesting a Data Broker Combined Report with Credit Information

To request a person's Data Broker Combined Report with credit information, go to Individual Information on the left navigation bar in TIERS. Click on **Individual**, then click the Edit icon for each individual to request the Data Broker Combined Report. In the **Individual Information — Other Information** area, answer yes to the two questions about Data Broker. Continue through the driver flow by clicking the **Next** button. This will send the request to the Data Broker vendor. Click the **Previous** button to go back to the **Individual Information** page and click on the DB icon at the top of the page to access the Data Broker window. The Data Broker Combined Report link will display. Click on the **Report link** to view the Data Broker Combined Report for the individual. Follow the same process for each additional household member for whom a Data Broker Combined Report is needed.

Note: When clicking the **Previous** button, the answers to both Data Broker questions will revert back to **No**; this is normal. Do not answer the questions again and click the **Next** button. Doing so will send a second Data Broker request for the same individual resulting in multiple requests.

C—827 Data Broker Combined Reports

Revision 14-1; Effective January 1, 2014

Data Broker Combined Reports – with or without a credit report – should be requested through TIERS. If TIERS is not available, use the Data Broker stand-alone system.

C—827.1 Combined Report Without Credit Report Sources

Revision 16-3; Effective July 1, 2016

All Programs

The Data Broker Combined Report includes the following information, if available:

- Driver license information
- Persons at entered address
- Neighborhood address search
- Out-of-state shopping data
- Texas vehicle
- Property value
- Inmate/Parolee Match
- Criminal history
- The Work Number

- Employee new hire data
- TWC
- OAG child support data
- SAVE alien status verification
- Credit header

C—827.1.1 Combined Report With Credit Report Sources

Revision 15-4; Effective October 1, 2015

The Data Broker Combined Report with credit information includes all of the sources found in C-827.1, Combined Report Without Credit Report Sources, in addition to the sources in the following sections.

HHSC gets credit information from two reporting agencies: Equifax Information Services and Experian. The credit bureau source varies depending on the geographical location (ZIP code) of the applicant's or individual's address. Each credit bureau has its own codes. These codes are available under the **Help** link in the stand-alone system.

C—827.1.2 Confirmation Information – Credit Header

Revision 13-3; Effective July 1, 2013

All Programs

Use the information on this screen, also referred to as a Credit Header, to verify the name and other identifying information of the individual before reviewing credit information. If the information on the screen does not match the individual's biographical information, review the Special Messages report to determine if the SSN is associated with any reported fraud. If staff can't find any discrepancies, check to ensure the correct SSN was entered.

C—827.1.3 Special Messages

Revision 13-3; Effective July 1, 2013

All Programs

This screen displays warning messages related to the individual on whom the inquiry is requested. These special messages alert users to suspicious or potentially fraudulent application information. The screen displays two categories of messages:

- Message on Address — Indicates potential problems, such as a mail drop, prison or previously misused addresses.
- Message on SSN — Identifies Social Security numbers of deceased individuals or numbers reported as misused or invalid.

For more information regarding special messages, refer to the HELP link in the stand-alone system.

When a warning message is generated, the advisor should review the message and clear questionable information.

C—827.1.4 Credit Summary

Revision 13-3; Effective July 1, 2013

All Programs

This screen is a record of information creditors provide to the credit reporting agencies. Use the information as a case clue in determining:

- household cash flow,
- vehicle ownership,
- employment, and
- other potential causes of case errors.

The information is generally accurate; however, it cannot be considered verification for any action taken by HHSC. The advisor must verify credit report information before taking any action on an EDG.

C—827.1.5 Active and Inactive Accounts

Revision 13-3; Effective July 1, 2013

All Programs

This screen contains a detailed breakdown of individual creditors and corresponding payment records.

C—827.1.6 Lender Information

Revision 13-3; Effective July 1, 2013

All Programs

This screen provides the name, address and phone number of the creditor. Staff may access this information by clicking on:

- the Member ID hyperlink for the creditor listed in the Active and Inactive Accounts section of the credit report, or
- Lender Information on the DCS Search Options menu.

C—827.1.7 Client Income

Revision 13-3; Effective July 1, 2013

All Programs

This screen includes information the individual reported to lenders regarding his the individual's income. This information is not available on every report and is only based on the individual's statement.

Compare employers and income listed to information received during the interview or from the application. Explore any other income or discrepancies reported by the individual to lenders.

C—827.1.8 Inquiries for New Credit

Revision 13-3; Effective July 1, 2013

All Programs

This screen lists the names and dates of credit inquiries for this individual. Each time a credit report is requested, the consumer's record is tagged with the name of the requestor, and the date of the request.

A large number of inquiries may indicate a need to further explore the individual's income and resources. For example, inquiries from auto dealers or auto lending institutions (such as GMAC) are case clues to a possible vehicle purchase.

Note: Additional sources not included in the combined report, but are available in the Data Broker system that workers can access via the Data Broker stand-alone system, left navigation bar are:

- SSA death index,
- telephone search,
- Texas marriage/divorce search,
- vehicle valuation.

C—828 Retention of Data Broker Reports and Providing Copies

Revision 14-3; Effective July 1, 2014

All Programs

Unless required by regional procedure, staff are not required to print Data Broker reports. If reports are printed, staff must store them in a central file until the EDG action is processed. Once the EDG processes, staff may then shred the reports.

At the individual's request, provide a copy of the Data Broker report:

- including a credit report, if the complete report is currently filed in the local office; or
- excluding a credit report, even if the report is not filed in the local office.

Do not provide a copy of a credit report when there is no copy filed in the office, unless the individual requests it for a fair hearing.

If the individual requests a fair hearing and the advisor used a Data Broker report (including acredit report) to determine eligibility, mail a copy of the Data Broker report, including the credit information, to the hearing officer with the other case information.

If the individual questions the credit report information, the advisor will explain that eligibility was based on several sources, including a credit report obtained from the consumer reporting agency.

For most inquiries, the Data Broker system retains historical information for three years from the initial inquiry date. After that time, the vendor archives the information for another three years. Advisors can retrieve and view previously pulled Data Broker inquiries at no cost to the agency.

Individuals have a right under FCRA to obtain a free copy of their credit report from the reporting agency within 60 days from receipt of notice of adverse action. Individuals can contact the consumer reporting agencies at:

- Equifax Information Services LLC
  P.O. Box 740241
  Atlanta, GA 30374-0241
  800-685-1111
  www.equifax.com
- Equifax Workforce Solution
  11432 Lackland Rd.
  St. Louis, MO 63146
  866-604-6570
  www.theworknumber.com
- Experian
  701 Experian Parkway
  P.O. Box 2002
  Allen, TX 75013
  888-397-3742
  www.experian.com

For more information regarding credit bureau codes, refer to the Help link in the stand-alone system.

C—829 Case Actions

Revision 14-3; Effective July 1, 2014

All Programs

When taking action on an EDG as a result of information from a Data Broker report, different procedures apply depending on the report used. Whenever there is a discrepancy between information on any report and the individual's statement, offer the individual an opportunity to verify the information. See C-920, Questionable Information, for policy.

When the advisor discovers questionable information at a complete review, treat it as any other questionable information. Provide the individual Form H1020, Request for Information or Action, and pend for verification.

When the advisor requests Data Broker information during a SNAP certification period and the report reveals information regarding anything other than property or vehicles, follow procedures in B-125.1, Due Dates.

When HHSC takes adverse action on an EDG based on information gained either directly or indirectly through the use of a credit report, the FCRA requires HHSC to give a notice to the individual. The notice must contain specific information mandated by the FCRA. Enter the following comments on Form TF0001, Notice of Case Action:

Our eligibility decision was based on a variety of sources, including information in a credit report obtained from:
Nuestra decisión sobre la elegibilidad se basó en varias fuentes, entre ellas, datos de un informe de crédito que se obtuvo de:

- Equifax Information Services LLC
  P.O. Box 740241
  Atlanta, GA 30374-0241
  800-685-1111
  www.equifax.com
- Equifax Workforce Solution
  11432 Lackland Rd.
  St. Louis, MO 63146
  866-604-6570
  www.theworknumber.com
- Experian
  701 Experian Parkway
  P.O. Box 2002
  Allen, TX 75013
  888-397-3742
  www.experian.com

You have a right under the Fair Credit Reporting Act to obtain a free copy of your credit report from the reporting agency within 60 days of this notice. You have the right to dispute the accuracy of any information in the report. Credit reporting agencies do not make eligibility determination decisions and will not be able to provide you with the specific reason for the action taken on your application/case. Information from the reporting agency was independently verified before taking this action (C-820). Please contact your advisor if you have questions about this eligibility decision./De conformidad con la Ley sobre Informes de Crédito Justos, usted tiene el derecho de pedir a la agencia una copia gratis del informe de crédito dentro de los 60 días después de este aviso. Tiene el derecho de cuestionar la exactitud de cualquier información en el informe. Las agencias que dan esta información no toman las decisiones sobre la elegibilidad y no podrán darle la razón específica de la acción que tomamos en su solicitud o caso. Antes de tomar la acción (C-820), se verificó independientemente la información que recibimos de dicha agencia. Favor de comunicarse con su consejero si tiene alguna pregunta sobre esta decisión de elegibilidad.

C—830 Child Support Systems

Revision 01-7; Effective October 1, 2001

C—831 Grant in Jeopardy Process

Revision 15-4; Effective October 1, 2015

TANF

The OAG sends the TANF recipient child support collection interface after the close of business on the last day of each month. HHSC uses the interface to determine if child support collections exceed the TANF grant plus the disregard and processes grant in jeopardy.

The TANF recipient child support collection interface includes the:

- TANF case information;
- amount of collections from each absent parent; and
- amount of excess payments.

HHSC automation staff:

- compare the OAG collection information to the current TIERS information;
- send a notice of excess payment to the advisor, if applicable;
- determine if any member of the certified group was certified for TP 01 or TP 61 in at least three of the last six months; and
- determine if the collection still exceeds the TANF grant plus the disregard.

If the collection amount exceeds the TANF grant plus the disregard, the system:

- places the EDG on hold, pending denial;
- produces a notice reflecting automated action to the advisor and individual; and
- denies the EDG if the EDG is still on hold at cutoff in the hold effective month.

Examples

November – The OAG receives child support collections on TANF EDGs. At the end of the month, the OAG sends the collection information to HHSC. HHSC determines:

- whether the collection causes grant in jeopardy; and
- if there is an excess payment.

December – HHSC receives the collection information the first week of the month. TIERS compares the collection to the grant plus disregard. If it exceeds the grant plus disregard, TIERS:

- places the TANF EDG on hold effective January 1;
- produces a notice to the advisor;
- produces a notice to the individual; and
- sends the updated tape to the OAG at cutoff.

The OAG repeats the process shown in November for any December child support collections received.

January – The TANF EDG is on hold. In the first week of the month, the OAG sends:

- the disregard to the individual (from the December child support collection);
- any excess payment to the individual (from the December child support collection); and
- any January child support collections (as they are received) to the individual.

At cutoff, TIERS denies the case.

February – The OAG sends any collected child support to the individual.

C—832 Office of the Attorney General (OAG) Inquiry

Revision 05-5; Effective October 1, 2005

All Programs

The Texas Child Support Enforcement System (TXCSES) is the OAG computer inquiry system. Staff access TXCSES for verification of child support information. In order to access TXCSES, staff must have an OAG user identification number. Obtain a user ID by:

- completing OAG security Form 08.010, Office of the Attorney General Child Support Division Information Access Statement of Responsibility, and HHSC security Form 4743, Request for Applications and System Access; and
- mailing both forms to the Regional Security Officer (or designee), who forwards them to the state office security officer. The state office security officer coordinates assignment with the OAG.

Staff must use their security IDs at least every 30 days or the ID becomes dormant and must be reset through the security system.

This section contains information about entering and exiting the system and an explanation of the screens. Refer to the user guide for detailed information.

C—832.1 Accessing Texas Child Support Enforcement System (TXCSES)

Revision 05-5; Effective October 1, 2005

All Programs

Download the system from www.tx.net/download/oag. Use the following steps to access the system.

1. Click on the designated icon or click on the Start button and then click Qws3270.Exe.
2. At the ENTER LOGON prompt (Texas map screen), type TXAGCNTY, press Enter.
3. On the same screen, click on the Reset button, and then click on the Clear button. These buttons are at the bottom of the application window.
4. The OAG Child Support Enforcement screen appears.
5. Follow the standard logon procedures:
    1. In the Application ID field, type "CSES."
    2. Tab to the User ID field and type in your User ID.
    3. Tab to the Password field. The first time you sign on, type your temporary password assigned on Form 4743.
    4. Tab to the New Password field and type in a new password. The new password must:
        - be exactly eight characters in length;
        - be a combination of alpha, numeric and allowable special characters(allowable characters are @, # and $);
        - contain at least one special character that must not be located in the first or last positions;
        - contain only one set of repeating characters;
        - be changed every 32 days;
        - not be shared, written down or posted; and
        - not be reused for periods of up to one year.

        When you press Enter, the system will ask you to retype your new password. The next time you sign on you will use your new password.

    5. The Child Support Enforcement Menu appears. To access a screen, you may type the number corresponding to a screen shown on the menu or you may go directly to the screen by typing the four-letter screen ID in the Command line. Press Enter.

C—832.2 TXCSES Menu Screens

Revision 08-4; Effective October 1, 2008

All Programs

The following is a partial list of available inquiry screens in the Texas Child Support Enforcement System (TXCSES):

- **Member Search Selection Screen (MSCH)** — Use to search for a member with a minimum amount of identifying information.
- **Member to Cases Inquiry (MCAS)** — Identifies all cases a member is associated with and other members related to these cases.
- **Case Information (CINF)** — Displays basic information about a case.
- **Case Profile (CPRF)** — Displays high level information on a case, such as case type, status of case, number of dependents, grant amount, custodial parent (CP) and non custodial parent (NCP) name and their member ID number and current addresses, NCP earnings, and whether health insurance is available through the employer.
- **Grant History Screen (GRNT)** — Displays the monthly detail of the grant history and Prior Months Unrecovered Assistance (PMUA) by HHSC Case No..
- **Monthly Receipt Summary (MRSM)** — Displays the distribution of the collections for a CP on a monthly basis.
- **Warrant Status History (WHIS)** — Displays the disbursement status for a specific warrant or electronic fund transfer (EFT) identifying a direct deposit. The date the warrant was disbursed, issued, mailed, or cancelled. The dollar amount of the warrant and warrant number. The CP's current address and the address where the warrant was mailed.
- **Child Support Office Directory (CSOD)** — Provides general information about a child support office.
- **Child Support Staff Directory (CSSD)** — Use to search for a specific employee or group of employees. Also, use to identify the name, current address, and telephone number of the child support officer who initiated asanction request.

C—832.3 Exiting TXCSES

Revision 04-7; Effective October 1, 2004

All Programs

To exit TXCSES:

- press F3 when the main menu (CSEM) displays;
- type exit or end in the Command line; or
- click on the windows X or close while in any of the screens and then click on Exit, located on the top bar menu.

C—833 TXCSES Web Child Support Portal Inquiry

Revision 08-4; Effective October 1, 2008

All Programs

The TXCSES Web is an Internet-based application developed by the OAG. The TXCSES Web is a comprehensive verification source that allows users to view child support collection, distribution and support obligation records.

TXCSES Web replaces the TXCSES OAG computer inquiry system as the primary verification source for child support payment information.

C—833.1 Requesting Access to TXCSES Web

Revision 08-4; Effective October 1, 2008

All Programs

Advisors with access to the TXCSES OAG computer inquiry system will use a USER identification (ID) and password to access TXCSES Web. New users must obtain a USER ID by completing:

- the OAG security Form 08.010, Office of Attorney General Child Support Division Information Access Statement of Responsibility; and
- the HHSC security Form 4743, Request for Applications and System Access.

Mail both forms to the Regional Security Officer (or designee), who forwards the forms to the state office security officer. The state office security officer coordinates assignment with the OAG.

C—833.2 Logging On to TXCSES Web

Revision 08-4; Effective October 1, 2008

All Programs

Advisors must have an active USER identification (ID) to access the TXCSES Web. The USER ID and password for TXCSES Web is the same logon as the one used to access the TXCSES OAG computer inquiry system. To log on to TXCSES Web:

1. Open the link to the TXCSES Web application in the browser (https://portal.cs.oag.state.tx.us/wps/portal).
2. Type your USER ID in the User ID field.
3. Type your password and click **Login**.
4. Read the Statement of Responsibility and click **I Agree**.
5. Read the Account Policy and click **I Agree**.
6. Click **TXCSES Web** located at the top under the header **Child Support Online**. This will bring up the **Main Search Income Verification Screen**.

C—833.3 Procedures for Obtaining Payment Information

Revision 08-4; Effective October 1, 2008

All Programs

The Texas Child Support Enforcement System (TXCSES) **Web Main Search Income Verification Screen** includes four member search options:

- Last Name and/or First Name
- DOB, MMDDYYYY
- SSN, 123456789
- Member ID (OAG Member ID)

Note: Advisors should use an SSN for inquiry when possible for a more accurate method of locating an applicant's information.

From the Search Results section, click on the case ID number with an "active status" to retrieve the child support payment information such as collections, distributions and support order obligations.

Note: By clicking on the + icon on the **Disbursement Summary Details** column, the advisor can view the payment type such as warrant, direct deposit/electronic transfer and Texas debit card. See A-1326.2.1, Counting Child Support, for assistance in determining when to consider the payment type available to the custodial parent.

C—833.4 Logging Off of TXCSES Web

Revision 08-4; Effective October 1, 2008

All Programs

Click Logout to exit the Texas Child Support Enforcement System (TXCSES) Web application. Users are automatically logged off the application after 30 minutes of inactivity. Three unsuccessful logon attempts or 30 days of inactivity in either TXCSES or TXCSES Web suspends the USER identification (ID). Contact the regional security officer to reset the password if this occurs.

It is important to keep the user name active by logging on periodically. If staff do not logon to TXCSES or TXCSES Web within 90 days of the last logon, the user name is deleted.

C—834 Child Support Noncooperation (CSNC) Online System

Revision 05-5; Effective October 1, 2005

TANF and Medical Programs

The OAG provides HHSC a weekly interface indicating when anindividual fails to cooperate with child support or medical support requirements. The Office of Family Services receives the interface, processes and maintains the data on the Child Support Noncooperation (CSNC) online system. The online system replaces the manual process for clearing reports of noncooperation.

C—834.1 Requesting Access to CSNC

Revision 05-5; Effective October 1, 2005

TANF and Medical Programs

Texas Works staff responsible for assigning, clearing, reviewing and/or monitoring child support noncooperation data may request access to the system.

Supervisors/managers complete Form 4743, Request for Applications and System Access, for each employee needing access to the CSNC system and writes CSNC in Box 14. The supervisor/manager sends the completed Form 4743 to their regional security officer (or designee). The regional security officer forwards it to the state office security officer.

C—834.2 CSNC Passwords

Revision 05-5; Effective October 1, 2005

TANF and Medical Programs

Once Form 4743 is approved, the initial password is returned on the form. Staff may change their password at anytime. For password changes, click "Tools" on the CSNC home page and enter the old and new password information in the appropriate fields. For forgotten passwords, contact the HHSC help desk to have the password reset.

C—834.3 Logging on to CSNC

Revision 05-5; Effective October 1, 2005

TANF and Medical Programs

After accessing the HHSC Intranet, enter http://opi-pa.dhs.state.tx.us/1708-Online/1708.aspx for the CSNC website. To log on, select Search/Login from the main menu header. Enter username and password. Click "OK" to complete the login.

C—834.4 Procedures for Requesting CSNC Data

Revision 05-5; Effective October 1, 2005

TANF and Medical Programs

The CSNC system searches the database to locate information by:

- mail code;
- region; or
- case number.

When searching by mail code or region, staff may request data by report run date and download the data to Excel. Click "OK" to obtain the request.

When a match is found, CSNC generates a list of noncooperation data meeting the inquiry criteria.

C—834.5 CSNC Field Descriptions

Revision 05-5; Effective October 1, 2005

TANF and Medical Programs

The following is a list of data fields and descriptions:

- **MC_WKR** — Mail code found on SAVERR for the case record.
- **MC_SUP** — Supervisor's mail code for the BJN associated with the case record on SAVERR.
- **TANF_CASE** — TANF case number.
- **TP** — Type program. Reports are generated for both TANF and medical type program cases.
- **CARETAKER_PARENT** — Identifies the person who is noncooperating with the child support requirements.
- **CARETAKER_PARENT_ADDRESS** — Caretaker/parent's address.
- **ABSENT_PARENT** — Name of the absent parent.
- **REASON_CODE** — Reason code associated with the noncooperation.
    1. Failed to keep appointment and did not make another appointment.
    2. Failed to appear for court.
    3. Failed to respond to AFDC questionnaire.
    4. Failed to appear for blood testing scheduled.
    5. Failed to submit payments received directly from NCP to OAG.
    6. Failed to return a URESA-O testimony or paternity affidavit.
    7. Failed to adhere to the terms of a repayment agreement.
    8. Failed to submit or sign legal documents.
    9. AF named by CP excluded by blood test, CP failed to provide info.
    0. (Alpha) Form Text.
- **REASON_DESCRIPTION** — Reason code description.
- **ACTION_CODE** — Indicates the action the person must take to clear the noncooperation.
    1. Schedule and keep appointment with the child support officer.
    2. Appear in court on set date.
    3. Complete and return questionnaire to child support officer.
    4. Appear with child/children and submit to blood testing when rescheduled.
    0. Free form text.
- **ACTION_DESCRIPTION** — Action code description.
- **AG_ADDRESS** — Local OAG child support office address.
- **AG_PHONE** — Local OAG child support office telephone number.
- **AG_MC** — Local OAG child support office mail code.
- **AG_BJN** — Local OAG child support officer's BJN.
- **BJN** — SAVERR case budgeted job number.
- **REG** — HHSC region where the case is located.
- **RUN_DATE** — Indicates the date OAG sends the file to HHSC.
- **POST _DATE** — Date the Office of Family Services Business Support posted the data to the website.

C—834.6 Exiting CSNC

Revision 05-5; Effective October 1, 2005

TANF and Medical Programs

To exit CSNC Inquiry, click "Logout" on the menu bar, then:

- click the "X" in the upper right-hand corner; or
- select "File" on the browser tool bar, then select "Close."

C—840 DataMart

Revision 15-4; Effective October 1, 2015

All Programs

DataMart provides a series of online reports, accessed through the State Portal. The reports are used as monitoring tools for various case action activities within Texas Works.

Instructions for accessing and using the various reports may found at the following Texas Works Policy page on the Loop:

http://oss.txhhsc.txnet.state.tx.us/sites/tw/TW%20Data%20Mart%20Instructions/Forms/AllItems.aspx

C—841 DataMart Reports

Revision 17-2; Effective April 1, 2017

Number	The Report …
DF-001a	**Felony Drug Conviction (FDC) Disqualification for SNAP** Provides a monthly count of individuals previously disqualified for an FDC occurring on or after August 22, 1996 who are now receiving SNAP benefits on an approved SNAP EDG.
DF-001b	**EDGs Denied for Parole/Community Supervision Compliance Verification** Provides data on SNAP EDGs denied for failure to provide verification of compliance with parole or community supervision.
DF-001c	**SNAP FDC Disqualifications** Provides data on the number of individuals who have a two-year or permanent SNAP disqualification related to FDC.
DG-001	**Reviews and Recertifications Due by Office** Allows managers and appropriate field staff to identify TANF, Texas Works (TW) Medicaid, CHIP and SNAP Redeterminations that are due in a month specified by the user.
DG-002	**Pending Applications** Allows managers and appropriate field staff to identify pending TANF, SNAP, TW Medicaid, CHIP, CHIP perinatal and Healthy Texas Women (HTW) applications on a daily basis.
DG-003	**Work In Progress (WIP)** Allows managers and appropriate field staff to identify open TANF, SNAP, TW Medicaid, CHIP, CHIP perinatal, and HTW actions on a daily basis.
DG-004R	**Delinquency Analysis Data Report** Provides detailed data that is consolidated to aid in the analysis of causal factors contributing to each delinquency.
DG-006	**Task List Manager (TLM) Task Aging by Past Due Date** Allows managers and appropriate field staff to identify all the tasks that are not closed by the TLM task due date.
DG-007	**Appointment No Show** Gathers all the details for an appointment with a No Show (NS) status to ensure TLM No Show task actions are completed timely.
DG-008	**Appointment Slots Utilization** Allows managers and appropriate field staff to identify all the appointment slots published for a specific office or group of offices using State Portal Scheduler and the number of appointments slots already scheduled for an interview for a selected office and reporting period.
DG-009	**Tickets/Service Request Status Report** Provides a consolidated source for viewing all open Remedy and Project and Portfolio Management Center (PPM) tickets or recently closed PPM tickets.
DG-010	**Disposition Timeliness Report** Assists management to efficiently monitor the timeliness percentage, total dispositions for all applications and redeterminations, timely and untimely dispositions and the number of disposing employees for TANF, SNAP, TW Medicaid, CHIP, CHIP perinatal, and Medicaid for the Elderly and People with Disabilities (MEPD) programs. This report will display the timeliness based on the disposition date. **Note:** This report provides timeliness for redeterminations disposed timely or untimely. Types of Assistance (TOAs) that have a passive renewal will be included if a recertification package is received and processed.

Number	The Report …
DG-011	**Review Timeliness Report** Assists managers to efficiently monitor the number of delinquent reviews, the age of the delinquent reviews and the percentage of the total caseload that is delinquent for the following three types of assistance in TIERS: • MA - Parent and Caretaker Relatives • TANF Basic • TANF State Program **Note:** This report provides information on past due redeterminations that have not been processed and/or disposed. Timeliness for other programs is monitored through other reporting mechanisms. TOAs that have a passive renewal will not be included on this report.
DG-012	**Pending Applications and Redeterminations over 60 Days** Assists management to identify and monitor applications and redeterminations pending over 60 days for SNAP, TW Medicaid, CHIP, CHIP perinatal, TANF, and MEPD on a daily basis, and to identify the current employee assigned with pending applications and redeterminations.
DG-014	**Merge/Separate (M/S) WIP Report** Assist management and Data Integrity staff to identify and monitor pending M/S TLM request tasks on a daily basis.
DG-015	**M/S Timeliness Report** Assist management to efficiently monitor the number of completed M/S TLM requests, and the number and percentage of timely completed M/S TLM requests.
DG-016	**M/S Daily Potential Duplicate Report** Provides Data Integrity staff a daily list of potential TIERS duplicate individual IDs created and/or updated on any given day and an individual summary and potential match detailed level reports.
DG-017	**Office of Eligibility Services (OES) Community Based Organization (CBO) Data Report** Assists with statistics for federal reporting on the Community Partner project. The report provides the number of CBO applications and redeterminations: • submitted; • pending; • disposed; and • percentage of total EDGs processed timely.
DG-019	**Medicaid Eligibility and Health Information Services (MEHIS) Usage Summary Report** Provides a summary report to capture the daily usage of the MEHIS client portal from Self Service Portal. The report provides the number of unique, successful and denied attempts.
DG-020	**Community Partner Case Action and Status View Report** Case Action Summary report provides CBOs with the ability to track the volume of applications, redeterminations, and changes submitted by their organization. Case Status View Activity report tracks the inquiries completed.
DG-021	**Request for Review Report** Allows managers and appropriate field staff to view the CHIP and CHIP perinatal request for review report by region, status, manager and employees. The report captures the number of requests for review pending, completed, and requests for retro coverage.
DG-022	**Automated Electronic Reminders** Provides the status of the total number of current subscriptions to electronic reminders at the end of each month and provides the number of electronic reminders sent to individuals for each reminder type.
DG-038	**EDG-Level Processing for Medicaid Renewals** Provides EDG-level information for EDGs completed through the automated Medicaid Renewal Process.
DG-039	**ACA Periodic Income Check Report** Provides EDG-level information for EDGs eligible for the periodic income check.
DF-040	**Eligibility Performance Report** Provides a method for managers to measure productivity at the Employee and Manager Levels; provides daily and monthly statistics for employees and managers; monitors applications, redeterminations, and changes for SNAP, TANF, Texas Works Medical Assistance (including Children's Medicaid, CHIP and CHIP p), MEPD, and State Paid coverage for a selected time period; and presents the average processing time from the file date to date disposed for applications and redeterminations.

Number	The Report …
DM-002	**Qualified Hospital/Qualified Entity Presumptive Eligibility Report** Provides Community Access Services (CAS) staff with statistical data on Presumptive Eligibility (PE) regarding the number of approved and denied PE determinations. It also provides the number of Medicaid-assisted approved or denied applications. Allows CAS staff to determine if an error should be counted toward a qualified hospital based on the accuracy and timely submission of a PE determination.
DM-005	**Reasonable Opportunity Report** Provides the total number of individuals receiving a period of reasonable opportunity to provide verification of alien status or citizenship and the number of times an individual was given a period of reasonable opportunity to provide verification of alien status or citizenship.
DM-007	**HB 839 Reinstatement of Medicaid** Provides Centralized Benefit Services (CBS) staff a listing of children whose TP 44 eligibility has been suspended upon notification from Texas Juvenile Justice Department (TJJD)/Juvenile Probation Department (JPD) of placement in a juvenile facility, or reinstated upon notification from TJJD/JPD of release from a juvenile facility.

DM-008	**FFCC Ongoing Monitoring Reports**
	Allows management and appropriate staff to track and review various data regarding individuals who may be eligible for or are currently receiving Former Foster Care Children's (FFCC) Medicaid (TA 82). There are six sub-reports:
	• Individuals Certified for Non-FFCC Program, Lower than FFCC Hierarchy
	  ◦ Provides a list of individuals who are age 18 through 25, received Foster Care - Federal Match - No Cash (TP 93) or Foster Care - Federal Match - With Cash (TP 94) on their 18th birthday or later, and are certified for a Medicaid program that is below TA 82 in the Medicaid hierarchy.
	• Individuals Certified for Non-FFCC Program, Higher than FFCC in Hierarchy
	  ◦ Provides a list of individuals who are age 18 through 25, received TP 93 or TP 94 on their 18th birthday or later, and are certified for a Medicaid program that is above TA 82 in the Medicaid hierarchy.
	• Individuals Terminated Ongoing Medicaid or Denied at Application
	  ◦ Provides a list of individuals who are age 18 through 25, received TP 93 or TP 94 on their 18th birthday or later, applied for non-TA 82 coverage and were denied, or who were on a non-TA 82 Medicaid program and were denied coverage at application or denied on-going Medicaid coverage.
	• Active FFCC Individuals Denied
	  ◦ Provides a list of individuals who received TA 82 and were denied TA 82 coverage in the report month.
	• Active FFCC Individuals
	  ◦ Provides a list of all active individuals on TA 82.
	• TP 93 and TP 94 Denied
	  ◦ Provides a list of individuals age 18 through 20 who were receiving TP 93 or TP 94 in the report month but are not receiving Medicaid in the month following the report month.

C—850 One-Time Grandparent Payment System

Revision 10-4; Effective October 1, 2010

TANF

The Grandparent Payment System (GPS) is designed to:

- list the history of One-Time Grandparent payments, and
- allow SODI staff to enter One-Time Grandparent payment requests.

C—851 Sign-On Screen

Revision 10-4; Effective October 1, 2010

TANF

Users request access to the GPS application by:

- registering on the Health and Human Services (HHS) Enterprise Portal, then

- requesting access to the GPS application in the HHS Enterprise Portal.

Users must register and have access to the HHS Enterprise Portal before access to the GPS application is requested and granted.

First-time portal users must register on the HHS Enterprise Portal at https://hhsportal.hhs.state.tx.us/wps/portal and follow prompts to receive log-in credentials.

Returning portal users do not have to register again. Every 90 days, the user's HHS Enterprise Portal password expires and a prompt will appear to change it.

C—851.1 GPS Application Access

Revision 10-4; Effective October 1, 2010

Once in the HHS Enterprise Portal, users must request access to the GPS application by clicking on the Request Application Access tab at the top of the page. Select GPS Account from dropdown list of applications. A request is sent to the user's supervisor for approval and is automatically forwarded to the regional security officer for final approval. An email notification is sent to the user when the request is approved.

After permission to access the GPS application is granted, a tab labeled GPS appears on the HHS Enterprise Portal home page when the user is logged in. A message indicating Sign-On Successful appears on the GPS home page after the user clicks on the GPS tab.

C—852 GPS Inquiry Screen

Revision 10-4; Effective October 1, 2010

TANF

This screen allows you to search by case or search by individual. To search by case, enter the case number and click on Search by Case. To search by individual, enter the client number, client name or client SSN and click on Search by Client. When inquiring by name, enter the last name. The first name is optional.

C—852.1 Case Inquiry

Revision 10-4; Effective October 1, 2010

TANF

This screen lists case information. It includes the:

- case number,
- case name (last,first),
- address,
- benefit effective date,
- data entry date,
- advisor name,
- advisor BJN, and
- advisor telephone number.

There are three additional options on the screen, View Case Members, View Case Warrants and Return to Inquiry Results. View Case Members lists household members who were included in the One-Time Grandparent certified group. View Case Warrants lists warrants and when they were issued, including the:

- primary client number (PCN),
- SSN,

- employee number,
- entry date,
- pay date,
- issued by comptroller date,
- warrant number,
- amount, and
- status.

C—852.2 Client Inquiry

Revision 05-5; Effective October 1, 2005

TANF

When you search by client and enter the client number, name, or SSN, you get the Client Inquiry screen that lists the:

- primary client number (PCN),
- client name,
- client DOB,
- client SSN,
- client sex, and
- case number.

You must click on the case number to get the Case Inquiry screen. See C-852.1.

C—860 Birth Verification System

Revision 12-3; Effective July 1, 2012

All Programs

The Birth Verification System (BVS) is a system developed and maintained by the Department of State Health Services (DSHS). The BVS database includes birth records of people who were born in Texas.

Advisors access BVS as a source to verify age, relationship and citizenship. Perform a separate request for each individual.

C—861 Accessing BVS in TIERS

Revision 12-3; Effective July 1, 2012

All Programs

BVS inquiry can only be performed when the TIERS case is in read/write mode. From the left navigation bar select Individual from Data Collections to access birth verification information. This displays the Individual Household page, which lists all household members. Click the Edit icon for the appropriate individual. This displays the Individual Information page.

A BVS icon appears on the Individual Information page, near the page title. The icon consists of a circle with the letters BV in it. Click the icon to display the page. TIERS displays the Birth Verification – Details page, displaying the initial demographic information for the individual, individual's first, middle and last name, gender, and date of birth. Select the Birth County (if available) and enter Mother's full Maiden Name (if available), then click the Submit button.

TIERS sends an online request to BVS. BVS conducts an online real-time verification of birth information and displays the information on the details page.

Note: TIERS does not display historical birth verification information. If staff make another BVS request for an individual, TIERS generates a new request to the BVS system.

C—861.1 BVS Field Entries and Descriptions

Revision 13-1; Effective January 1, 2013

All Programs

TIERS displays the Birth Verification – Details page, displaying the initial demographic information for the individual:

- child's last, first and middle name,
- date of birth, and
- gender.

Birth County — Select the birth county from the drop-down menu. **Note:** Although not a required field, entering the county code shortens the search.

Mother's Maiden Name (optional field) — Enter mother's full maiden name if available; this is an optional field. Do not enter a single letter, numerical value, spaces or special characters.

Once the BVS request is submitted, the request is transmitted to DSHS. DSHS returns the following response information when there is response from DSHS indicates a positive match:

- mother's maiden name,
- certificate no.,
- father's name, and
- birth county.

Status — This field displays one of the following responses to the request submitted.

Y = Match Found

M = Multiple Records Exist

N = No Match Found

F = Fraudulent Record

D = Individual is Deceased

S = Birth File Read Error

T = Invalid Date of Birth

X = Unknown Error. Call Help Desk

When a match is not received, staff must review entries for accuracy and resubmit the BVS request.

Message — The following exception messages are displayed when a response is not received and the request and response have caused some type of exception. This means there is an error with the system or the data. Call the HHSC Help Desk if problems persist at 512-438-4720.

Message Codes	Descriptions
20745	Unable to send MQ message. Please try again later and contact Help Desk if problem persists.
20732	Invalid data received in the response. Please try again later and contact Help Desk if problem persists.
20731	Response timed out. Please try again later and contact Help Desk if problem persists.

Message Codes	Descriptions
20730	An unexpected error has occurred. Please try again later and contact Help Desk if problem persists.

C—870 Other Systems

Revision 13-3; Effective July 1, 2013

C—871 Wire Third-Party Query (WTPY)

Revision 15-4; Effective October 1, 2015

All Programs

WTPY is an SSA automated system that verifies Social Security benefits, SSI, 40 quarters information and citizenship verification for Medicaid. WTPY is a Windows application. Staff obtain information by using the individual's name, SSN or Social Security claim number (SSCN) (not applicable for Medicaid citizenship verification), and DOB. If staff transmit the request by 2:30 p.m., the response is received the following business day. If staff transmit the request after 2:30 p.m., the response is delayed one additional day.

When an inquiry match occurs, the response provides all available benefit information. If the individual has entitlement under more than one SSCN, those SSCNs and benefits are identified. Staff may have to submit separate inquiries to obtain data related to those claims.

The WTPY system provides the following types of responses:

- **Standard Response:** individual name, DOB, verified SSN, and error messages regarding any discrepancies between inquiry and response match.
- **Title II (Retirement, Survivors and Disability Insurance [RSDI]):** individual demographics, enrollment in Medicare Part A and/or Part B, supplementary medical income benefits (SMIB) premium deduction, benefit amounts and dates, unearned income, disability onset dates, etc.
- **Title XVI (SSI):** individual demographics, Medicaid, SSI payment history, benefit amount, payment status code, and resource and earned income leads, etc.
- **40 Quarters:** Use to verify quarters for legal permanent residents, their spouse or parents. Response provides employment history, coverage of quarters, and the type of income the individual has received during that period (wages, agricultural, self-employment, etc.). Note: Response time for this data is within two days of transmittal.
- **Medicaid Citizenship Verification:** Use to verify SSN and citizenship for Medicaid applicants. Response codes of A or C indicate citizenship is verified. However, response code C means there is an indication of death. If this response code is received, treat this as a report of change using policy in B-600, Changes. Response codes of B or D or any other error code indicate citizenship is not verified. If one of these responses is received, follow the steps outlined in A-351.2, Using State Online Query (SOLQ) or Wire Third-Party Query (WTPY) to Verify Citizenship.

C—872 Accessing Wire Third-Party Query (WTPY)

Revision 13-3; Effective July 1, 2013

All Programs

Supervisors complete Form 4743, Request for Applications and System Access, for employees who need access to the system. Staff must sign the WTPY User Information Security Agreement. Send both forms to the regional security officer. A user may access WTPY after hardware and software requirements are met and they have a password.

To access the system, staff:

1. Double click the LONG TERM CARE or WTPY icon or http://portal.hhs.state.tx.us/wps/portal. The sign-on screen appears.
2. Enter employee's username and password.
3. Click on LOGON or press ENTER.

4. Click on LOGOUT to close the WTPY system.

You must change your password every 90 days or the system automatically revokes your access. If this occurs, contact your regional security officer.

The *WTPY Reference Guide* provides details regarding menus, screen and data field references for all SSA response screens. Access the user guide via Training & Curriculum Eligibility Support's Reference Guides website at https://oss.txhhsc.txnet.state.tx.us/sites/eo/support/tdd/WTPY/Forms/WTPY%20Guides.aspx.

C—873 Texas Works Automated Systems Problem Reporting Guide

Revision 13-4; Effective October 1, 2013

All Programs

TEXAS WORKS AUTOMATED SYSTEMS PROBLEM REPORTING GUIDE
IEE/TIERS Technical Help Desk
1-800-214-4175 (Option 1)
8 am to 8 pm CST, Monday - Friday
For all TIERS/State Portal-related issues, call 1-800-214-4175 (Option 1)

For Problems With	Examples of problems the Help Desk handles
Security	**Security/permissions/lockout problems for TIERS and State Portal only**
Management Reports	TIERS and DataMart report problems Prepare to have the following information available: • State Portal User ID • Office or cubicle number (desk location) • Supervisor's name and phone number • Full computer name • Report number trying to view • Screens within the report attempting to view • Exact steps attempting to make • TIERS Case number (if applicable)

For Problems With	Examples of problems the Help Desk handles
TIERS	• Application problems • System availability • Errors messages and functionality issues Prepare to have the following information available: • Contact name • Contact employee ID • Contact phone number • Contact email address • Last time access TIERS • Office/region • ART name • ART phone number • ART email address • Alt contact/supervisor name • Alt contact/supervisor phone number • Alt contact/supervisor email address • Case name • Case number • Individual number (if problem is specific to an individual) • EDG number and EDG name (if specific to an EDG) • Current case mode • Programs • URL of site • Number of people having this issue • Description of the error or issue • Be prepared to email screen shot when reporting an error **Note:** Individuals call 2-1-1 for issues with the Self-Service Portal.
Caller Contact Information	• Contact information (phone number, email address, office/cubicle number, street address) • Supervisor's contact information (full name, phone number, email address)
Error	• Exact error message and sequence of events leading to problem • Detailed description of the problem • Application type (application, redetermination) • Specific screen in TIERS/State Portal the error is or was on prior to the error message **Note:** Make a screen shot of error message and be prepared to email screen shot as a Microsoft Word attachment.
Impact	Identify impact as: • Affects multiple advisors, programs or cases. • Prevents staff from continuing their work. • Single person impacted. **Note:** Have specific examples of others impacted.

Note: Contact your local help desk to report non-TIERS and non-State Portal related issues

Or

PROBLEM REPORTING VIA EMAIL
IEE_Help@HHSC.state.tx.us

For Problems With	Examples of problems the Help Desk handles
Security	Report all security or password-related issues by calling the IEE/TIERS Technical Help Desk.

For Problems With	Examples of problems the Help Desk handles
Management Reports	TIERS and DataMart report problems Prepare the same information as required above. **Note:** Make a screen shot of the error message and attach it to the email as a Microsoft Word document.
TIERS	• Application problems • System availability • Errors messages and functionality issues Make a screen shot of the error message and attach it to an email as a Microsoft Word document. **Note:** It is highly recommended to report TIERS-related issues using the TIERS Application Support Email Ticket Submission at http://hhscx.hhsc.state.tx.us/tech/CS/TIERS%20Template%202013%20(revised%202013-02-13-1910).pdf in a secure email.
State Portal	• Application problems • System availability • Error messages and functionality issues Provide the same information as required above. **Note:** Make a screen shot of the error message and attach it to an email as a Microsoft Word document.
Self-Service Portal	• Application problems • System availability • Error messages and functionality issues Provide the same information as required above. **Notes:** • Make a screen shot of the error message and attach it to an email as a Microsoft Word document. • Individuals call 2-1-1 for issues with the Self-Service Portal.
Error	When describing your error or issue: • Explain the exact error message and sequence of events relating to the problem • Include a detailed description of the problem • Include the Application type (application, redetermination) • Identify the specific screen in Self-Service Portal/State Portal the error is on or was on prior to the error message
Impact	Identify impact as: • Affects multiple advisors, programs or cases • Prevents staff from continuing their work • Single person impacted **Note:** Have specific examples of others impacted.

http://hhscx.hhsc.state.tx.us/tech/CS/TIERS%20Template%202013%20(revised%202013-02-13-1910).pdf

TWH, C-900, Verification and Documentation

Revision 17-3; Effective July 1, 2017

C—910 Required Verification

Revision 04-7; Effective October 1, 2004

C—911 Required Verification for TANF

Revision 15-4; Effective October 1, 2015

TANF

Mandatory Verifications	At Application	When a Change Occurs	At Redetermination
Household Composition – Out of State Disqualifications for Felony Drug Convictions	All household members applying	Any new household members applying	Any new household members applying
Citizenship	All household members applying who claim to be U.S citizens	Any new household members applying who claim to be U.S. citizens	Any new household members applying who claim to be U.S. citizens
Alien Status	Household members identified as aliens	New members identified as aliens	• New members identified as aliens • When the U.S. Citizenship and Immigration Services (USCIS) document has expired.
Social Security Number (SSN)	Household members who cannot provide an SSN, verify they applied for an SSN	New members who cannot provide an SSN, verify they applied for an SSN	Household members who cannot provide an SSN, verify they applied for an SSN
Age/Relationship	All children applying	New children applying	New children applying
Identity	Individual being interviewed	If not previously verified	If not previously verified
Residence	• Physical address • Intent to remain in Texas • New Texas residents applying, verify the last month a member received benefits in another state	New Texas resident applying, verify the last month any new member received benefits in another state	• Physical address • Intent to remain in Texas • New Texas residents applying, verify the last month any new member received benefits in another state

Mandatory Verifications	At Application	When a Change Occurs	At Redetermination
Domicile	• All children applying • Unmarried minor parents applying • Temporary absence for all household members applying	• New children applying • New unmarried minor parents applying • If questionable, all certified children • Temporary absence for any new household members applying	• All certified children • Certified unmarried minor parents • Temporary absence for all certified household members
Child Support – Good Cause Claims	Any good cause claim	Good cause claim for new children applying	Good cause claim for new children applying
Resources	• Checking/savings/ retirement/ education account(s) • Other – if within $300 of the maximum	• New checking/savings/ retirement/education account(s) • Other – if within $300 of the maximum	• New checking/savings/ retirement/education account(s) • Other – if within $300 of the maximum
Income – Nonexempt including Lump Sums	Total gross amount	Total gross amount	• Total gross amount • Accept self-declaration of interest, unless from a new source or the amount changed by more than $50
Income - Terminated	When terminated in the application month or prior two months, verify: • Source • Final gross amount • Date received • Reason terminated • Termination date	Verify source, final gross amount, date received, reason terminated, and termination date for: • Any loss of income • Loss of income for new member	Verify source, final gross amount, date received, reason terminated, and termination date for: • Any loss of income • Loss of income for new member
Deductions – Dependent Care Costs	Total amount	New amount	Total amount
Deductions – Child Support	Total amount	New amount	Total amount
Deductions – Alimony and Payment to Persons Outside the Home	Total amount	New amount	Total amount
School Attendance	School age children applying	New school age children applying	• Certified school age children • New school age children applying
Management	If the household's basic expenses are paid or delinquent, when management is questionable	Not Applicable	If the household's basic expenses are paid or delinquent, when management is questionable
Employment Services	All exemptions	Any new exemptions	All exemptions
Federal Time Limits (FTLs)	• Out-of-state benefits received on or after October 1999 • Hardship exemptions for adults applying	• Out-of-state benefits received on or after October 1999 • Hardship exemptions for new adults applying	• Out-of-state benefits on or after October 1999 • Hardship exemption for new adults applying

Mandatory Verifications	At Application	When a Change Occurs	At Redetermination
Personal Responsibility Agreement (PRA)	• Child Support cooperation • Voluntary quit • School Attendance • Household was in cooperation with PRA requirements according to policy in A-2131.1, Initial Application	Not Applicable	All certified members are complying with all PRA components: • Choices • Child Support • Drug/Alcohol • Immunizations • Parenting Skills • School Attendance • THSteps • Voluntary Quit
PRA – When in Pay for Performance	All certified members are complying with all PRA components: • Choices • Child Support • Drug/Alcohol • Immunizations • Parenting Skills • School Attendance • THSteps • Voluntary Quit	Not Applicable	Not Applicable
Workforce Orientation	Compliance by caretaker and second parent applying who are not disqualified and reside in a full service Choices county	Compliance by any new caretaker or second parent being added who are not disqualified and reside in a full service Choices county.	Compliance by any new caretaker and second parent applying who are not disqualified and reside in a full service Choices county
One-Time Temporary Assistance for Needy Families (OTTANF)	Crisis criteria	Not Applicable	Not Applicable

C—912 Required Verification for SNAP

Revision 17-3; Effective July 1, 2017

SNAP

Mandatory Verification	At Application	When a Change Occurs	At Redetermination *

Mandatory Verification	At Application	When a Change Occurs	At Redetermination *

Household Composition	• household size, if questionable;
	• eligible status of each household member whose individual eligibility is questionable;
	• new Texas residents applying, verify any out-of-state disqualifications for intentional program violation and/or a felony drug conviction;
	• compliance with parole or community supervision for individuals with a felony drug conviction on or after September 1, 2015;
	• whether a felony drug conviction is:
	  ○ subsequent to another felony drug conviction on or after September 1, 2015; and
	  ○ received while the individual was receiving SNAP.
		• if change reported makes household size questionable;
		• new members who are new Texas residents, verify any out-of-state disqualifications for intentional program violation and/or a felony drug conviction;
		• new members with a felony drug conviction on or after September 1, 2015, verify compliance with parole or community supervision;
		• new members with a felony drug conviction, verify whether the conviction is:
		  ○ subsequent to another felony drug conviction on or after September 1, 2015; and
		  ○ received while the individual was receiving SNAP.
			• household size, if questionable;
			• new members who are new Texas residents, verify any out-of-state disqualifications for intentional program violation and/or a felony drug conviction;
			• compliance with parole or community supervision for individuals with a felony drug conviction on or after September 1, 2015;
			• whether a felony drug conviction is:
			  ○ subsequent to another felony drug conviction on or after September 1, 2015; and
			  ○ received while the individual was receiving SNAP.

Citizenship	If questionable, or if a regional requirement.	If questionable, or if a regional requirement.	If questionable, or if a regional requirement.
Alien Status	Household members identified as aliens.	New members identified as aliens.	• new members identified as aliens; and • when the U.S. Citizenship and Immigration Services (USCIS) document has expired.
Social Security Number (SSN)	Household members who cannot provide an SSN, verify they applied for an SSN, unless exempt.	New members who cannot provide an SSN, verify they applied for an SSN, unless exempt.	Household members who cannot provide an SSN, verify they applied for an SSN, unless exempt.
Identity	Individual being interviewed (also, identity of case name if authorized representative is interviewed).	Individual being interviewed, if not previously verified, or if questionable.	Individual being interviewed, if not previously verified, or if questionable.
Residence**	• physical address; and • the last month a member received benefits in another state.	The last month any new member received benefits in another state.	• physical address; and • the last month any new member received benefits in another state.

Mandatory Verification	At Application	When a Change Occurs	At Redetermination *
Resources**	• checking, savings, retirement, education account(s); and • other, if within $300 of the maximum. **Note:** If the total combined balance for all checking/savings accounts does not exceed $1,000 on the day of the reported change and is not questionable, accept the individual's statement. Pend the Eligibility Determination Group (EDG) only if the reported account balance is questionable or it exceeds $1,000.	• new checking, savings, retirement, education account(s); and • other, if within $300 of the maximum. **Note:** If the total combined balance for all checking/savings accounts does not exceed $1,000 on the day of the reported change and is not questionable, accept the individual's statement. Pend the EDG only if the reported account balance is questionable or it exceeds $1,000.	• new checking, savings, retirement, education account(s); and • other, if within $300 of the maximum. **Note:** If the total combined balance for all checking/savings accounts does not exceed $1,000 on the day of the reported change and is not questionable, accept the individual's statement. Pend the EDG only if the reported account balance is questionable or it exceeds $1,000.
Income – Nonexempt including Lump Sums	Verify total gross amount.	Verify total gross amount.	• Verify total gross amount; and • accept self-declaration of interest, unless from a new source or the amount changed by more than $50.
Income – Terminated	If terminated in the application month or prior two months, verify: • source; • final gross amount; • date received; • reason terminated; and • termination date.	Verify source, final gross amount, date received, reason terminated and termination date for: • any loss of income; and • loss of income for new member.	Verify source, final gross amount, date received, reason terminated and termination date for: • any loss of income; and • new member (See A-1370, Verification Requirements, for streamlined reporting requirements).
Deductions – Child Support	• legal obligation to pay; • amount of obligation; and • amount actually paid.	• amount actually paid; and • a change in legal obligation.	• amount actually paid; and • a change in legal obligation.
Deductions – Dependent Care Costs	Total amount if verification can be obtained at the interview. **Note:** If verification cannot be obtained during the interview and the total expense does not exceed $300 a month, total for the entire EDG, and is not questionable, then accept the individual's statement. Pend the EDG only if the claimed expense is questionable or exceeds $300 a month, total, for the entire EDG.	A new amount. **Note:** If the amount cannot be verified and is less than $300, accept the individual's statement. Pend the EDG only if the reported expense is questionable or exceeds $300 a month, total, for the entire EDG.	Total amount if verification can be obtained at the interview. **Note:** If verification cannot be obtained during the interview and the total expense does not exceed $300 a month, total for the entire EDG, and is not questionable, then accept the individual's statement. Pend the EDG only if the claimed expense is questionable or exceeds $300 a month, total, for the entire EDG.
Deductions – Actual and Standard Medical Expenses	Refer to A-1428.2, Budgeting Medical Deductions.	Refer to A-1428.2, Budgeting Medical Deductions.	Refer to A-1428.2, Budgeting Medical Deductions.

Mandatory Verification	At Application	When a Change Occurs	At Redetermination *
Deductions – Shelter	• Rent or mortgage, if questionable, or if this information is a regional requirement. • The total amount of shelter cost for an unoccupied home.	• If change in rent or mortgage is questionable, or if this information a regional requirement. • The total amount of shelter cost for an unoccupied home, if amount changed.	• Rent or mortgage, if questionable, or if this information is a regional requirement. • The total amount of shelter cost for an unoccupied home.
Management	If the household's basic expenses are paid or delinquent, when management is questionable.	Not Applicable	If the household's basic expenses are paid or delinquent, when management is questionable.
Employment Services	• exemptions that are questionable; • any member claiming to be physically or mentally unable to work, if not obvious; • any member claiming an exemption based on caring for a person with a disability living in the home; • at least 30 hours worked if a self-employed individual does not receive earnings equal to 30 hours multiplied by the federal minimum wage (Code P); and • a refugee is participating, at least half-time in a training program administered by a refugee contractor or Match Grant Program (Code S).	• new exemptions that are questionable; • any new member claiming to be physically or mentally unable to work, if not obvious; and • any new member claiming to be caring for a person with a disability living in the home.	• exemptions that are questionable; • any new member claiming to be physically or mentally unable to work, if not obvious; and • any new member claiming to be caring for a person with a disability living in the home.

Mandatory Verification	At Application	When a Change Occurs	At Redetermination *
Federal Time Limits – 18-50 Work Requirement, Able-Bodied Adult Without Dependents (ABAWD)	Individual's exemption from requirement is based on: • pregnancy or being physically or mentally unfit to work 20 hours a week; • participation in the Workforce Innovation and Opportunity Act (WIOA) or the Trade Adjustment Act Program; • participation in the Supplemental Nutrition Assistance Program (SNAP) Employment and Training (E&T) program using Form H1822, ABAWD E&T Work Requirement Verification • that the employee works an average of 20 hours a week, if employed; • verify the individual worked or complied with a work program for at least 80 hours in a 30-day period for eligibility of the second three months of time-limited benefits; • volunteer employment hours • countable months of benefits received in another state.	Individual's exemption from requirement is based on • pregnancy or being physically or mentally unfit to work 20 hours a week; • participation in WIOA, the Trade Adjustment Act Program, or the SNAP E&T program using Form H1822 • that the employee works an average of 20 hours a week, if employed; • verify the individual worked or complied with a work program for at least 80 hours in a 30-day; • volunteer employment hours; • countable months of benefits received in another state.	• individual's exemption from requirement is based on pregnancy or being physically or mentally unfit to work 20 hours a week; • participation in WIOA, the Trade Adjustment Act Program, or the SNAP E&T program using Form H1822 • that the employee works an average of 20 hours a week, if employed; • verify the individual worked or complied with a work program for at least 80 hours in a 30-day; • volunteer employment hours; and • countable months of benefits received in another state.
Elderly or Household Members with a Disability	If not previously verified: • household members are age 60 or older; and • household members meet the disability criteria in B-432, Definition of Disability.	If not previously verified: • household members are age 60 or older; and • household members meet the disability criteria in B-432, Definition of Disability.	If not previously verified: • household members are age 60 or older; and • household members meet the disability criteria in B-432, Definition of Disability.

* Requirements are the same for all redeterminations whether filed timely or untimely.

** Categorically eligible households in which all members receive Temporary Assistance for Needy Families (TANF) cash assistance (TP 01/61) and/or Supplemental Security Income (SSI) are exempt from verification.

Note: Verify the eligible status of the facilities listed below as required in B-400, Special Households:

- homeless shelters;
- group living arrangements;
- drug and alcohol treatment centers; and
- family violence shelters.

C—913 Required Verification for Medical Programs

Revision 15-4; Effective October 1, 2015

Medical Programs

Mandatory Verifications	At Application	When a Change Occurs*	At Redetermination

Mandatory Verifications	At Application	When a Change Occurs*	At Redetermination
Citizenship (except TA 31, TP 32, TP 33, TP 34, TP 35, and TP 36)	All household members applying	Any new member applying	Any new member applying
Alien Status Exception: The Systematic Alien Verification for Entitlements (SAVE) procedures do not apply to an alien in TA 31, TP 32, TP 33, TP 34, TP 35, and TP 36 who does not meet citizenship or alien status requirements, unless the individual potentially meets the citizenship or alien status requirement for another program	Any person identified as an alien who wishes to be certified	Any new person identified as an alien who wishes to be certified	Any new person identified as an alien who wishes to be certified
Social Security Number (SSN) (except TA 31, TP 32, TP 33, TP 34, TP 35, TP 36, and TP 45)	• All household members who are applying • Household members who are applying who cannot provide an SSN, verify they applied for an SSN, unless exempt	• New members who are applying • New members who are applying who cannot provide an SSN, verify they applied for an SSN, unless exempt	• Household members who are applying • Household members who are applying who cannot provide an SSN, verify they applied for an SSN, unless exempt
Age/Relationship	All children applying; if not available, accept self-declaration For TP 08, if not available, follow the policy in A-523.1, How to Make an Evaluative Conclusion.	Newly added children; if not available, accept self-declaration For TP 08, if not available, follow the policy in A-523.1.	Newly added children; if not available, accept self-declaration For TP 08, if not available, follow the policy in A-523.1.
Identity (except TA 31, TP 32, TP 33, TP 34, TP 35, and TP 36)	All individuals requesting benefits When an interview is required, the identity of the person being interviewed must be verified.	Any new member requesting benefits	Any new member requesting benefits When an interview is required, the identity of the person being interviewed must be verified.
Residence **Note:** Accept self- declaration for Children's Medicaid and TP 56 for a child	• Physical address • Intent to remain in Texas • New Texas residents, verify the last month the member received Medicaid in another state	Not Applicable	• Physical address • Intent to remain in Texas • New Texas residents, verify the last month any new member received Medicaid in another state
Three Months Prior	• Unpaid medical bills • Income for each of the months of prior coverage (see A-831.2, Eligibility for Three Months Prior Coverage, for TP 40)	Not Applicable	Not Applicable

Mandatory Verifications	At Application	When a Change Occurs*	At Redetermination
Third-Party Resources	• Any household member applying who has private health insurance	• For each certified household member whose coverage has changed • New members applying who have private health insurance	• For each certified household member whose insurance coverage has changed • New members applying who have private health insurance
Pregnancy (TP 40 and TP 36)	Accept self-declaration for pregnancy, pregnancy start date, number of children expected and the anticipated date of delivery.	Not Applicable	Not Applicable
Medicaid Eligibility of Mother (TP 45 only)	For each certified child	For a newly certified child	For each certified child
Emergency Medical Condition Treatment (TA 31, TP 32, TP 33, TP 34, TP 35, and TP 36)	For each certified undocumented alien or ineligible alien treated for an emergency condition	Not Applicable	Not Applicable
Resources* (Children on TP 56, Children on TP 32, and TP 02 only)	• Checking/savings/ retirement/education account(s) • Other – if within $300 of the maximum	• New checking/savings/ retirement/education account(s) • Other – if within $300 of the maximum	• New checking/savings/ retirement/education account(s) • Other – if within $300 of the maximum
Income – Nonexempt including Lump Sums*	• Total gross amount **Note:** Frequency is self-declared for Children's Medicaid***	• Total gross amount **Note:** Frequency is self-declared for Children's Medicaid***	• Total gross amount • Accept self-declaration of interest, unless from a new source or the amount changed by more than $50 **Note:** Frequency is self-declared for Children's Medicaid***
Income – Terminated	If terminated in the application month or prior two months, verify: • Source • Final gross amount • Date received • Reason terminated • Termination date **Note:** For Children's Medicaid***, verify only income that terminated in the month of application.	Verify source, final gross amount, date received, reason terminated, and termination date for: • Any loss of income • Terminated income of new member	Verify source, final gross amount, date received, reason terminated, and termination date for: • Any loss of income • Terminated income of new member **Note:** For Children's Medicaid, verify only income that terminated in the application month for new members.
Modified Adjusted Gross Income (MAGI) Expenses	Total amount	New amount	Total amount

Mandatory Verifications	At Application	When a Change Occurs*	At Redetermination
School Attendance (TP 08 only)**	For the only dependent child(ren), if they are age 18	For the only dependent child(ren), if they are age 18	For the only dependent child(ren), if they are age 18
Child Support — Good Cause Claims (TP 08 only)	Any good cause claim	Good cause claim for new children applying	Good cause claim for new children applying **Note:** All good cause claims must be re-evaluated at redetermination.
Domicile (TP 08 only)	For a dependent child	When a change impacts the living situation or care and control of the dependent child	For a dependent child
Household Composition — Family Violence Exemption	Any family violence exemption	Any new family violence exemption	Any new family violence exemption
Management (Except: TP 40 and Children's Medicaid*)**	If the household's basic expenses are paid or delinquent, when management is questionable	Not Applicable	If the household's basic expenses are paid or delinquent, when management is questionable

* Children certified on TP 43, TP 44, and TP 48 are continuously eligible for the first six months of the 12-month certification period; children certified on TP 45 are continuously eligible for 12 months. Address changes in income as explained in B-600, Changes.

** School attendance is only verified if the **only** child that makes the parent or caretaker relative eligible for TP 08 is age 18 years.

*** Children's Medicaid simplified verification requirements also apply when processing a Medically Needy with Spend Down (TP 56) or Medically Needy with Spend Down — Emergency (TP 32) EDG for a child under age 19.

C—920 Questionable Information

Revision 15-4; Effective October 1, 2015

All Programs

Consider the individual's statements on the application or during the interview questionable if they:

- are contradictory;

  (**Example:** The individual states he has had no income for several months, but his application shows $30 cash on hand.)

- do not agree with information in the case record;

  (**Example:** The individual states he has no resources. An earlier application was denied because bank accounts and property were over the resource limits.)

- do not agree with other information the advisor has;

  (**Example:** The individual provides paycheck stubs showing a 40-hour week in an industry such as construction that has frequent overtime.)

- do not adequately explain the household's circumstances; or

  (**Example:** The individual states he has not paid rent or utilities for several months, but he has not been evicted or had his utilities cut off.)

- do not agree with information obtained from precertification activity, such as information retrieved from the Data Broker System's Employer New Hire Report (ENHR) or another automated source.

Note: The ENHR and other sources in Data Broker may list the corporate name and address instead of the local business name and address. Before denying an EDG, consider that the commonly known name of a business may be different from the corporate name.

Before taking adverse action, allow the individual an opportunity to resolve any discrepancy by providing documentary proof or designating a suitable collateral source.

After the initial application or redetermination interview, if the advisor obtains unverified information from a source other than the individual which contradicts the individual's statement, then the advisor may:

- allow the applicant an opportunity to resolve the discrepancy, or
- verify the information by directly contacting a collateral source.

  Example: The individual states on the application and at the interview that the household has no income from wages. The advisor contacts the landlord to verify residence, and the landlord reports the applicant is working. The advisor may either contact the individual or the employer to verify the information.

Sources of verification are listed at the end of each applicable section in the *Texas Works Handbook*.

C—930 Providing Verification

Revision 02-6; Effective July 1, 2002

C—931 Household Responsibility for Providing Verification

Revision 15-4; Effective October 1, 2015

All Programs

Households or the independent child's representative have the primary responsibility for providing documented or collateral evidence needed for proof of their circumstances. Households need not specifically designate a collateral source if that source is named on the application form or during the interview or application processing. The advisor may assist the household in designating a collateral contact by suggesting a source that may be reliable.

If documented evidence is not available or not sufficient, the household must:

- designate an alternate source of verification, or
- permit a prescheduled home visit.

C—932 Advisor Responsibility for Verifying Information

Revision 15-4; Effective October 1, 2015

All Programs

When verifying information, follow these guidelines:

- Photocopy and send for imaging all paper documents an individual provides as verification. If the household indicates that a document is verification for more than one case, send for imaging for each case.
- Do not reverify eligibility factors that were previously verified and are not subject to change, if the previous verification is available in the electronic case record. (**Examples:** relationship, birth proof/citizenship, and deprivation due to death.)
- Advisors may not request additional information or documentation from applicants or clients unless such information is not available electronically or the information obtained electronically is not consistent with the information on the application.

- Do not ask an individual to provide additional proof if:
  - verification is available through the Texas Integrated Eligibility Redesign System (TIERS) inquiry, Texas Workforce Commission (TWC) inquiry, the Birth Verification System (BVS), TALX, Child Support inquiry, or other automated systems that are acceptable verification sources and accessible to the advisor, or if the individual indicates that verification is readily available in the electronic case record; and
  - the information is sufficient to establish current eligibility.
- Do not verify income information by using 1-900 telephone numbers. Accessing these numbers results in a substantial charge ($2 - $20 per call) to the Texas Health and Human Services Commission (HHSC).
- Accept any reasonable evidence provided by the household whether it is provided in person, by mail, fax, other electronic device or via an authorized representative. Verification should be reliable and sufficient to prove an individual's statement.
- Determine what types of verification are readily available to the household and request that verification first if it is anticipated to be sufficient proof. If preferred sources of verification are not readily available, alternate sources of proof must be accepted if they are reliable and provide sufficient proof. Sources of documentary proof and collateral sources are listed at the end of the applicable section of the *Texas Works Handbook*.
- Do not disclose any information the household provides when contacting a third party for verification. The advisor cannot disclose that the household has applied for any specific program or suggest the household is suspected of any wrong doing.

  Note: If the collateral source asks why the information is necessary, inform the collateral source that HHSC is required to verify eligibility for assistance. If the collateral source asks for specific information regarding the individual, inform the collateral source of the individual's confidentiality rights.
- Evaluate the documented evidence or collateral source the household provides and determine if it is reliable and sufficient to decide eligibility and benefit amount. If a source of verification is unreliable:
  - designate another collateral source, or
  - ask the household to designate another collateral source, or
  - schedule a home visit. Do not conduct a home visit solely because the household meets error-prone criteria.

    Note: HHSC may also designate a collateral source if the individual fails to provide one.
- Contact the designated collateral source unless the individual claims it will result in negative consequences, such as eviction or loss of job.
- Offer reasonable assistance in obtaining verification if the individual has difficulty in obtaining the required verification. Also offer assistance if discrepancies exist in the documentary information the individual provides or if the individual requests assistance in clearing the discrepant information.
- Accept collateral sources or documents from the household that are reliable and provide sufficient proof. Do not deny or delay benefits if this requirement is met, or if:
  - a collateral source refuses to provide verification, and
  - there is no reasonable alternate verification available.
- There may be unusual circumstances in which an applicant's statement must be accepted as proof if:
  - there is a reasonable explanation why documentary evidence or a collateral source is not available, and
  - the applicant's statement does not contradict other individual statements or other information received by the advisor.

    Exception: For verification of relationship, follow procedures in A-522, Legal Parent-Child Relationship, and A-540, Documentation Requirements.
- If an individual is able to cooperate but clearly indicates orally or in writing that they refuse to take action necessary to complete the certification process, deny the EDG. This also applies to evaluations such as audits, quality control, or investigations. See A-1324.18, Temporary Assistance for Needy Families (TANF), for action required on a SNAP EDG when the associated TANF EDG is denied due to any of these reasons.
- Have the individual sign Form H0003, Agreement to Release Your Facts, for collateral sources that will not release information without the individual's written consent.
  Note: Do not request signatures on blank forms for future use.
- For individuals born in Puerto Rico, HHSC can submit a birth verification request by mail, fax or email to the Department of Healthcare Demographic Registry Office of Puerto Rico. Include in the request the applicant's name as it appears on the birth certificate (including both last names if more than one last name), the applicant's date of birth and the applicant's place of birth.

  To submit a request by:
  - email, send the request to Registrodemografico@salud.gov.pr. In the request, indicate the government email address to which the response should be sent.
  - fax, make the request on official letterhead and fax it to the attention of Validation Office at 1-787-767-8605 or 1-787-766-1299. Indicate in the fax the government fax number to which the response should be sent.
  - regular mail, make the request on official letterhead and mail it to the attention of Validation Office, Demographic Registry Office of Puerto Rico, Department of Health, P.O. Box 11854, San Juan, Puerto Rico 00910. Indicate in the letter the full mailing address to which the response should be sent.

  The Registry Office will provide findings within two business days that verify the individual's submitted demographic information or will advise that the submitted information is inconsistent with the information in the Registry Office.

Document collateral sources that are designated orally by the individual or by HHSC.

Medical Programs except Emergency Medicaid

Assist an individual in obtaining documentary evidence of citizenship. Identify if the individual is unable to provide documentary evidence of citizenship in a timely manner because of incapacity of mind or body or the lack of a representative to assist. Assisting an individual consists of referrals to appropriate entities that can assist the individual. When assisting an individual in providing documentary evidence of citizenship and identity, use any available document, regardless of level of evidence.

Related Policy
Processing Special Reviews, B-125

C—940 Documentation

Revision 15-4; Effective October 1, 2015

All Programs

Document in TIERS Data Collection and in Case Comments information to support all decisions about eligibility and allotment, whether at application, change, or redetermination. Documentation must be sufficient so that anyone can understand all computations and advisor decisions, including denials.

Always include the following:

- mandatory verifications;
- why information is questionable;
- how questionable information is cleared;
- why alternate methods are used rather than standard methods;
- why one collateral contact was rejected in preference for another;
- name, address, and/or telephone number for all collateral contacts; and
- documentation in the Agency Use Only section of the application or redetermination forms or change report form for address changes regarding voter registration actions provided to the individual.

Document contacts between redeterminations that may affect eligibility or benefit amount. **Note:** Documentation requirements are listed at the end in the applicable section in the *Texas Works Handbook*.

SNAP

Always document why another verification source such as a collateral contact or home visit was necessary (except when using a collateral contact to verify where the household lives or its size).

Related Policy
Registering to Vote, A-1521
The Texas Works Documentation Guide

C—941 Texas Works Documentation Guide

Revision 13-1; Effective January 1, 2013

All Programs

TIERS Data Collection pages handle the majority of required documentation for a case record. The documentation requirements not captured by these pages have been compiled into a comprehensive documentation guide, *The Texas Works Documentation Guide*.

TWH, C-1000, Procedures for Clearance of Income & Eligibility (IEVS) Reports & Internal Revenue (IRS) Federal Tax Information (FTI)

Revision 14-4; Effective October 1, 2014

C—1010 Clearance of IEVS Reports by the Office of Inspector General (OIG) that Do Not Include IRS FTI

Revision 11-1; Effective January 1, 2011

C—1011 OIG IEVS Process

Revision 09-4; Effective October 1, 2009

TANF, SNAP and Medicaid

The IEVS module within the Automated System for Office of Inspector General (ASOIG) automates the distribution and clearance of IEVS data for OIG staff. OIG uses the IEVS module to process and clear IEVS reports within 45 days of the secure automated download of the IRS files to ASOIG.

C—1012 Review the Case Record

Revision 13-4; Effective October 1, 2013

TANF, SNAP and Medicaid

OIG staff research information for cases in the Texas Integrated Eligibility Redesign System (TIERS) through disposition inquiry, either by individual or case number in TIERS Historical Case Reports, located within the State Portal.

OIG staff research the complete action that occurred immediately prior to the time period listed on the IEVS. If the information is not found for the period in question, OIG staff review all actions from the period in question through the current action. **Exception:** If there are obvious gaps, OIG staff request the case record from Texas Works via an electronic mail message to the unit supervisor with a copy to the program manager. OIG will allow 10 workdays for receipt of the case record. OIG staff:

- check the Texas Workforce Commission (TWC) inquiry for the most current quarter of income reported by the employer; and
- document the IEVS clearance on the worksheet in the IEVS module.

C—1013 Request Verification

Revision 09-4; Effective October 1, 2009

TANF, SNAP and Medicaid

OIG staff request verification if the IEVS:

- wage information was not reported and the case is active; or
- information on wages was budgeted in the case but the IEVS discrepancy amount for an individual employer is more than $300 per month.

In these situations, verification is required to determine if the income is ongoing and impacts current benefits, and/or the income causes an overpayment.

OIG staff obtain verification by calling the employer, accessing Data Broker or sending a verification letter to the individual and payer. OIG staff allow the individual 10 days from the print date of the letter to provide verification. The request for verification letter informs individuals that the information is needed "to make a final decision on your eligibility."

C—1014 Non-IRS FTI IEVS Income Action Messages

Revision 13-4; Effective October 1, 2013

TANF, SNAP and TP 08

OIG staff may create an income action message in the IEVS module for the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) program and Medicaid programs, except for TP 40, TP 43, TP 44, TP 47 and TP 48, that requires action by Texas Works staff.

OIG creates an income action message when:

- verification indicates income is ongoing and affects current eligibility or benefits; or
- the individual fails to provide verification of ongoing income (OIG Claims Investigation staff complete an overpayment referral for the time period of the overissuance).

Texas Works staff must process non-Internal Revenue Service FTI income action messages according to procedures in C-1020, Clearance of IEVS Reports by Texas Works Staff that Do Not Include FTI.

OIG staff summarize findings in the comment section of the income action message. Detailed information regarding the income may be viewed on the automated worksheet within the IEVS module.

C—1020 Clearance of IEVS Reports by Texas Works Staff that Do Not Include IRS FTI

Revision 11-1; Effective January 1, 2011

C—1021 Regional IEVS Coordinator

Revision 13-4; Effective October 1, 2013

TANF, SNAP and TP 08

When OIG staff create an action message in the IEVS module, regions have the flexibility to process the report by:

- having a centralized process for clearing action messages (one designated individual or a group of staff), or
- designating a regional IEVS coordinator to assign the clearance of action messages to Texas Works staff (supervisors or advisors) throughout the region.

The regional IEVS coordinator is responsible for:

- the daily review of "IEVS TW Alert Detail" in the IEVS Reports Module;
- assigning clearance of action messages to centralized staff or Texas Works staff throughout the region, depending on the region's option; and
- monitoring the clearance of action messages.

C—1022 Non-IRS FTI IEVS Action Message Clearance Process

Revision 13-4; Effective October 1, 2013

TANF, SNAP and TP 08

After checking IEVS, the regional coordinator assigns for clearance each action message to the appropriate unit supervisor or designated staff. Create a task for clearance of the action message for cases in TIERS. If clearance of the action message is assigned to individual units, the unit supervisor is responsible for assigning the clearance of the action message request to the appropriate advisor. The regional IEVS coordinator has two workdays after receipt to assign the action message.

If the IEVS regional coordinator assigns clearance of the action message to a supervisor/unit, the supervisor or clerk must assign the action message no later than the next workday. The advisor must complete the change within 10 days after the date it is assigned. The date of assignment is day zero.

If the regional coordinator assigns the clearance of the action message to other designated staff, the designated staff must complete the change within 10 days after the date of assignment.

Each worksheet with a message from OIG will indicate the type of action required. OIG staff process action messages if the household did not provide accurate information during the interview or application processing, or if the increase in income identified via IEVS caused the household income to exceed 130% Federal Income Poverty Limits (FPIL) for SNAP streamlined reporting (SR) cases.

Upon receipt of an action message, Texas Works staff must take the following action to clear the message based on the reason the message was issued.

If the ...	then Texas Works staff ...
verification provided to OIG indicates income affects current eligibility,	• send manual Form H1017, Notice of Benefit Denial or Reduction, to deny or reduce the benefits based on income or resources. If the advisor does not receive verification from OIG, then document that OIG has the verification. Copies of verification received by OIG may be provided to Texas Works staff upon request. • provide advance notice and process the denial or adjustment after the adverse action period expires.
individual fails to provide verification to OIG,	• send a manual Form H1017 to deny the benefits for failure to provide the information. **Note:** A manual notice and denial is required because TIERS will not allow a denial for failure to provide information without previously issuing Form H1020, Request for Information or Action. In the comments section, document the information the individual failed to provide and what the individual can do to re-establish eligibility as specified in the instructions to Form H1017. If the individual fails to provide the requested information within the adverse action time frame, process the denial for failure to provide information. • if verification is provided within the adverse action time frame, send an email to the OIG claims investigator notifying the investigator about receipt of the information and forward a copy of the verification. Take action on the case based on new information. • determine the benefit/overpayment amount based on verification documentation included in the action message comments.

Notes:

- The investigator's name and telephone number are listed on the automated worksheet in the IEVS module.
- If Texas Works staff do not provide the case record upon OIG request, OIG staff will contact the regional director.

C—1023 TP 40 and Children's Medicaid Clearance Process

Revision 13-4; Effective October 1, 2013

Children certified for children’s Medicaid other than TP 45, which is certified for 12 months, receive six months of continuous eligibility, regardless of changes in family income or resources. A pregnant woman certified for TP 40 is continuously eligible regardless of income changes. There is no asset test for TP 40.

OIG staff will create action or information messages for these type programs only if the household did not provide accurate information during the interview or application processing.

At the children's Medicaid renewals, or before certifying a TP 40 recipient for another type program, advisors must inquire in the Income and Eligibility Verification System (IEVS) module to review the reports and handle any information that may affect ongoing eligibility.

Follow normal regional security procedures to request access. To access the ASOIG IEVS module, go to https://hhsportal.hhs.state.tx.us/wps/portal.

C—1024 Client Reapplies

Revision 13-4; Effective October 1, 2013

TANF, SNAP and TP 08

If the individual reapplies after being denied for failure to provide information to OIG, advisors must obtain the verification requested by OIG before recertifying the case. **Exception:** If the individual can reasonably explain why the requested information cannot be obtained or provided, use the best available information. See C-920, Questionable Information.

C—1025 Appeals

Revision 13-4; Effective October 1, 2013

TANF, SNAP and TP 08

If the advisor receives a request for an appeal based on action taken by:

- OIG, contact the claims investigation supervisor in the region on the same day the request is received.
- Texas Works as a result of an action message, the advisor files the appeal. Complete Form H4800, Fair Hearing Request Summary, and Form H4800-A, Fair Hearing Request Summary (Addendum). On Form H4800-A, Section 2, Materials Attached, indicate under Other Related Materials, that action messages generated by OIG need to be considered in the appeal. Enter the claims investigator's name and telephone number on Form H4800 and send OIG copies of Form H4800 and Form H4800-A. OIG provides the additional information to the hearing officer.

If OIG receives a request for an appeal based on action taken by the Texas Works advisor, OIG will notify Texas Works the same day.

C—1026 Non-IRS FTI IEVS Information Message Clearance Process

Revision 13-4; Effective October 1, 2013

TANF, SNAP and TP 08

At the region's discretion, Texas Works staff may review the messages in the IEVS module before certification. Information messages serve as a case clue to Texas Works staff to identify potential resources not reported by the individual.

C—1030 Clearance of IEVS Reports by OIG that Includes IRS FTI

Revision 11-1; Effective January 1, 2011

C—1031 OIG Procedures

Revision 11-3; Effective July 1, 2011

TANF, SNAP and Medical Programs

The ASOIG Match module with the sources listed as FTI, Self or Earn contains IRS FTI that requires adherence to FTI safeguarding procedures.

IRS FTI is defined as any information included in ASOIG. This includes:

- payee's account number,
- tax year income reported,
- payer's name and address,
- payer's employer identification number,
- pay amount, or
- type of income.

More information about IRS FTI can be found by reviewing the training, "Safeguarding IRS Tax Sensitive Information," at http://mhmrweb02.mhmr.state.tx.us/cbt/enterprise/Training_login.asp.

C—1032 Review Case Record

Revision 13-4; Effective October 1, 2013

TANF, SNAP and TP 08

OIG staff follow the procedures in C-1012, Review the Case Record.

C—1033 Request Verification

Revision 13-4; Effective October 1, 2013

TANF, SNAP and TP 08

OIG staff follow procedures in C-1013, Request Verification. Page one of the IEVS verification letters (KC-63, KC-64, KC-65 and KC-68) is considered IRS FTI when the IEVS source is identified as such and staff must secure it according to IRS safeguarding requirements.

C—1034 Types of IRS FTI Action/Information Messages

Revision 13-4; Effective October 1, 2013

TANF, SNAP and TP 08

There are three different types of action/information messages that OIG may create in the IEVS module for SNAP, TANF and Medicaid programs, except for TP 40, TP 43, TP 44, TP 47 and TP 48 that require action by Texas Works staff.

OIG creates	when
Income Action Message **Note:** Action messages created based on IRS FTI are limited to those matches with a source listed as "Self" or "Earn."	• verification indicates income is ongoing and affects current eligibility or benefits; or • the individual fails to provide verification of ongoing income (OIG claims investigation (CI) staff complete an overpayment referral for the time period listed on the IEVS module).

OIG creates	when
Resource Action Message	• verification indicates a resource affects current eligibility (OIG completes overpayment referral); or • the individual fails to provide verification of ongoing resources (OIG-CI completes an overpayment referral for the time period listed on the IEVS if the report indicates resources affect prior eligibility).
Resource Information Message	• the resource is ongoing and is under limit or inaccessible; • the resource is ongoing and the case is denied; or • the individual did not provide the verification and the case is denied.

OIG staff summarize findings in the TW comments section of the IEVS worksheet. Detailed information regarding the income may be viewed on the automated worksheet of the IEVS module.

C—1040 Clearance of IEVS Reports by Texas Works that Includes IRS FTI

Revision 11-1; Effective January 1, 2011

C—1041 Regional IEVS Coordinator

Revision 13-4; Effective October 1, 2013

TANF, SNAP and TP 08

The regional IEVS coordinator and Texas Works staff use the same procedures and time frames found in C-1021, Regional IEVS Coordinator, to process action messages with IRS FTI.

When an IEVS is generated based on IRS FTI, the action or resource message will be on a screen clearly labeled with a FTI warning. All information on the IEVS module (payer name, account number, pay amounts, etc.) is considered IRS FTI. While printing of IEVS module worksheets with Texas Works or TW messages is not prohibited, staff must secure these worksheets according to safeguarding requirements.

C—1042 IRS FTI IEVS Action Message Clearance Process

Revision 13-4; Effective October 1, 2013

TANF, SNAP and TP 08

Texas Works staff take the following action to clear the action message.

If the ...	then ...

If the ...	then ...
verification provided to OIG indicates income/resource affects current eligibility,	• send manual Form H1017, Notice of Benefit Denial or Reduction, to deny or reduce the benefits based on income or resources. If the advisor does not receive verification from OIG, then document that OIG has the verification. Copies of verification received by OIG may be provided to Texas Works staff upon request. • provide advance notice, and process the denial or adjustment after the adverse action period expires.
individual fails to provide verification to OIG,	• send a manual Form H1017 to deny the case. **Note:** A manual notice and denial is required because the TIERS will not allow a denial for failure to provide information without previously issuing Form H1020, Request for Information or Action. In the comments section, document the following message: "You failed to provide information to the Office of Investigator General. Contact [OIG investigator's name] at [investigator'sphone number] if you have questions. You may reapply for benefits and will be required to provide the information previously requested." "Usted no presentó información a la Fiscalía General. Si tiene alguna pregunta, comuníquese con [OIG investigator's name] al [investigator's phone number]. Puede volver a solicitar beneficios, pero tendrá que presentar la información que se le pidió anteriormente." • if the individual fails to provide the requested information within the adverse action time frame, manually process the denial for failure to provide information. **Note:** A manual notice and denial is required because TIERS will not allow a denial for failure to provide information without previously issuing Form H1020. • if verification is provided within the adverse action time frame, send an overpayment referral to the OIG claims investigator indicating receipt of verification and forward a copy of verification, if appropriate. Take action based on the verification provided. • determine the benefit/overpayment amount based on verification documentation included in the comments section of the IEVS worksheet.

Reminder: Texas Works staff must not enter any IRS FTI into TIERS (including individual TW comments). Documentation in TIERS case comments is limited to the following language: **"IEVS match, action message generated from IEVS requesting denial."**

Notes:

- The investigator's name and telephone number are listed on the online version of the automated worksheet in the IEVS module.
- If Texas Works staff do not provide the case record in 10 days, OIG staff will contact the regional director.

C—1043 Client Reapplies

Revision 13-4; Effective October 1, 2013

TANF, SNAP and TP 08

If the individual reapplies after being denied for failure to provide information to OIG, the advisor must verify the IRS FTI. If the individual indicates the verification was provided to OIG, contact the OIG investigator. If the individual self-discloses the information on the application, the information is no longer considered IRS FTI.

If the individual does not have the resource or income for which OIG requested information, the advisor must request verification of the IRS FTI using a manual Form H1020, Request for Information or Action. If the advisor attaches a verification form, such as a bank verification form or Form H1028, Employment Verification, do not include any IRS FTI on the verification form. File the manual Form H1020 in the case record and secure the case according to the IRS safeguarding requirements because the case record now contains IRS FTI.

When the individual provides the information requested on the verification form, the information on the verification form is no longer considered IRS FTI. The file copy of Form H1020 remains IRS FTI and must be kept in the case record for the duration of the retention period.

If the advisor is requesting additional information that does not contain IRS FTI, the advisor may issue a second Form H1020 through TIERS or request the information on a manual Form H1020.

Note: If the advisor completes a manual Form H1020 because the only required verification is IRS FTI, TIERS will not allow a denial based on failure to provide verification, since Form H1020 was not generated via TIERS. The advisor may generate Form H1020 indicating a manual Form H1020 was provided to the individual. Do not provide the notice generated from TIERS to the individual. The advisor must document in the case comments the reason for generating an electronic pending notice and reference the manual Form H1020 that was issued.

If the individual fails to provide the information, issue a manual Form H1017, Notice of Benefit Denial or Reduction, to deny the case for failure to provide information.

C—1044 Appeals

Revision 13-4; Effective October 1, 2013

TANF, SNAP and TP 08

If the advisor receives a request for an appeal based on action taken by:

- OIG staff, contact the claims investigation supervisor in the region on the same day the request is received. OIG will process Form H4800, Fair Hearing Request Summary.
- Texas Works, as a result of the clearance of an action message, the advisor files the appeal. Complete Form H4800 and Form H4800-A, Fair Hearing Request Summary (Addendum).
    - On Form H4800-A, Section 2, Materials Attached, indicate under Other Related Materials that action messages generated by OIG need to be considered in the appeal.
    - Document the claims investigator's name and telephone number on Form H4800 and send OIG a copy of Form H4800 and Form H4800-A. OIG provides the additional information to the hearing officer using the instructions in the annual review of the Internal Revenue Service safeguarding requirements memo.

If OIG receives a request for an appeal based on action taken by the Texas Works advisor, OIG will notify Texas Works the same day. Texas Works staff must file Form H4800.

C—1050 Additional IRS FTI Sources and Security Issues

Revision 11-1; Effective January 1, 2011

C—1051 Retention and Distribution of IRS FTI

Revision 13-4; Effective October 1, 2013

TANF, SNAP and TP 08

Retain IEVS reports for three years for SNAP and four years for TANF. Staff may log and destroy the IEVS module records using IRS safeguarding requirements as soon as they are no longer needed, as they are available in ASOIG.

The following list of forms must be retained for five years from the date of the last entry on the form:

- Form H1861, Federal Tax Information Destruction Log
- Form H1862, Federal Tax Information Transmittal Memorandum
- Form H1863, Federal Tax Information Removal Log
- Form H1864, Federal Tax Information Fax Transmittal
- Form H1865, Federal Tax Information Transmittal Log

C—1052 Discovery of Existing IRS FTI in HHSC Offices and Records

Revision 13-4; Effective October 1, 2013

TANF, SNAP and TP 08

Advisors review information in each case record to identify any IRS FTI as cases come up for recertification or review. Examples of IRS FTI include, but are not limited to hard copies of old IEVS alerts, manual Form H1020, Request for Information or Action, and notices requesting verification of IRS FTI. If IRS FTI is found in the case record, the advisor evaluates whether retention periods have been met per IRS FTI retention periods addressed in C-1051, Retention and Distribution of IRS FTI. If information can be destroyed, complete Form H1861, Federal Tax Information Destruction Log, before destroying the information. If the information needs to remain in the case record to support documentation or verification, secure the case record in a two-barrier secure environment until the case can be purged. Regions may elect to separate IRS FTI and place it in a secure centralized location. If the local office does not file the IRS FTI in the case record, note in the case record that IRS FTI exists and is located in the centralized location.

C—1053 Purging Records

Revision 13-4; Effective October 1, 2013

TANF, SNAP and TP 08

When Texas Works staff purge case records, review the records for IRS FTI. If information can be removed from the actual file, completeForm H1861, Federal Tax Information Destruction Log, and destroy the information. If the record indicates that IRS FTI is filed separately in a secure location, destroy the IRS FTI when the file is purged. Refer to the IRS FTI retention periods addressed in C-1051, Retention and Distribution of IRS FTI.

Follow regional or local office procedures for storage and purging of IRS FTI.

C—1060 Reporting a Security Incident Regarding Internal Revenue Service (IRS) Federal Tax Information (FTI)

Revision 14-4; Effective October 1, 2014

Upon discovery of an actual or possible compromise of an unauthorized inspection or disclosure of IRS FTI, including breaches and security incidents, the individual making the observation or receiving the information must immediately contact the HHSC IRS coordinator. The individual sends a secure email to HHSC_IRS_FTI_Safeguards@hhsc.state.tx.us.

The HHSC IRS coordinator will report the incident by contacting the office of the appropriate special agent-in-charge, Treasury Inspector General for Tax Administration (TIGTA), in addition to the IRS Office of Safeguards, as directed in Section 10.2 of IRS Publication 1075.

TWH, C-1100, Other/Miscellaneous

Revision 18-1; Effective January 1, 2018

C—1110 Medical Information

Revision 05-1; Effective January 1, 2005

C—1111 State Medicaid Agencies

Revision 13-3; Effective July 1, 2013

Medical Programs

For links to all State Medicaid Agencies, go to https://www.medicaid.gov/medicaid/by-state/by-state.html.

C—1112 Services Under the Texas Medical Assistance Program

Revision 13-3; Effective July 1, 2013

Medical Programs

Benefits provided through health insuring agent:

- In-patient hospital services*
- Out-patient hospital services*
- Laboratory and x-ray services
- Physician's services
- Podiatrist's services
- Optometric services*
- Ambulance services*
- Family planning services*
- Home health services limited to nurse and home health aide visits*
- Medicare Part A deductible and coinsurance when benefits would otherwise be payable under Medical Assistance and Medicare Part B deductible and coinsurance for assigned claims only
- Chiropractic treatment — limited to Medicare Part B deductible and coinsurance for assigned claims only
- Eyeglasses*
- Rural health clinics*

Services provided through contract or by direct vendor payments from the Health and Human Services Commission (HHSC):

- Nursing care skilled and intermediate care. Skilled care is limited to recipients age 21 and over. Medicare SNF coinsurance.*
- Active treatment for recipients/patients of any age in licensed and approved section of institutions for individuals with intellectual disabilities.*
- In-patient hospital care for recipients/patients age 65 and older in contracted mental hospitals and state (tuberculosis) hospitals.*
- Texas Health Steps (THSteps) screening program and limited dental treatment for eligible individuals under age 21.
- Prescriptions limited to no more than three covered per month if over 18. Unlimited if 18 and under.
- Prior authorized hearing aid services.*
- Primary home care for recipients age 18 and over.*
- Other medical transportation.

*With limitations — see appropriate provider manuals for details.

The benefits of this program do not extend to:

- Inmates in a public institution. (Recipients in approved medical units in certain contracted institutions are eligible for vendor payments made by HHSC.)
- Special shoes or other supportive devices for the feet or walking aids.
- Services in military medical facilities, Veteran's Administration (VA) facilities, or United States Public Health Service Hospitals.
- Care and treatment related to any condition for which benefits are provided or are available under Workman's Compensation laws.
- Dental care and services except certain oral surgery or that provided under THSteps.
- Any services or supplies provided in connection with a routine physical examination except family planning services.
- Any care or services payable under Title XVIII (Medicare).
- Any service provided by an immediate relative of the recipient or member of the recipient's household.
- Any services or supplies not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of the malformed body member.
- Custodial care.
- Any services provided to the recipient after a Utilization Review or medical review finding that such services are not medically necessary.
- Any services or supplies that are payable through a third party.
- Any service or supplies not specifically provided by the Texas Medical Assistance Program.

Disclaimer: This list is for convenient reference and does not have the effect of law, regulation, or policy. If there is a conflict between this list and law, regulations, and policy, the latter will prevail. If there is a question, use the appropriate provider manuals or filed releases for clarification.

C—1113 Qualified Hospital/Qualified Entity Policy and Procedures for Presumptive Eligibility Determinations

Revision 15-3; Effective July 1, 2015

TA 66, TA 74, TA 75, TA 76, TA 83, TA 86 and TP 42

Presumptive eligibility (PE) provides short-term medical coverage to pregnant women, Medicaid for Breast and Cervical Cancer (MBCC) applicants, children under age 19, parents and caretaker relatives of dependent children under age 19, and former foster care children. PE provides full fee-for-service Medicaid with the exception of pregnant women. Pregnant women receive ambulatory prenatal care only.

Qualified hospitals (QHs) determine PE for all groups except MBCC.

Qualified entities (QEs) determine PE for pregnant women and MBCC applicants. For MBCC applicants, only QEs that are also Texas Department of State Health Services (DSHS) Breast and Cervical Cancer Services contractors can make MBCC PE determinations, following the process outlined in X-100, Application Processing.

C—1113.1 Eligible Groups

Revision 15-3; Effective July 1, 2015

The following groups can receive presumptive eligibility coverage:

- Children:
    1. MA-Children Under 1 Presumptive — TA 74
    2. MA-Children 1–5 Presumptive — TA 75
    3. MA-Children 6–18 Presumptive — TA 76
- Former Foster Care Children (MA-FFCC Presumptive — TA 83)
- Pregnant Women (MA-Pregnant Women Presumptive — TP 42)
- Parents and Other Caretaker Relatives (MA-Parents and Caretaker Relatives Presumptive — TA 86)

C—1113.2 Household Composition

Revision 15-3; Effective July 1, 2015

The QH/QE uses the non-taxpayer/non-tax dependent rules to determine the household composition.

C—1113.3 Modified Adjusted Gross Income (MAGI) Methodology

Revision 15-4; Effective October 1, 2015

The QH/QE uses a simplified MAGI methodology to determine if an individual meets the income requirements for PE. The income limits for each PE type of assistance are the same as the income limits for the associated regular Medicaid type of assistance. For example, MA-Children Under 1 Presumptive has the same income limit as MA-Children Under 1.

C—1113.4 Verifications

Revision 15-3; Effective July 1, 2015

The individual must attest to being:

- a Texas resident, and
- a United States citizen or an eligible immigrant.

For all other PE criteria, the individual's statement is acceptable verification. Additional forms of verification beyond an individual's statement are not required.

C—1113.5 Medical Effective Dates

Revision 15-4; Effective October 1, 2015

The medical effective date (MED) is the date the QH or QE determines the individual is presumptively eligible for Medicaid. If the individual is presumptively eligible, QH/QE staff give the individual Form H1266, Short-term Medicaid Notice: Approved. It informs the individual when the PE coverage begins and when the PE coverage ends, based on whether the individual applies for regular Medicaid.

Note: An individual is not eligible for PE if they are currently receiving Medicaid, Children's Health Insurance Program (CHIP) or CHIP perinatal.

If the individual does not apply for regular Medicaid, the PE coverage ends the last day of the month after the month of the PE determination (see scenario 1 below).

If the individual submits Form H1205, Texas Streamlined Application, or Form H1010, Texas Works Application for Assistance — Your Texas Benefits, HHSC staff determine whether the individual is eligible for regular Medicaid. If the individual is not eligible for regular Medicaid, the individual's PE coverage ends the date that HHSC determines the individual is ineligible (see scenario 2 below). If the individual is eligible for regular Medicaid, the individual's PE coverage ends when HHSC makes the Medicaid eligibility determination, following cutoff rules.

If an individual is Medicaid-eligible during the application month, the individual receives Medicaid from the first of that month through the PE MED. Regular Medicaid coverage for the ongoing period begins once the PE period ends (see scenarios 3 and 4 below). **Exception:** Since PE for pregnant women provides only limited prenatal services, ongoing Medicaid coverage overlays the PE coverage (see scenario 5 below).

Examples:

PE Scenarios

1. Individual does not apply for regular Medicaid	A child is determined eligible for MA-Children 6–18 Presumptive on February 2. Her mother does not submit an application for regular Medicaid. The child's PE coverage ends on March 31.
2. Individual is ineligible for regular Medicaid	A child is determined eligible for MA-Children Under 1 Presumptive on April 4. Her father submits an application for regular Medicaid on the same date. HHSC determines on April 20 that the child is not eligible for regular Medicaid. Her PE coverage ends on April 20.
3. Individual is eligible for regular Medicaid (HHSC makes eligibility determination before cutoff)	A child is determined eligible for MA-Children 1–5 Presumptive on March 6. His mother submits an application for regular Medicaid on the same date. HHSC determines on March 15 (before cutoff) that the child is eligible for regular Medicaid. His PE coverage ends March 31. He is certified for regular Medicaid effective March 1 to March 5 and April 1 through ongoing.
4. Individual is eligible for regular Medicaid (HHSC makes eligibility	A former foster care child is determined eligible for MA-FFCC Presumptive on May 9. He submits an application for regular Medicaid on the same date. HHSC determines on May 22 (after cutoff) that the individual is eligible for regular Medicaid. His PE coverage ends June 30. He is certified for regular Medicaid effective May 1 to May 8 and July 1 through ongoing.

determination after cutoff)	
5. Pregnant woman is eligible for regular Medicaid	A woman is determined eligible for MA-Pregnant Women Presumptive on June 4. She submits an application for regular Medicaid on the same date. HHSC determines on June 10 that the woman is eligible for regular Medicaid. Her PE coverage ends on June 30. Regular Medicaid overlays her PE coverage with an effective date of June 1.

C—1113.6 Periods of Presumptive Eligibility

Revision 15-3; Effective July 1, 2015

Pregnant women are allowed one PE period per pregnancy.

For all other PE groups, an individual is allowed no more than one period of PE per two calendar years. **Example:** An individual receives MA-Children 6–18 Presumptive in June 2015. He cannot receive another period of PE until January 2017.

C—1113.7 Three Months Prior Coverage

Revision 15-3; Effective July 1, 2015

Three months prior coverage does not apply to presumptive eligibility. Eligibility for three months prior Medicaid coverage is determined when HHSC eligibility staff make a regular Medicaid determination, if requested.

C—1113.8 Application Processing

Revision 15-4; Effective October 1, 2015

QH/QE staff first must perform a PE portal inquiry to find out if an individual is currently receiving Medicaid, CHIP or CHIP perinatal or if the applicant has received a period of PE within the PE period limit.

QH/QE staff make the PE determination based on information the individual provides about citizenship/immigration status, Texas residency, income and household composition. To determine whether the individual is presumptively eligible, QH/QE staff fill out Form H1265, Presumptive Eligibility (PE) Worksheet, using the information the individual provides.

If the individual is presumptively eligible, QH/QE staff do the following:

- Enter the individual's demographic information and the PE type of assistance for which the individual is eligible into the PE portal. QH/QE staff use the PE portal to conduct limited inquiries and submit PE determinations.
- Give the individual Form H1266, Short-term Medicaid Notice: Approved. QH/QE staff also help the individual complete and submit the regular Medicaid application via YourTexasBenefits.com if the individual wants to apply. **Note:** An individual is not required to submit a regular Medicaid application to receive PE Medicaid.

If the individual is not eligible for PE, QH/QE staff issue Form H1267, Short-term Medicaid Notice: Not Approved, to the individual and tell the individual about the right to apply for regular Medicaid.

C—1113.9 Due Dates and Processing Time Frames

Revision 15-3; Effective July 1, 2015

Within one business day of the PE determination, the QH/QE must submit the PE determination to HHSC through the PE portal.

C—1113.10 How to Become a Qualified Hospital or Qualified Entity

Revision 15-3; Effective July 1, 2015

Hospitals or entities that want to become qualified to make PE determinations must (1) submit to HHSC a notice of intent, (2) sign a Memorandum of Understanding, and (3) complete online training at the PE website at www.TexasPresumptiveEligibility.com.

C—1113.11 Presumptive Eligibility Forms

Revision 15-3; Effective July 1, 2015

Qualified hospital/qualified entity staff use the following forms in the presumptive eligibility process:

- **Form H1265, Presumptive Eligibility (PE) Worksheet** — Completed by the QH/QE and used to determine if an applicant is presumptively eligible.
- **Form H1266, Short-term Medicaid Notice: Approved** — Completed by the QH/QE and given to an individual determined presumptively eligible. This form notifies the individual about PE coverage and lists the eligibility start date and end date, which is based on whether the individual submits an application for regular Medicaid. If an individual needs proof of Medicaid coverage before receiving their Medicaid identification card, the individual can present this form in an HHSC local eligibility determination office, and HHSC staff will provide the individual with Form H1027-A, Medicaid Eligibility Determination.
- **Form H1267, Short-term Medicaid Notice: Not Approved** — Completed by the QH/QE and given to an individual determined ineligible for PE coverage. This form explains the reason for ineligibility and how to apply for regular Medicaid.

Related Policy
Processing Presumptive Eligibility Applications, A-124

C—1114 Guidelines for Providing Retroactive Coverage for Children and Medical Programs

Revision 17-2; Effective April 1, 2017

Medical Programs

When determining retroactive eligibility for children and pregnant women, use the following decision table and the applicable income chart.

If determining eligibility for ...	for a child and the child's age in the retroactive month was ...	use the income limits in chart ...
March 2015 through February 2016	less than one, one through five, six through 18,	one, 198% one, 144% one, 133%

Chart One, March 2015 through February 2016

Family Size	133% FPIL (3-1-15) TP 44, 34	144% FPIL (3-1-15) TP 48, 33	198% FPIL (3-1-15) TP 40, 43, 36, 35

1	$1,305	$1,413	$1,943
2	1,766	1,912	2,629
3	2,227	2,411	3,315
4	2,688	2,910	4,002
5	3,149	3,410	4,688
6	3,610	3,909	5,375
7	4,071	4,408	6,061
8	4,532	4,907	6,747
9	4,994	5,406	7,434
10	5,455	5,906	8,120
11	5,916	6,405	8,807
12	6,377	6,904	9,493
13	6,838	7,403	10,179
14	7,299	7,902	10,866
15	7,760	8,402	11,552
For each additional member	462	500	687

Family Size	**200% FPIL (3-1-15) TP 02**	**201% FPIL (3-1-15) TA 84**	**202% FPIL (3-1-15) TA 85**	**400% FPIL (3-1-15) TA 77**	**413% FPIL (3-1-15) TP 70**
1	$1,962	$1,972	$1,982	$3,924	$4,051
2	2,655	2,669	2,682	5,310	5,483
3	3,349	3,366	3,382	6,697	6,915
4	4,042	4,062	4,083	8,084	8,347
5	4,735	4,759	4,783	9,470	9,778
6	5,429	5,456	5,483	10,857	11,210
7	6,122	6,153	6,183	12,244	12,642
8	6,815	6,850	6,884	13,630	14,073
9	7,509	7,546	7,584	15,017	15,505
10	8,202	8,243	8,284	16,404	16,937
11	8,895	8,940	8,984	17,790	18,369
12	9,589	9,637	9,685	19,177	19,800
13	10,282	10,334	10,385	20,564	21,232
14	10,975	11,030	11,085	21,950	22,664

Family Size	200% FPIL (3-1-15) TP 02	201% FPIL (3-1-15) TA 84	202% FPIL (3-1-15) TA 85	400% FPIL (3-1-15) TA 77	413% FPIL (3-1-15) TP 70
15	11,669	11,727	11,786	23,337	24,096
For each additional member	694	697	701	1,387	1,432

Chart Two, March 2016 through February 2017

Family Size	133% FPIL (3-1-16) TP 44, 34,	144% FPIL (3-1-16) TP 48, 33	198% FPIL (3-1-16) TP 40, 43, 36, 35
1	$1,317	$1,426	$1,961
2	1,776	1,923	2,644
3	2,235	2,420	3,327
4	2,694	2,916	4,010
5	3,153	3,413	4,693
6	3,611	3,910	5,376
7	4,071	4,408	6,061
8	4,532	4,907	6,747
9	4,994	5,406	7,434
10	5,455	5,906	8,120
11	5,916	6,405	8,807
12	6,377	6,904	9,493
13	6,838	7,403	10,179

Family Size	133% FPIL (3-1-16) TP 44, 34,	144% FPIL (3-1-16) TP 48, 33	198% FPIL (3-1-16) TP 40, 43, 36, 35
14	7,299	7,902	10,866
15	7,760	8,402	11,552
For each additional member	462	500	687

Family Size	200% FPIL (3-1-16) TP 02	201% FPIL (3-1-16) TA 84	202% FPIL (3-1-16) TA 85	400% FPIL (3-1-16) TA 77	413% FPIL (3-1-16) TP 70
1	$1,980	$1,990	$2,000	$3,960	$4,089
2	2,670	2,684	2,697	5,340	5,514
3	3,360	3,377	3,394	6,720	6,939
4	4,050	4,071	4,091	8,100	8,364
5	4,740	4,764	4,788	9,480	9,789
6	5,430	5,458	5,485	10,860	11,213
7	6,122	6,153	6,183	12,244	12,642
8	6,815	6,850	6,884	13,630	14,073
9	7,509	7,546	7,584	15,017	15,505
10	8,202	8,243	8,284	16,404	16,937
11	8,895	8,940	8,984	17,790	18,369
12	9,589	9,637	9,685	19,177	19,800
13	10,282	10,334	10,385	20,564	21,232

Family Size	200% FPIL (3-1-16) TP 02	201% FPIL (3-1-16) TA 84	202% FPIL (3-1-16) TA 85	400% FPIL (3-1-16) TA 77	413% FPIL (3-1-16) TP 70
14	10,975	11,030	11,085	21,950	22,664
15	11,669	11,727	11,786	23,337	24,096
For each additional member	694	697	701	1,387	1,432

C—1115 Immunization Terms

Revision 13-3; Effective July 1, 2013

TANF and Medical Programs

Immunization by inoculation or vaccination protects against childhood diseases. Except for tetanus, these diseases are contagious. Encourage individuals to follow the Texas Department of Health's recommended schedule found on Form H1012, Immunization Record. If a child is on an alternate schedule refer to A-2125, Immunizations.

The following are descriptions of the diseases and symptoms associated with immunizations.

- **Diphtheria —** An acute, bacterial illness that causes a sore throat and a fever and sometimes causes more serious or even fatal complications.
- **Haemophilus Influenza Type b (HIB) —** A bacterium that can cause meningitis and pneumonia and infect other body systems such as blood, joints, bones and soft tissue under the skin, throat, and the covering of the heart.
- **Hepatitis A —** An infection of the liver caused by the Hepatitis A virus.
- **Hepatitis B —** An infection of the liver caused by the Hepatitis B virus.
- **Measles —** An acute, highly contagious viral disease involving the respiratory tract that causes a characteristic rash, fever, runny nose, sore eyes, and cough.
- **Mumps —** An acute viral disease mainly of childhood. It is characterized by a swelling of the parotid (salivary) glands on one or both sides and may cause fever, headache, and difficulty swallowing may develop.
- **Pertussis (Whooping Cough) —** An acute highly contagious respiratory disease characterized by a severe attack of coughing that ends in a characteristic "whoop" as breath is drawn in.
- **Poliomyelitis (Polio – once known as "infantile paralysis") —** An infectious disease that may lead to extensive paralysis of the muscles.
- **Rubella (German Measles) —** A viral infection characterized by a mild fever, swollen glands in the neck and a rash that lasts up to three days.
- **Tetanus (Lockjaw) —** A very serious disease of the central nervous system caused by an infection of a wound that makes an individual unable to open his/her mouth or swallow and causes muscle spasms in the jaw, neck, leg or other muscles.
- **Varicella (Chickenpox) —** A highly contagious viral infection which presents as a generalized, itchy, vesicular rash. The rash begins as smooth, red spots which develop into blisters that last three to four days before forming crusty scabs.

C—1116 Managed Care Plans

Revision 18-1; Effective January 1, 2018

Medical Programs

STAR – Bexar Service Area

(Counties: Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson)

Plan Code	Plan Name	Member Services
40	Superior HealthPlan	800-783-5386
42	Community First Health Plans	800-434-2347
43	AETNA Better Health	800-248-7767
44	Amerigroup	800-600-4441

STAR – Dallas Service Area

(Counties: Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, Rockwall)

Plan Code	Plan Name	Member Services
90	Amerigroup	800-600-4441
93	Parkland HEALTH First	888-672-2277
95	Molina Healthcare of Texas	866-449-6849

STAR – El Paso Service Area

(Counties: El Paso and Hudspeth)

Plan Code	Plan Name	Member Services
36	Superior HealthPlan	800-783-5386
37	El Paso First Premier Plan	877-532-3778
31	Molina Healthcare of Texas	866-449-6849

STAR – Harris Service Area

(Counties: Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Waller, Wharton)

Plan Code	Plan Name	Member Services
71	Amerigroup	800-600-4441
72	Texas Children's Health Plan	866-959-2555
79	Community Health Choice	888-760-2600
7G	Molina Healthcare of Texas	866-449-6849
7H	UnitedHealthcare Community Plan	888-887-9003

STAR – Hidalgo Service Area

(Counties: Cameron, Duval, Hidalgo, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy, Zapata)

Plan Code	Plan Name	Member Services
H4	Driscoll Children's Health Plan	855-425-3247
H3	Molina Healthcare of Texas	866-449-6849
H2	Superior HealthPlan	800-783-5386
H1	UnitedHealthcare Community Plan	888-887-9003

STAR – Jefferson Service Area

(Counties: Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, Walker)

Plan Code	Plan Name	Member Services
8G	Amerigroup	800-600-4441
8H	Community Health Choice	888-760-2600
8J	Molina Healthcare of Texas	866-449-6849
8K	Texas Children's Health Plan	866-959-2555
8L	UnitedHealthcare Community Plan	888-887-9003

STAR – Lubbock Service Area

(Counties: Carson, Crosby, Deaf Smith, Floyd, Garza, Hale, Hockley, Hutchinson, Lamb, Lubbock, Lynn, Potter, Randall, Swisher, Terry)

Plan Code	Plan Name	Member Services
50	FirstCare STAR	800-431-7798
52	Superior HealthPlan	800-783-5386
53	Amerigroup	800-600-4441

STAR – Nueces Service Area

(Counties: Aransas, Bee, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kenedy, Kleberg, Live Oak, Nueces, Refugio, San Patricio, Victoria)

Plan Code	Plan Name	Member Services
82	Driscoll Children's Health Plan	877-220-6376
83	Superior HealthPlan	800-783-5386
88	CHRISTUS Health Plan	877-428-3057

STAR – Tarrant Service Area

(Counties: Denton, Hood, Johnson, Parker, Tarrant, Wise)

Plan Code	Plan Name	Member Services
63	Amerigroup	800-600-4441
66	Cook Children's Health Plan	800-964-2247
67	AETNA Better Health	800-306-8612

STAR – Travis Service Area

(Counties: Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, Williamson)

Plan Code	Plan Name	Member Services
1P	Blue Cross Blue Shield of Texas	888-292-4480
1N	Sendero Health Plans	855-526-7388

Plan Code	Plan Name	Member Services
1A	Dell Children's Health Plan	888-596-0268
10	Superior HealthPlan	800-783-5386

STAR – Medicaid RSA West Texas Service Area

(Counties: Andrews, Archer, Armstrong, Bailey, Baylor, Borden, Brewster, Briscoe, Brown, Callahan, Castro, Childress, Clay, Cochran, Coke, Coleman, Collingsworth, Concho, Cottle, Crane, Crockett, Culberson, Dallas, Dawson, Dickens, Dimmit, Donley, Eastland, Ector, Edwards, Fisher, Foard, Frio, Gaines, Glasscock, Gray, Hall, Hansford, Hardeman, Hartley, Haskell, Hemphill, Howard, Irion, Jack, Jeff Davis, Jones, Kent, Kerr, Kimble, King, Kinney, Knox, LaSalle, Lipscomb, Loving, Martin, Mason, McCulloch, Menard, Midland, Mitchell, Moore, Motley, Nolan, Ochiltree, Oldham, Palo Pinto, Parmer, Pecos, Presidio, Reagan, Real, Reeves, Roberts, Runnels, Schleicher, Scurry, Shackelford, Sherman, Stephens, Sutton, Taylor, Terrell, Throckmorton, Tom Green, Upton, Uvalde, Val Verde, Ward, Wheeler, Wichita, Wilbarger, Winkler, Young, Zavala)

Plan Code	Plan Name	Member Services
W2	Amerigroup	800-600-4441
W3	Superior HealthPlan	877-644-4494
W4	FirstCare STAR	800-431-7798

STAR – Medicaid RSA Northeast Texas Service Area

(Counties: Anderson, Angelina, Bowie, Camp, Cass, Cherokee, Cooke, Delta, Fannin, Franklin, Grayson, Gregg, Harrison, Henderson, Hopkins, Houston, Lamar, Marion, Montague, Morris, Nacogdoches, Panola, Rains, Red River, Rusk, Sabine, San Augustine, Shelby, Smith, Titus, Trinity, Upshur, Van Zandt, Wood)

Plan Code	Plan Name	Member Services
N1	Amerigroup	800-600-4441
N2	Superior HealthPlan	800-783-5386

STAR – Medicaid RSA Central Texas Service Area

(Counties: Bell, Blanco, Bosque, Brazos, Burleson, Colorado, Comanche, Coryell, DeWitt, Erath, Falls, Freestone, Gillespie, Gonzales, Grimes, Hamilton, Hill, Jackson, Lampasas, Lavaca, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Somervell, Washington)

Plan Code	Plan Name	Member Services
C1	Amerigroup	800-600-4441
C2	Superior HealthPlan	877-644-4494
C3	RightCare from Scott and White Health Plan	855-897-4448

STAR+PLUS – Bexar Service Area

(Counties: Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson)

Plan Code	Plan Name	Member Services
45	Amerigroup	800-600-4441
46	Molina Healthcare of Texas	866-449-6849

Plan Code	Plan Name	Member Services
47	Superior HealthPlan	800-516-4501

STAR+PLUS – Dallas Service Area

(Counties: Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, Rockwall)

Plan Code	Plan Name	Member Services
9F	Molina Healthcare of Texas	866-449-6849
9H	Superior HealthPlan	800-516-4501

STAR+PLUS – El Paso Service Area

(Counties: El Paso and Hudspeth)

Plan Code	Plan Name	Member Services
34	Amerigroup	800-600-4441
33	Molina Healthcare of Texas	866-449-6849

STAR+PLUS – Harris Service Area

(Counties: Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Waller, Wharton)

Plan Code	Plan Name	Member Services
7P	Amerigroup	800-600-4441
7S	Molina Healthcare of Texas	866-449-6849
7R	UnitedHealthcare Community Plan	888-887-9003

STAR+PLUS – Hidalgo Service Area

(Counties: Cameron, Duval, Hidalgo, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy, Zapata)

Plan Code	Plan Name	Member Services
H7	Cigna HealthSpring	877-653-0327
H6	Molina Healthcare of Texas	866-449-6849
H5	Superior HealthPlan	866-516-4501

STAR+PLUS – Jefferson Service Area

(Counties: Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, Walker)

Plan Code	Plan Name	Member Services
8R	Amerigroup	800-600-4441
8T	Molina Healthcare of Texas	866-449-6849
8S	UnitedHealthcare Community Plan	888-887-9003

STAR+PLUS – Lubbock Service Area

(Counties: Carson, Crosby, Deaf Smith, Floyd, Garza, Hale, Hockley, Hutchinson, Lamb, Lubbock, Lynn, Potter, Randall, Swisher, Terry)

Plan Code	Plan Name	Member Services
5A	Amerigroup	800-600-4441
5B	Superior HealthPlan	866-516-4501

STAR+PLUS – Nueces Service Area

(Counties: Aransas, Bee, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kenedy, Kleberg, Live Oak, Nueces, Refugio, San Patricio, Victoria)

Plan Code	Plan Name	Member Services
85	UnitedHealthcare Community Plan	888-887-9003
86	Superior HealthPlan	800- 516-4501

STAR+PLUS – Tarrant Service Area

(Counties: Denton, Hood, Johnson, Parker, Tarrant, Wise)

Plan Code	Plan Name	Member Services
69	Amerigroup	800-600-4441
6C	Cigna HealthSpring	877-966-9272

STAR+PLUS – Travis Service Area

(Counties: Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, Williamson)

Plan Code	Plan Name	Member Services
19	Amerigroup	800-600-4441
18	UnitedHealthcare Community Plan	888-887-9003

STAR+PLUS– Medicaid RSA West Texas Service Area

(Counties: Andrews, Archer, Armstrong, Bailey, Baylor, Borden, Brewster, Briscoe, Brown, Callahan, Castro, Childress, Clay, Cochran, Coke, Coleman, Collingsworth, Concho, Cottle, Crane, Crockett, Culberson, Dallas, Dawson, Dickens, Dimmit, Donley, Eastland, Ector, Edwards, Fisher, Foard, Frio, Gaines, Glasscock, Gray, Hall, Hansford, Hardeman, Hartley, Haskell, Hemphill, Howard, Irion, Jack, Jeff Davis, Jones, Kent, Kerr, Kimble, King, Kinney, Knox, LaSalle, Lipscomb, Loving, Martin, Mason, McCulloch, Menard, Midland, Mitchell, Moore, Motley, Nolan, Ochiltree, Oldham, Palo Pinto, Parmer, Pecos, Presidio, Reagan, Real, Reeves, Roberts, Runnels, Schleicher, Scurry, Shackelford, Sherman, Stephens, Sutton, Taylor, Terrell, Throckmorton, Tom Green, Upton, Uvalde, Val Verde, Ward, Wheeler, Wichita, Wilbarger, Winkler, Young, Zavala)

Plan Code	Plan Name	Member Services
W5	Amerigroup	800-600-4441
W6	Superior HealthPlan	877-644-4494

STAR+PLUS – Medicaid RSA Northeast Texas Service Area

(Counties: Anderson, Angelina, Bowie, Camp, Cass, Cherokee, Cooke, Delta, Fannin, Franklin, Grayson, Gregg, Harrison, Henderson, Hopkins, Houston, Lamar, Marion, Montague, Morris, Nacogdoches, Panola, Rains, Red River, Rusk, Sabine, San Augustine, Shelby, Smith, Titus, Trinity, Upshur, Van Zandt, Wood)

Plan Code	Plan Name	Member Services
N3	Cigna-HealthSpring	877-653-0327
N4	UnitedHealth Care	888-887-9003

STAR+PLUS – Medicaid RSA Central Texas Service Area

(Counties: Bell, Blanco, Bosque, Brazos, Burleson, Colorado, Comanche, Coryell, DeWitt, Erath, Falls, Freestone, Gillespie, Gonzales, Grimes, Hamilton, Hill, Jackson, Lampasas, Lavaca, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Somervell, Washington)

Plan Code	Plan Name	Member Services
C4	Superior HealthPlan	866-516-4501
C5	UnitedHealth Care	888-887-9003

STAR Health – Statewide

Plan Code	Plan Name	Member Services
1E	Superior HealthPlan	866-912-6283

STAR Kids - Bexar Service Area

(Counties: Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson)

Plan Code	Plan Name	Member Services
KA	Community First Health Plans	855-607-7827
KE	Superior HealthPlan	844-590-4883

STAR Kids - Dallas Service Area

(Counties: Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, Rockwall)

Plan Code	Plan Name	Member Services
K2	Amerigroup	844-756-4600
K9	Children's Medical Center	800-947-4969

STAR Kids - El Paso Service Area

(Counties: El Paso and Hudspeth)

Plan Code	Plan Name	Member Services
K3	Amerigroup	844-756-4600
KF	Superior HealthPlan	844-590-4883

STAR Kids - Harris Service Area

(Counties: Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Waller, Wharton)

Plan Code	Plan Name	Member Services
K4	Amerigroup	844-756-4600
KM	Texas Children's Health Plan	800-659-5764
KQ	UnitedHealthcare Community Plan	877-597-7799

STAR Kids - Hidalgo Service Area

(Counties: Cameron, Duval, Hidalgo, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy, Zapata)

Plan Code	Plan Name	Member Services
KC	Driscoll Children's Health Plan	877-324-7543
KG	Superior HealthPlan	844-590-4883
KR	UnitedHealthcare Community Plan	877-597-7799

STAR Kids - Jefferson Service Area

(Counties: Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, Walker)

Plan Code	Plan Name	Member Services
KN	Texas Children's Health Plan	800-659-5764
KS	UnitedHealthcare Community Plan	877-597-7799

STAR Kids - Lubbock Service Area

(Counties: Carson, Crosby, Deaf Smith, Floyd, Garza, Hale, Hockley, Hutchinson, Lamb, Lubbock, Lynn, Potter, Randall, Swisher, Terry)

Plan Code	Plan Name	Member Services
K5	Amerigroup	844-756-4600
KH	Superior HealthPlan	844-590-4883

STAR Kids - Nueces Service Area

(Counties: Aransas, Bee, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kenedy, Kleberg, Live Oak, Nueces, Refugio, San Patricio, Victoria)

Plan Code	Plan Name	Member Services
KD	Driscoll Children's Health Plan	877-324-7543
KV	Superior HealthPlan	844-590-4883

STAR Kids - Tarrant Service Area

(Counties: Denton, Hood, Johnson, Parker, Tarrant, Wise)

Plan Code	Plan Name	Member Services
K1	Aetna	844-787-5437
KB	Cook Children's Health Plan	844-843-0004

STAR Kids - Travis Service Area

(Counties: Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, Williamson)

Plan Code	Plan Name	Member Services
K8	Blue Cross Blue Shield of Texas	877-688-1811
KL	Superior HealthPlan	844-590-4883

STAR Kids - Medicaid RSA - West Texas Service Area

(Counties: Andrews, Archer, Armstrong, Bailey, Baylor, Borden, Brewster, Briscoe, Brown, Callahan, Castro, Childress, Clay, Cochran, Coke, Coleman, Collingsworth, Concho, Cottle, Crane, Crockett, Culberson, Dallas, Dawson, Dickens, Dimmit, Donley, Eastland, Ector, Edwards, Fisher, Foard, Frio, Gaines, Glasscock, Gray, Hall, Hansford, Hardeman, Hartley, Haskell, Hemphill, Howard, Irion, Jack, Jeff Davis, Jones, Kent, Kerr, Kimble, King, Kinney, Knox, LaSalle, Lipscomb, Loving, Martin, Mason, McCulloch, Menard, Midland, Mitchell, Moore, Motley, Nolan, Ochiltree, Oldham, Palo Pinto, Parmer, Pecos, Presidio, Reagan, Real, Reeves, Roberts, Runnels, Schleicher, Scurry, Shackelford, Sherman, Stephens, Sutton, Taylor, Terrell, Throckmorton, Tom Green, Upton, Uvalde, Val Verde, Ward, Wheeler, Wichita, Wilbarger, Winkler, Young, Zavala)

Plan Code	Plan Name	Member Services
K6	Amerigroup	844-756-4600
KJ	Superior HealthPlan	844-590-4883

STAR Kids - Medicaid RSA - Northeast Texas Service Area

(Counties: Anderson, Angelina, Bowie, Camp, Cass, Cherokee, Cooke, Delta, Fannin, Franklin, Grayson, Gregg, Harrison, Henderson, Hopkins, Houston, Lamar, Marion, Montague, Morris, Nacogdoches, Panola, Rains, Red River, Rusk, Sabine, San Augustine, Shelby, Smith, Titus, Trinity, Upshur, Van Zandt, Wood)

Plan Code	Plan Name	Member Services
KP	Texas Children’s Health Plan	800-659-5764
KU	UnitedHealthcare Community Plan	877-597-7799

STAR Kids - Medicaid RSA - Central Texas Service Area

(Counties: Bell, Blanco, Bosque, Brazos, Burleson, Colorado, Comanche, Coryell, DeWitt, Erath, Falls, Freestone, Gillespie, Gonzales, Grimes, Hamilton, Hill, Jackson, Lampasas, Lavaca, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Somervell, Washington)

Plan Code	Plan Name	Member Services
K7	Blue Cross Blue Shield of Texas	877-688-1811
KT	UnitedHealthcare Community Plan	877-597-7799

Dental – Statewide

Plan Code	Plan Name	Member Services
1M	DentaQuest	800-516-0165
1J	MCNA Dental	855-691-6262

Note: Each region has a designated representative whom managed care plan staff contact to resolve issues related to eligibility, county code assignments and other concerns for individuals enrolled in managed care. The plan representative has access to the same information in an individual's record as the individual's medical provider does.

Related Policy
Managed Care, A-821.2
Releasable Information for Medicaid Providers and Their Contractors, B-1230
Office of the Ombudsman, B-1420

C—1117 Texas Health Steps (THSteps) Quick Reference Guide and Recipient Enrollment Script

Revision 16-4; Effective October 1, 2016

Children's Medicaid

Medicaid Managed Care (MMC)/THSteps QUICK REFERENCE GUIDE STAR+PLUS (Dual Eligibles)

The caller's identity must be verified.

Eight Steps to VERIFICATION and ENROLLMENT

- Medicaid Identification (ID) No. or Social Security Number (SSN)
- Name
- Address
- Primary Language Spoken in Home
- Phone No.
- DOB
- Third-Party Resources (Private Insurance)
- Pregnancy

POINTS OF EDUCATION

- Introduction (Name, program)
- Medicaid Managed Care Enrollment-Medicaid Managed Care Recipients

1. Explain Managed Care
2. Explain that STAR+PLUS for dual eligibles is for LONG TERM CARE Services only
3. Explain recipients will continue to use your doctors and hospitals as before.

4. Explain your doctor's office will continue to bill Medicare and Medicaid for your visit, you do not need to show your STAR+PLUS Health Plan ID card.
5. Explain that dual eligibles will still receive their prescription drugs through Medicare.
6. Explain the enrollment will be effective in 15-45 days and traditional Medicaid is in effect until then
7. Enroll recipient. Give health plan's member services phone number.
8. Explain they will receive an ID card from the health plan with the phone number on it.
9. STAR+PLUS plan changes, call the STAR+PLUS HelpLine

For more information on drug coverage for dual eligibles:

If you are on Medicare and Medicaid, you will continue to use Medicare for your regular health care needs and all prescription drugs. You will use STAR+PLUS only for your Medicaid long-term service and support needs. Enrollment in STAR+PLUS will not change the way you use Medicare.

Resource Directory

Resource List	Toll Free Numbers	TDD LINE
2-1-1-Information and Referral	2-1-1, Option 1	2-1-1, Option 1
Medicaid Hotline Number	1-800-252-8263	1-800-735-2988
HHS Ombudsman Managed Care Assistance Team	1-866-566-8989	7-1-1
HHSC	1-888-834-7406	1-888-425-6889
Social Security Administration (SSI)	1-800-772-1213	1-800-325-0778
Billing Questions Hotline	1 800-335-8957	1-800-735-2988

Recipient Enrollment Script for STAR+PLUS Dual Eligibles Expanded (11/06)

Introduction

Standard Greeting to include your name, program and purpose for calling. For example: Hello, may I speak with [case name]: Hello, Mr/Mrs_____. My name is _____.

The caller's identity must be verified.

Eight Steps to VERIFICATION and ENROLLMENT

- Medicaid Identification (ID) No. or Social Security Number (SSN)-Do you have Your Texas Benefits Medicaid ID card handy? Will you read the number that appears on your card below your name?
- Name-Is this your name?
- Address-Are you still living at this address?
- Primary Language Spoken in Home-Document what language
- Phone No. -Is this the correct phone number?
- DOB-Is this your DOB?
- Third Party Resources (Private Insurance)-Does your child have any private health insurance?
- Pregnancy-Are you or anyone in your home pregnant at this time?
- Special Health Care Questions-3 questions for each adult:

Health Plan Information-STAR+PLUS for Dual Eligibles in Harris, Harris Expansion, Travis, Nueces and Bexar Service Areas

1. Explain Managed Care STAR + PLUS "Let me tell you a little about the STAR+PLUS program. STAR+PLUS is a managed care program that provides Medicaid long-term services and supports in your area. Long-term services and supports may include personal attendant services, adaptive aids, adult foster home service, assisted living, nursing services, and medical supplies. There are different STAR+PLUS health plans in your area that will provide these services. You must choose a STAR+PLUS health plan for your long-term services and supports, or a plan will be chosen for you. You will not choose a primary care provider.
2. Explain that STAR+PLUS for dual eligibles is for long-term services and supports ONLY. For STAR+PLUS members who are also on Medicare, STAR+PLUS only provides long-term services and supports. You will use Medicare for your regular health care needs and prescription drugs, just as you did before.
3. Explain recipients will continue to use your doctors and hospitals as before. You will continue to go to your regular Medicare doctor for general health care needs. STAR+PLUS also does not affect the way you receive hospital services.
4. Explain your doctor's office will continue to bill Medicare and Medicaid for your visit; you do not need to show your STAR+PLUS Health Plan ID card. Because STAR+PLUS only includes long-term services and supports, make sure you bring your Medicare card with you to all of your doctor visits. You do not need to bring your STAR+PLUS health plan ID card.

5. Explain that dual eligibles will still receive prescription drugs through Medicare. You will continue to use your Medicare Part D plan for all of your prescription drugs. STAR+PLUS does not include prescriptions.
6. Enroll recipient. Give health plan's member services phone number. Have you received a STAR+PLUS enrollment packet? The packet has an enrollment form for you to choose a health plan, as well as other program information and the health plan provider directories. Have you already enrolled? If not, I will be glad to help you enroll today!

7. Explain the enrollment will be effective in 15-45 days and traditional Medicaid is in effect until then. Advise the client a new Your Texas Benefits Medicaid ID card will not be issued due to a change to a Medicaid Managed Care health plan.

8. Explain they will receive an ID card from the health plan with the phone number on it. You will also receive an ID card from the health plan you chose. The health plan ID card will have a phone number for you to call with any questions.

9. STAR+PLUS plan changes, call the STAR+PLUS HelpLine. In the STAR+PLUS program you may change health plans at any time. Just call the STAR+PLUS HelpLine. The phone number is 1-800-964-2777.

10. Summary

- Any Questions regarding your benefits?

- Provide your name

Resource Directory

Resource List	Toll Free Numbers	TDD LINE
2-1-1-Information and Referral	2-1-1, Option 1	2-1-1, Option 1
STAR Help Line	1-800-964-2777	1-800-267-5008
Medicaid Hotline Number	1-800-252-8263	1-800-735-2988
HHS Ombudsman Managed Care Assistance Team	1-866-566-8989	7-1-1
HHSC	1-888-834-7406	1-888-425-6889
Social Security Administration (SSI)	1-800-772-1213	1-800-325-0778
Billing Questions Hotline	1 800-335-8957	1-800-735-2988

C—1118 Health Care Orientation Quick Reference Guide and Enrollment Script

Revision 16-4; Effective October 1, 2016

TP 43, TP 44 and TP 48

MMC/THSteps QUICK SCRIPT REFERENCE GUIDE STAR/PCCM Expansion/FFS/STAR+PLUS (except for Dual Eligibles)

Effective 11/1/06

STEPS TO VERIFICATION and ENROLLMENT

Verification

- Medicaid ID No. or SSN
- Name
- Address
- Phone No.
- DOB

Enrollment

- Third Party Resources (Private Insurance)
- Pregnancy
- Primary Language Spoken in Home
- Special Health Care Questions-STAR Only

If all family members are over 21, only provide information from the first five bullets below and MTP as appropriate.

15 Steps to EDUCATION

- Introduction (Name, program, Health Care Orientation) (Face to face HCO's should receive "Helpful Toll-free Number" Handout)
- Medicaid Managed Care Enrollment-Medicaid Managed Care Recipients

1. Explain Managed Care and PCP.
2. Explain about PCP / emergency rooms.
3. Explain about specialist and referrals.
4. Explain about preventive health checkups.
5. Explain the STAR/STAR+PLUS enrollment will be effective in 15-45 days and traditional Medicaid is in effect until then. PCCM Expansion area recipients are automatically enrolled.
6. Enroll recipient. Give health plan's member services phone number.
7. Explain they will receive an ID card from the health plan (except PCCM).
8. Other education is provided as necessary (i.e., TP40 education script, newborn education).
9. Managed Care changes – Plan and/or PCP how often, who to call to make changes.
10. NorthSTAR script-Dallas SA only.

- Medicaid Program Knowledge – don't pay bills, what Medicaid covers, excluding SSI recipients
- Your Texas Benefits Medicaid ID card - STAR plan, PCCM PCP, restrictions.
- Maintaining Eligibility – reading mail, sending back information, receiving checkups
- THSteps Program Knowledge - under age 21 – preventive checkups, medical and dental
- Checkup Schedule & Components – when a checkup is due and what happens at a checkup
- Medical and Dental Providers – Give choices/handout or we can have a list mailed, immediate call 1-877-847-8377.
- How to Schedule an Appointment – offer to help or give the toll free number; keeping/canceling appointments.
- Case Management for Children/Pregnant Women – health risk or health condition, trouble finding services, CMI Script
- Medical Transportation – available benefit, call for transportation assistance
- CHIP – any uninsured children in the household?
- WIC –Pregnant Women or child in the family who is under 5
- Summary – HCO provided, Enrollment information, Medical and dental providers and their telephone numbers, verify address and phone, assistance scheduling appointment.

Resource Directory

Resource List	Toll Free Numbers	TDD LINE
2-1-1-Information and Referral	2-1-1, Option 1	2-1-1, Option 1
Billing Questions Hotline (Fee-for-Service)	1 800-335-8957	1-800-735-2988
HHSC	1-888-834-7406	1-888-425-6889
Medicaid Hotline Number	1-800-252-8263	1-800-735-2988
Medical Transportation Program	1-877-633-8747	1-800-735-2988
PCCM	1-888-302-6688	1-800-735-2988
Social Security Administration (SSI)	1-800-772-1213	1-800-325-0778
STAR/STAR+PLUS/NS Help Line	1-800-964-2777	1-800-267-5008
HHS Ombudsman Managed Care Assistance Team	1-866-566-8989	7-1-1
Texas Health Steps (& Case Mgmt)	1-877-847-8377	1-800-735-2988
Children's Health Insurance Program (CHIP)	1-800-647-6558	1-800-735-2988
WIC	1-800-942-3678	1-800-735-2988

Health Care Orientation/Enrollment Script STAR/PCCM Expansion/FFS/STAR+PLUS (except for Dual Eligibles)

Expanded (Effective 11/1/06)

Introduction

Standard Greeting to include your name, program and purpose for calling. For example: Hello, may I speak with [case name]: Hello, Mr./Mrs._____. My name is _____. Since your child/children are new to Medicaid, a state law requires that you received what is known as a Health Care Orientation. This will only take a few minutes and I will give you some valuable information about how to use your child's/children's Medicaid benefits.

Did I verify the caller's identity?

8 Steps to VERIFICATION and ENROLLMENT

- Medicaid ID No. or SSN-Do you have Your Texas Benefits Medicaid ID card handy? Will you read the number that appears on the card below your child's name?
- Name-Is this the name of your child?
- Address-Are you still living at this address?
- Primary Language Spoken in Home-Ask and Document what language
- Phone No. -Is this the correct phone number?
- DOB-Is this your child's date of birth?
- Third Party Resources (Private Insurance)-Does your child have any private health insurance?
- Pregnancy-Are you or anyone in your home pregnant at this time?
- Special Questions: Ask at initial enrollment only.

15 Steps to EDUCATION

Health Plan Information-Only for Managed Care Areas

1. **Explain Managed Care and Primary Care Provider.** STAR/STAR+PLUS: "Let me tell you a little about the STAR/STAR+PLUS program. The STAR/STAR+PLUS program is the Medicaid Managed Care program plans in your area." Managed care means that you will receive your Medicaid services through a health plan. You only have 30 days from the date you are certified to select a health plan and a primary care provider. The primary care provider can be a doctor, specially trained nurse, clinic or health center. If you don't choose, the STAR/STAR + PLUS program will pick a health plan and primary care provider for you. The primary care provider is available 24 hours a day, 7 days a week to coordinate care for you and/or your child/children. Have you received an enrollment packet? This is a large white envelope with the different health plan booklets, enrollment form and instructions. Have you already enrolled? If not, I will be glad to help you enroll today! (or change plan if they have been defaulted) PCCM Expansion: "Let me tell you a little about the PCCM program. The PCCM program is the Medicaid managed care program in your area." The PCCM program will send you a welcome letter and a member handbook for your child/children. The Primary Care Provider (PCP) can be a doctor, specially trained nurse, clinic or health center. The PCP is available 24/7 to coordinate care for your child/children.
2. **Explain about primary care providers and emergency rooms.** Your child's primary care provider is the one you contact first when your child/children needs/need any kind of medical health care. Unless it is an emergency, you should contact your primary care provider before you take your child to the emergency room. An emergency would be a problem or condition, including severe pain that is so serious that waiting for routine care might result in serious harm. In an emergency, you may not have time to contact the primary care provider, in that case, call 911 or take your child to the nearest emergency room.
3. **Explain referrals:** Referrals to specialists for both STAR/STAR+PLUS and PCCM Expansion recipients must be obtained through the primary care provider. However, families do not need a referral for the following services: Family Planning, Eye Care, Behavioral Health and THSteps medical/dental checkups. The primary care provider will refer your child/children to specialists or hospitals when needed.
4. **Preventive checkups:** THSteps: Recipients under 21 are eligible for preventive medical and dental checks-ups through THSteps program no matter what service delivery system is in their area. STAR/STAR+PLUS: Adults receive one annual preventive exam per year. PCCM Expansion: Adults will receive services currently eligible in traditional Medicaid.
5. **Tell the family the effective date of the enrollment:** Advise the client a new Your Texas Benefits Medicaid ID card will not be issued due to a change to a managed care health plan. PCCM Expansion recipients are automatically enrolled.
6. **Enroll family if they are in a STAR/STAR+PLUS area.** Once the family has enrolled, provide them with the name and phone number of their health plan and the primary care provider. If the family is in the PCCM Expansion area, PCCM will send you a welcome letter and a member handbook for your child/children. You will need to contact the PCCM helpline if you want to change their primary care provider. (For pregnant women, go to #8)
7. **Explain the recipients will receive a Your Texas Benefits Medicaid ID card.** STAR/STAR+PLUS: After the recipient is enrolled in the STAR/STAR+PLUS program, a regular Your Texas Benefits Medicaid ID card will be mailed. The recipient will also receive a member ID card from the plan (except in the PCCM expansion area).
8. **Pregnant Women:** If applicable, expand education to include TP40 (pregnant women) I information.

STAR/STAR+PLUS: Pregnant woman - ask "Are you currently seeing a provider for your prenatal care?" Inform - Pregnant women must choose a plan and primary care provider within 15 days from their Medicaid application. The enrollment will take effect as soon as the recipient is found eligible for Medicaid. All efforts will be made to expedite the enrollment. If that is not possible, the enrollment will be effective within 15-45 days. Remind the recipient the importance of selecting a plan for herself and the baby since the recipient will not be able to change the baby's plan until the baby is three months old. After the baby is born, the recipient should call the plan to pick a primary care provider for the baby. Explain when the STAR Program is effective for pregnant women. If the pregnant woman's Medicaid is certified before the 10th of the month, the enrollment is effective the first day of the certification month (retroed). If the pregnant woman's Medicaid is certified after the 10th of the month, the enrollment is effective the first day of the month following the certification date (prospective).

PCCM Expansion: TIERS automatically establishes an enrollment in PCCM for all mandatory recipients at certification. Enrollments are prospective. (Depends on certification date and state cutoff). Direct recipient to contact PCCM to change PCP for herself and/or newborn.

Note for Pregnant Women: If a pregnant woman has 12 weeks or less remaining in her pregnancy (third trimester), she may choose to remain with her current OB/GYN for the remainder of her pregnancy, delivery, and postpartum checkup, even if the OB/GYN does not participate with the chosen health plan.

9. **Changes:**
   STAR/STAR+PLUS recipients can change their primary care provider up to 4 times a year; they can have unlimited changes in health plan (however, there are time restrictions – each health plan change can take 15-45 days). Call the STAR helpline to change the health plan and call the health plan directly to request a primary care provider change. **PCCM expansion**recipients need to call the PCCM helpline to change their PCP.

Medicaid Program Knowledge

- Medicaid pays for you or your child's care when they go to the doctor, if they are in the hospital, if they go to the dentist and if they go to a specialist. It will also pay for prescriptions, shots, transportation to any Medicaid covered service, and for behavioral health services. It also pays for preventive medical and dental checkups for children under age 21 through the THSteps program even when they are not sick.
- Medicaid only pays providers like doctors, dentists, specialists and hospitals. You should not receive any bills. However, if you receive a bill don't pay it. First call the provider and find out why they did not send the bill to Medicaid. Make sure your provider has the Medicaid ID number needed for billing. If the recipient is on STAR/STAR+PLUS direct them to call their health plan. If they are in PCCM Expansion, direct them to call the PCCM helpline. If they are on fee for service direct them to call the number on the back of the Your Texas Benefits Medicaid ID card for billing questions 1-800-252-8263.

Your Texas Benefits Medicaid ID card-Process

- Ask the family if they have received their new Your Texas Benefits Medicaid Id card. If not, explain the new card they will receive is good for as long as they are on Medicaid. Describe the Your Texas Benefits Medicaid ID card.
- STAR Health: The STAR Health logo will be on the top right side of the Your Texas Benefits Medicaid Card. Their STAR or STAR+PLUS health plan will also be listed on the card. Thier STAR or STAR+PLUS logo will not show on the top right side of the Your Texas Benefits Medicaid ID card. PCCM Expansion: PCCM logo will be listed on the top right corner of the Your Texas Benefits Medicaid ID card.
- Remind the family to take the Your Texas Benefits Medicaid ID card to the doctor, dentist, pharmacy or every time they obtain a Medicaid service.
- Explain to the family if they do not receive their Your Texas Benefits Medicaid ID card in the next couple of weeks, to contact their local HHSC office to confirm eligibility. Once eligibility is confirmed, they can contact the Your Texas Benefits Medicaid ID card Help Desk to check the status of the card order. Inform them they can also print a copy of their card from the YourTexasBenefits.com website while they wait on their permanent card.

Maintaining Eligibility

- Follow up with any paper work you receive from the Health and Human Services Commission (also called HHSC). HHSC reviews your case from time to time, usually every 12 months and so it is very important to complete the paperwork to keep your child/children on Medicaid.
- It is a requirement to receive your health care orientation (we are providing that right now) and for your children to receive their THSteps preventive checkups to avoid having to go to the office for a face to face interview or to be required to return follow-up information at your redetermination.

THSteps Program Knowledge

- THSteps is Medicaid for people in Texas under age 21. It includes regularly scheduled medical and dental checkups to make sure your children are growing up healthy, as well as when your children are sick. Regular checkups find health problems while they are still small and easily treated.

Checkup Schedule & Components

- Explain to the family when each child is due for a medical checkup according to their date of birth following the periodicity schedule. Give the family a wallet card, *Checkups and a Whole Lot More* brochure and the *Visits to the Doctor/Dentist* brochure if in person.
- Explain that the children are eligible for a dental checkup beginning age 1 and every 6 months thereafter.
- Review components of both the medical and dental checkup for each child by age (see attached chart)
- Remind the family if a medical or dental problem is found during the THSteps checkup and is medically necessary, Medicaid will cover the follow up treatment.
- Your child/children may receive an excused absence from school for medical and dental appointments

Dental Providers

- Do you have a dentist who accepts Medicaid?
- Provide list of at least three providers in the individual's area so they can choose. A list can be mailed upon request. Advise the family to contact the helpline if they want a list immediately.

Medical Providers
PCCM / Traditional Medicaid

- Have you checked with your PCP to see if he/she will do the THSteps medical checkup? You can receive a THSteps checkup from any THSteps provider if your PCP does not do the checkups. It is important to have a medical home for your child. A medical/dental home is when you have a provider who treats your child regularly, who knows your child's health condition and has the responsibility

for keeping your child's medical records and for coordinating medical care. If you family needs help finding a THSteps provider call the THSteps helpline at 1-877-847-8377. It is open 8 a.m. to 8 p.m. Central time. It is a free call.

Managed Care

- Encourage family to go to PCP for THSteps Checkup if provider does checkup
- Explain if PCP doesn't do THSteps checkup call Plan for THSteps provider
- If enrollment into STAR has not processed yet, they can use any Medicaid provider for service until the enrollment is effective.

Scheduling the Appointment

- If the family has already chosen a THSteps Medical, Dental or Case Management Provider ask if they would like help scheduling an appointment. If they say yes and would like do a three way call with the provider's office, please process if your phone is capable or ask them to call the Customer Care Center for assistance.
- If they have not yet chosen a provider tell the family we would be happy to help them schedule an appointment when they choose a provider by calling the THSteps helpline at 1-877-847-8377.

Case Management for Children and Pregnant Women (CPW)-see the special services script

Medical Transportation Program (MTP)

- The Medical Transportation Program provides non-emergency medical transportation (NEMT) services.
- Explain the Medical Transportation Program is available for all Medicaid-covered health care services to those with full Medicaid (not Qualified Medicare Beneficiary [QMB] or Specified Low-Income Medicare Beneficiary [SLMB]), Children with Special Health Care Needs (CSHCN), and Transportation for Indigent Cancer Patients (TICP), who do not have any other means of transportation.
- Call at least two business days before the appointment in the same county or adjacent county and five business days before an appointment outside the county adjacent to your residence and be prepared to provide your:
  - name;
  - Medicaid ID number;
  - address;
  - phone number;
  - doctor's name and address;
  - doctor's phone number;
  - date; and
  - time of appointment.

Three Ways to Travel:

- If you don't have a car and you don't have anyone else to drive you, the Medical Transportation Program will help. This may be by bus tickets or by van.
- If you have a car, or know someone who can drive you to the appointment, the Medical Transportation Program can pay you or your driver gas reimbursement by the mile.

Call 1-877-MED-TRIP or 1-877-633-8747 (Option 1) to schedule a ride. If you have a complaint or concern, call 1-877-MED-TRIP or 1-877-633-8747 (Option 2).

Children's Health Insurance Program (CHIP)

- If anyone in household is under age 19 does not have health insurance, explain they may be eligible for some type of state funded health insurance. The may call 1 800-647-6558 to apply for CHIP and Children's Medicaid.

WIC (Women, Infant, and Children's Program)

- Explain WIC is a supplemental nutrition education program to provide nutritious foods to help women, infants and children improve on their nutrition. If you are receiving Medicaid, you are income eligible for the program, but will have to complete a nutritional screening to receive benefits.
- If pregnant or a postpartum woman, or a child in household under 5 lives in the household, give the parent the 1-800-942-3678 number to locate their nearest WIC office to them.

Summary

- Any Questions regarding THSteps or Medicaid?
- Inform individual that they have received a "Health Care Orientation"
- Verify individual information, phone number, migrant status, any other children in the household
- If enrolled, recap enrollment information include PCP and health plan.
- Follow up questions about having a medical or THSteps appointment or scheduled a medical or THSteps appointment since certification date (on list).
- Provide toll free number for future assistance. Thank the individual for their time.
- If in person, provide literature and "Helpful Toll Free Number" handout.

Medical Checkup components include:

Newborn to 2 weeks	2-6 months (every 2 months)	7-12 months (every 3 months)	13 months – 2 years (every 3 months)	3-5 years (once a year)	6-10 years (once a year) (except 7/9 for non-foster)	11-20 years (once a year)
Family and newborn history	Family and child health history	Family and child health history	Family and child health history	Family and child health history	Family and child health history	Family and child health history
Unclothed physical exam	Unclothed physical exam	Unclothed physical exam	Unclothed physical exam	Unclothed physical exam	Unclothed physical exam	Unclothed physical exam
Height, weight and head circumference	Height, weight and head circumference	Height, weight and head circumference	Height, weight and head circumference	Height, weight and blood pressure	Height, weight and blood pressure	Height, weight and blood pressure
Vision and hearing checks	Vision and hearing checks	Vision and hearing checks	Vision and hearing checks	Vision and hearing checks	Vision and hearing checks	Vision and hearing checks
Development progress including response to noise, eye contact	Development progress including interest in surroundings, vocalizing, smiling	Development progress including feeding self, beginning speech	Development progress including speech development and motor skills	Development progress including ability to dress self and speech development	Developmental progress and mental health screening: school performance, social interaction	Developmental progress and mental health screening: school performance, social interaction
Nutrition: how often and how much baby eats	Nutrition: how often and how much baby eats	Nutrition: eating solids, no bottle in bed	Nutrition: weaning and healthy diet	Nutrition: healthy diet and physical activities	Nutrition: iron rich foods, junk foods	Nutrition: healthy diet, physical activities
Blood tests for hereditary diseases	Blood tests for hereditary diseases	Blood tests or screening for anemia and lead poisoning	Blood tests or screening for anemia and lead poisoning	Blood tests or screening for anemia and lead poisoning	Blood tests or screening for anemia and lead poisoning	Blood tests or screening for anemia or other diseases
Shots (immunizations)	Shots (immunizations)	Shots (immunizations)	Shots (immunizations)	Shots (immunizations)	Shots (immunizations)	Shots (immunizations)
Health/ Safety information (sleep position, injury prevention, calling doctor)	Health/ Safety information (injury prevention, immunizations, sleep habits)	Health/ Safety information (car seats, child proofing home, speech)	Health/ Safety information (car seats, water safety, dental care)	Health/ Safety information (car safety, second hand smoke, reading)	Health/ Safety information (auto safety, bicycle helmets, water safety)	Health/ Safety information (car/motorcycle safety, sun exposure, substance abuse)
-	-	Dental referrals	Dental referrals	Dental referrals	Dental referrals	Dental referrals
-	-	TB Screening	TB Screening	TB Screening	TB Screening	TB Screening

Dental Checkup Components include*:

Newborn through 12 months	12 months	13 months through 2 years	3 through 20 years
No dental checkup at this age	First dental checkup at one year	Dental checkups every six months after the date of the last periodic checkup	Dental checkups every six months after the date of the last periodic checkup
-	Introduce child to dental checkups	Introduce child to dental checkups	-
-	Check for signs of baby bottle tooth decay	Check for signs of baby bottle tooth decay	-
-	Examination of gums and tooth development	Examination of gums and tooth development	Examination of gums and tooth development
-	Demonstration of tooth cleaning	Demonstration of tooth cleaning	Demonstration of tooth cleaning
-	-	Dental treatment if necessary	Dental treatment if necessary

* Emergency dental services are available at any age (do not require a check on ID)

C—1120 IRS Tax Code

Revision 15-4; Effective October 1, 2015

Unauthorized disclosure or unauthorized inspection of an applicant or client's federal tax information by HHSC staff is punishable by law, including but not limited to:

- felony charges,
- imprisonment,
- fines,
- employment dismissal, or
- civil charges.

See United States Code (U.S.C.), Title 26, §7213; 26 U.S.C. §7213A; and 26 U.S.C. §7431 for a complete list of penalties for the unauthorized disclosure or inspection of this information.

C—1130 Electronic Benefit Transfer (EBT) Charts and Guides

Revision 15-4; Effective October 1, 2015

C—1131 Advisor Guide for Explaining EBT

Revision 18-1; Effective January 1, 2018

TANF and SNAP

Instruct the cardholder to read Form H1185, Important Information About Your Lone Star Card, and to ask questions about any EBT issuance procedures the cardholder does not understand. Advisors must also explain:

- Procedures for Lone Star Card issuance and PIN issuance/self-selection to access benefits including:
  - primary cardholder and secondary cardholder (including how to establish a secondary cardholder);
  - how access is limited to a person with both the card and the PIN;
  - that there is no charge for using the Lone Star Card for food account purchases; and
  - that to obtain benefits they need to have a card, PIN and available benefits.
- When applicants will be able to use their initial benefits, if certified, and explain the availability of monthly benefits as specified in Form H1184, Here Is Your Lone Star Card.
- How and where to use the Lone Star Card including:
  - how to make a purchase (and/or cash withdrawal for TANF), availability of receipts and the need to save EBT receipts to keep track of account balance(s);
  - how to identify stores accepting SNAP/Lone Star Cards and how to ask store personnel if the store provides TANF cash-back services; and
  - the TANF cash-back policy. See B-239.1, Advisor Interview Requirements for Client Training.
- Card/PIN security including:
  - how to keep their benefits secure;
  - what to do if a card is lost or stolen or the PIN is compromised; and
  - that HHSC will not replace benefits used before a card is reported lost or stolen to the Lone Star Help Desk.
- The dormant account policy. If the cardholder does not access the EBT account for a limited number of consecutive months, their benefits become dormant. They may still access benefits in their EBT account. See B-361, Dormant Account Policy.
- Procedures when moving out of Texas including the:
  - use of the Lone Star Card to access:

        - TANF at retailers in other states; or
        - SNAP benefits at retailers; and
    - recommendation to withdraw all available cash benefits from the cash account before leaving the state.

    Note: HHSC may mail a benefit conversion warrant (full month's TANF benefit only) to the household's new address if the:

        - cardholder cannot find a retailer that accepts the Lone Star Card; and
        - household moved out of state on or after the first of the month but before accessing that month's TANF benefits. See B-331, Cancelling Benefits in EBT Accounts.

C—1132 Issuance Staff Guide for EBT Issuance and Client Training

Revision 18-1; Effective January 1, 2018

TANF and SNAP

After receiving Form H1172, EBT Card, PIN and Data Entry Request, authorizing an initial Lone Star Card and PIN to the primary cardholder, take the following actions:

- Issue and briefly explain the:
    - Lone Star Card;
    - card sleeve;
    - PIN packet, if applicable;
    - Form H1184, Here Is Your Lone Star Card; and
    - second cardholder form.
- If giving the Lone Star Card to someone other than the primary cardholder, then:
    - explain the use of each item to the person receiving the card;
    - place a registration sticker on the card; and
    - if applicable, request that the vendor mail a PIN packet to the primary cardholder.
- If mailing the Lone Star Card to the primary cardholder, then select vendor mail out.
- Explain:
    - the importance of saving the last receipt for the current account balance(s);
    - card registration, if required;
    - the requirement for the primary cardholder to sign the back of the card;
    - how to protect the card and what to do if it is lost or stolen; and
    - how to protect the PIN and what to do if it is compromised.
- Advise the individual to call the toll-free Lone Star Help Desk (800-777-7EBT or 800-777-7328) if they have problems accessing benefits or additional questions.

C—1140 TANF and SNAP Overpayment Determination Chart

Revision 01-7; Effective October 1, 2001

C—1141 Timely Reported

Revision 13-3; Effective July 1, 2013

TANF and SNAP

When the individual reports a change timely (i.e., individual reported within 10 days of knowing of the change), use B-600, Changes, B-752.1.2, Errors After Certification, and the following chart to determine the first month of overpayment.

If the household reported the change...	then the first month of potential overpayment is...
January 1-8	February
January 9-31	March
February 1-5	March
February 6-28 (or 29th)	April
March 1-8	April
March 9-31	May
April 1-7	May
April 8-30	June
May 1-8	June
May 9-31	July
June 1-7	July
June 8-30	August
July 1-8	August
July 9-31	September
August 1-8	September
August 9-31	October
September 1-7	October
September 8-30	November
October 1-8	November
October 9-31	December
November 1-7	December
November 8-30	January
December 1-8	January
December 9-31	February

Note: The first month of overpayment can be no later than two months from the month the change occurred.

C—1142 Untimely Reported

Revision 13-3; Effective July 1, 2013

TANF and SNAP

When the individual fails to report a change timely (i.e., does not report a change later discovered by HHSC or untimely reports a change), use B-600, Changes, B-752.1.2, Errors After Certification, and the following chart to determine the first month of overpayment.

If the change occurred...	then the first month of potential overpayment is...
January 1-31	March
February 1-28 (29)	April
March 1-31	May
April 1-30	June
May 1-31	July
June 1-30	August
July 1-31	September
August 1-31	October
September 1-30	November

If the change occurred...	then the first month of potential overpayment is...
October 1-31	December
November 1-30	January
December 1-31	February

Note: The first month of overpayment can be no later than two months from the month the change occurred.

C—1150 Type Programs (TP) and Type Assistance (TA)

Revision 18-1; Effective January 1, 2018

SNAP, TANF and Medical Programs/Assistance

SNAP

Code	Description	Long Description
TA 51	SNAP-CAP/FS-CAP	Supplemental Nutrition Assistance Program Combined Application Project
TA 52	SNAP-SSI/FS-SSI	Supplemental Nutrition Assistance Program Supplemental Security Income
TP 06	SNAP (PA)/FS-PA	Supplemental Nutrition Assistance Program Public Assistance
TP 09	SNAP/FS-NPA	Supplemental Nutrition Assistance Program

TANF

Code	Description	Long Description
TP 01	TANF Basic	Cash assistance for caretakers and deprived children with income below TANF recognizable needs
TP 60	TANF Grandparent Payment	One-time payment for grandparent who is caretaker of their TANF-certified grandchild
TP 61	TANF State Program	Cash assistance for two-parent household with income below TANF recognizable needs
TP 71	OTTANF – 1 Adult	One-Time TANF (OTTANF) payment for households with one parent
TP 72	OTTANF – 2 Parents	OTTANF payment for households with two parents

Medical Programs/Assistance — Texas Works

Code	Description	Long Description
TA 31	MA – Parents and Caretaker Relatives – Emergency	Medicaid for an emergency condition for parents and caretaker relatives who do not meet alien status requirements and are caring for a dependent child who receives Medicaid

TA 41	Health Care – Healthy Texas Women	Healthy Texas Women (HTW) for women age 15–44 with income at or below the applicable income limit
TA 66	MA – MBCC – Presumptive	Medicaid for Breast and Cervical Cancer – Presumptive
TA 67	MA – MBCC	Medicaid for Breast and Cervical Cancer
TA 74	MA – Children Under 1 Presumptive	Short-term Medicaid for children under age 1 with income at or below the applicable income limit
TA 75	MA – Children 1–5 Presumptive	Short-term Medicaid for children ages 1–5 with income at or below the applicable income limit
TA 76	MA – Children 6–18 Presumptive	Short-term Medicaid for children ages 6–18 with income at or below the applicable income limit
TA 77	Health Care – FFCHE	Health Care for Former Foster Care in Higher Education with income at or below the applicable income limit
TA 82	MA – Former Foster Care Children	Medicaid for former foster care children ages 18–25
TA 83	MA – FFCC Presumptive	Short-term Medicaid for former foster care children ages 18–25
TA 84	CI – CHIP	The Children's Health Insurance Program (CHIP) is health care coverage for children under age 19 who are ineligible for Medicaid due to income and who have income at or below the applicable income limit
TA 85	CI – CHIP perinatal	CHIP perinatal is health care coverage for unborn children whose mother is ineligible for Medicaid or CHIP due to income and/or immigration status and whose income is at or below the applicable income limit
TA 86	MA – Parents and Caretaker Relatives Presumptive	Short-term Medicaid for parents and caretaker relatives caring for a dependent child
TP 02	MA – Refugee	Refugee Medical Assistance (RMA) for refugees who are ineligible for any other type of Medicaid and have income at or below the applicable income limit **Note:** Effective Feb. 1, 2017, HHSC no longer adminsters RMA.
TP 07	MA – Earnings Transitional	Twelve months of transitional Medicaid resulting from an increase in earnings
TP 08	MA – Parents and Caretaker Relatives	Medicaid for parents and caretaker relatives caring for a dependent child with income at or below the applicable income limit
TP 20	MA Alimony/Spousal Support Transitional	Up to four months of post Medicaid resulting from an increase in alimony/spousal support
TP 32	MA – MN w/Spend Down – Emergency	Medicaid for an emergency condition for children or pregnant women who do not meet alien status requirements and who are ineligible for any other type of Medicaid, but who have medical expenses that spend down their income to below the Medically Needy Income Limit (MNIL)
TP 33	MA – Children 1–5 – Emergency	Medicaid for an emergency condition for children age 1–5 who do not meet alien status requirements and who have income at or below the applicable income limit
TP 34	MA – Children 6–18 – Emergency	Medicaid for an emergency condition for children age 6–18 who do not meet alien status requirements and who have income at or below the applicable income limit
TP 35	MA – Children Under 1 – Emergency	Medicaid for an emergency condition for children under age 1 who do not meet alien status requirements and who have income at or below the applicable income limit
TP 36	MA – Pregnant Women –	Medicaid for an emergency condition for pregnant women who do not meet alien status requirements and who have income at or below the applicable income limit

	Emergency	
TP 40	MA – Pregnant Women	Medicaid for pregnant woman with income at or below the applicable income limit
TP 42	MA – Pregnant Women Presumptive	Short-term Medicaid for pregnant women with income at or below the applicable income limit
TP 43	MA – Children Under 1	Medicaid for children under age 1 with income at or below the applicable income limit
TP 44	MA – Children 6–18	Medicaid for children age 6–18 with income at or below the applicable income limit
TP 45	MA – Newborn Children	Medicaid for children through age 1 who are born to a Medicaid-eligible mother
TP 48	MA – Children 1–5	Medicaid for children age 1–5 with income at or below the applicable income limit
TP 56	MA – MN w/Spend Down	Medicaid for children or pregnant women who are ineligible for any other type of Medicaid, but who have medical expenses that spend down their income to below the MNIL
TP 70	Medicaid for the Transitioning Foster Care Youth	Medicaid for Transitioning Foster Care Youth individuals with income at or below the applicable income limit
TPAL	MA – Historical FMA – Emergency	N/A
TPDE	MA – Deceased Prior Medical	Medicaid for a deceased individual
TPPM	MA/ME – Historical Prior Medical	Three months of prior Medicaid – not currently eligible

Medical Programs/Assistance — Texas Department of Family and Protective Services

Code	Description	Long Description
TP 52	MA – State Foster Care – A	Medicaid
TP 53	MA – State Foster Care – B	Medicaid
TP 54	MA – State Foster Care – 32	Medicaid
TP 57	MA – State Foster Care – D	Medicaid
TP 58	MA – State Foster Care – JPC	Medicaid
TA 78	PCA Medicaid – Federal Match – No Cash	Permanency Care Assistance (PCA) Medicaid – Federal Match – No Cash
TA 79	PCA Medicaid – No Federal Match – No Cash	PCA Medicaid – No Federal Match – No Cash
TA 80	PCA Medicaid – Federal Match – With Cash	PCA Medicaid – Federal Match – With Cash
TA 81	PCA Medicaid – No Federal Match – With Cash	PCA Medicaid – No Federal Match – With Cash
TP 88	MA – Non-AFDC Foster Care – JPC	Medicaid
TP 90	MA – State Foster Care	Medicaid
TP 91	Adoption Assistance – Federal Match – No Cash	Adoption Assistance – Federal Match – No Cash

TP 92	Adoption Assistance – Federal Match – With Cash	Adoption Assistance – Federal Match – With Cash
TP 93	Foster Care – Federal Match – No Cash	Foster Care – Federal Match – No Cash
TP 94	Foster Care – Federal Match – With Cash	Foster Care – Federal Match – With Cash
TP 95	Adoption Assistance – No Federal Match – No Cash	Adoption Assistance – No Federal Match – No Cash
TP 96	Adoption Assistance – No Federal Match – With Cash	Adoption Assistance – No Federal Match – With Cash
TP 97	Foster Care – No Federal Match – No Cash	Foster Care – No Federal Match – No Cash
TP 98	Foster Care – No Federal Match – With Cash	Foster Care – No Federal Match – With Cash
TP 99	MA – Non-AFDC Foster Care	Medicaid
TPAS	MA – Historical Adoption Subsidy	Medicaid

Medical Programs/Assistance — Medicaid for the Elderly and People with Disabilities

Code	Description	Long Description
TA 01	ME – Interim SSI Denied Child	Medicaid (processed by SSA)
TA 02	ME – SSI Waivers	SSI Recipient Waivers
TA 03	ME – Manual SSI Waivers	Manual SSI Waivers
TA 04	ME – Manual SSI State Group Home	Manual SSI Recipient State Community-based Group Homes
TA 05	ME – Manual SSI Non-State Group Home	Manual SSI Recipient Non-State Community-based Group Homes
TA 06	ME – Manual SSI Nursing Facility	Medicaid for Nursing Facility Resident
TA 07	ME – Manual SSI State Hospital	Medicaid for State Hospital Resident
TA 08	ME – SSI State Group Home	SSI Recipient State Community Based Group Home
TA 09	ME – Manual SSI State Supported Living Center	Medicaid for State Supported Living Center Resident
TA 10	ME – Waivers	Medicaid
TA 12	ME – State Group Home	Medicaid for ICF/IID Resident
TA 15	ME – Rider 51 – Non-State Group Home	
TA 16	ME – Rider 51 – State Supported Living Center	Medicaid for State Supported Living Center Resident
TA 17	ME – Rider 51 – Nursing Facility	Medicaid for Nursing Facility Resident
TA 18	ME – Grandfathered LTC	N/A

TA 21	ME – SSI Chest Hospital	Medicaid for Chest Hospital Patient
TA 22	ME – Manual SSI	Manually certified SSI — processed by SSA
TA 24	ME – Rider 51 – State Group Home	
TA 25	ME – Rider 51 – State Hospital	
TA 26	ME – SSI Non-State Group Home	SSI Non-State Community-based Group Homes
TA 27	ME – Prior Medicaid Institutional/Waiver	Prior Medicaid for individual applying for Institutional or Waiver Medicaid
TA 88	ME – Medicaid Buy-In for Children	Medicaid benefits to eligible children with disabilities who are not eligible for Supplemental Security Income (SSI) for reasons other than disability. Individuals must pay a share of the Medicaid premium
TP 03	ME – Pickle	RSDI COLA Disregard Programs — considered eligible based on the 1977 Pickle Amendment
TP 10	ME – State Supported Living Center	Medicaid for State Support Living Center Resident
TP 11	ME – SSI Prior	SSI, two or three months prior, as appropriate
TP 12	ME – Temp Manual SSI	Manually certified SSI (processed by SSA)
TP 13	ME – SSI	SSI (processed by SSA)
TP 14	ME – Community Attendant	Community Attendant Services
TP 15	ME – Non-State Group Home	Medicaid For ICF/IID Resident
TP 16	ME – State Hospital	Medicaid for ICF/IID Resident
TP 17	ME – Nursing Facility	Medicaid for State Hospital Resident
TP 18	ME – Disabled Adult Child	Adult children (at least age 18) who have a disability and who were denied SSI due to an entitlement to or an increase in their Social Security Disabled Adult Child benefits and who are eligible for Medicaid to ensure continued coverage
TP 21	ME – Disabled Widow(er)	Widows/widowers or surviving divorced spouses age 50–65 who have a disability and who are ineligible for Medicare and were denied SSI due to an increase in their RSDI widow/widower benefits. They are eligible for Medicaid under TP 21 until they reach age 65 or become eligible for Medicare, whichever occurs first
TP 22	ME – Early Aged Widow(er)	Early age widows/widowers or surviving divorced spouses age 50–65 who are ineligible for Medicare and who were denied SSI due to an increase in their RSDI widow/widower benefits. They are eligible for Medicaid under TP 22 until they reach age 65 or become eligible for Medicare, whichever occurs first
TP 23	MC – SLMB	Medicare Savings Program — Specified Low-Income Medicare Benefits
TP 24	MC – QMB	Medicare Savings Program — Qualified Medicare Beneficiary
TP 25	MC – QDWI	Qualified Disabled and Working Individuals — A special Medicare savings program that pays Part A Medicare premiums for certain working individuals under age 65 who have a disability and are no longer eligible for free Medicare Part A because of earnings
TP 26	MC – QI 1	Medicare savings program — Qualified individuals

TP 27	MC – QI 2	Medicare savings program — Qualified individuals (not an active program)
TP 30	ME – A and D Emergency	Emergency Medicaid for a nonqualified alien
TP 38	ME – SSI Nursing Facility	Medicaid for Nursing Facility Resident
TP 39	ME – SSI State Hospital	Medicaid for State Hospital Resident
TP 41	ME – Skilled Nursing Care	Skilled Nursing Facility Co-payments
TP 46	ME – SSI State Supported Living Center	Medicaid for State Supported Living Center Residents
TP 50	ME – Rider 51J	Medicaid for Nursing Facility Resident
TP 51	ME – Rider 51J Waivers	Medicaid
TP 87	ME – Medicaid Buy In	Working individuals with disabilities who pay a share of the Medicaid premium to be eligible for Medicaid

TWH, C-1200, Reserved for Future Use

TWH, C-1300, Reserved for Future Use

TWH, C-1400, Reference

Revision 18-1; Effective January 1, 2018

C—1410 Legal Aid

Revision 13-3; Effective July 1, 2013

All Programs

Staff are required to include the address and phone number of legal services available in the area on individual notices.

C—1420 SSA Claim Number Suffixes

Revision 13-3; Effective July 1, 2013

A	
B	
B1	Primary beneficiary

B2	Aged wife (1st claimant)
B3	Husband (1st claimant)
B4	Young wife (1st claimant)
B5	Aged wife (2nd claimant)
B6	Husband (2nd claimant)
B7	Young wife (2nd claimant)
B8	Divorced wife (1st claimant)
B9	Young wife (3rd claimant)
BA	Aged wife (3rd claimant)
BD	Divorced wife (2nd claimant)
BG	Aged wife (4th claimant)
BH	Aged wife (5th claimant)
BJ	Husband (3rd claimant)
BK	Husband (4th claimant)
BL	Husband (5th claimant)
BN	Young wife (4th claimant)
BP	Young wife (5th claimant)
BQ	Divorced wife (3rd claimant)
BR	Divorced wife (4th claimant)
BT	Divorced wife (5th claimant)
BY	Divorced husband (1st claimant)
BW	Divorced husband (2nd claimant)
C1, 2 etc.1	Young husband (1st claimant)
D	Young husband (2nd claimant)
D1	Child (including disabled or student child)
D2	Aged widow (1st claimant)
D3	Widower (1st claimant)
D4	Aged widow (2nd claimant)
D5	Widower (2nd claimant)
D6	Widow (remarried after attaining age 60)
D7	Widower (remarried after attaining age 62)
DB	Surviving divorced wife (1st claimant)
D9	Surviving divorced wife (2nd claimant)
DA	Aged widow (3rd claimant)
DC	Remarried aged widow (2nd claimant)
DD	Remarried aged widow (3rd claimant)
DG	Surviving divorced husband (1st claimant)
DH	Aged widow (4th claimant)
DJ	Aged widow (5th claimant)
DK	Aged widower (3rd claimant)
DL	Aged widower (4th claimant)
DM	Aged widower (5th claimant)
DN	Remarried aged widow (4th claimant)
DP	Surviving divorced husband (2nd claimant)

DQ	Remarried aged widow (5th claimant)
DR	Remarried aged widower (2nd claimant)
DS	Remarried aged widower (3rd claimant)
DT	Remarried aged widower (4th claimant)
DV	Surviving divorced husband (3rd claimant)
DW	Remarried aged widower (5th claimant)
DX	Surviving divorced wife (3rd claimant)
DY	Surviving divorced wife (4th claimant)
DZ	Surviving divorced husband (4th claimant)
E	Surviving divorced wife (5th claimant)
E1	Surviving divorced husband (5th claimant)
E2	Mother (widow) (1st claimant)
E3	Surviving divorced mother (1st claimant)
E4	Mother (widow) (2nd claimant)
E5	Surviving divorced mother (2nd claimant)
E6	Father (widower) (1st claimant)
E7	Surviving divorced father (1st claimant)
E8	Father (widower) (2nd claimant)
E9	Young mother (widow) (3rd claimant)
EA	Mother (widow) (4th claimant)
EB	Surviving divorced father (2nd claimant)
EC	Mother (widow) (5th claimant)
ED	Surviving divorced mother (3rd claimant)
EF	Surviving divorced mother (4th claimant)
EG	Surviving divorced mother (5th claimant)
EH	Father (widower) (3rd claimant)
EJ	Father (widower) (4th claimant)
EK	Father (widower) (5th claimant)
EM	Surviving divorced father (3rd claimant)
F1	Surviving divorced father (4th claimant)
F2	Surviving divorced father (5th claimant)
F3	Father
F4	Mother
F5	Stepfather
F6	Stepmother
F7	Adopting father
F8	Adopting mother
G1 – G9	Second alleged father
J1	Second alleged mother
J2	Claimants of lump-sum death payments
J3	Primary PROUTY entitled to HIB (less than 3 Q.C.)2
J4	Primary PROUTY entitled to HIB (3 or more Q.C.)
K1	Primary PROUTY not entitled to HIB (less than 3 Q.C.)
K2	Primary PROUTY not entitled to HIB (3 or more Q.C.)

K3	PROUTY wife entitled to HIB (less than 3 Q.C.)
K4	PROUTY wife entitled to HIB (3 or more Q.C.)
K5	PROUTY wife not entitled to HIB (less than 3 Q.C.)
K6	PROUTY wife not entitled to HIB (3 or more Q.C.)
K7	PROUTY wife entitled to HIB (less than 3 Q.C.) (2nd claimant)
K8	PROUTY wife entitled to HIB (3 or more Q.C.) (2nd claimant)
K9	PROUTY wife not entitled to HIB (less than 3 Q.C.) (2nd claimant)
KA	PROUTY wife not entitled to HIB (3 or more Q.C.) (2nd claimant)
KB	PROUTY wife entitled to HIB (less than 3 Q.C.) (3rd claimant)
KC	PROUTY wife entitled to HIB (3 or more Q.C.) (3rd claimant)
KD	PROUTY wife not entitled to HIB (less than 3 Q.C.) (3rd claimant)
KE	PROUTY wife not entitled to HIB (3 or more Q.C.) (3rd claimant)
KF	PROUTY wife entitled to HIB (less than 3 Q.C.) (4th claimant)
KG	PROUTY wife entitled to HIB (3 or more Q.C.) (4th claimant)
KH	PROUTY wife not entitled to HIB (less than 3 Q.C.) (4th claimant)
KJ	PROUTY wife not entitled to HIB (3 or more Q.C.) (4th claimant)
KL	PROUTY wife entitled to HIB (less than 3 Q.C.) (5th claimant)
KM	PROUTY wife entitled to HIB (3 or more Q.C.) (5th claimant)
LM	PROUTY wife not entitled to HIB (less than 3 Q.C.) (5th claimant)
LW	PROUTY wife not entitled to HIB (3 or more Q.C.) (5th claimant)
M	Black lung miner (1st claimant)
	Black lung miner's widow (1st claimant)
M1	Uninsured beneficiary — not entitled to **free** HIB, entitled to SMIB only or premium HIB/SMIB
	Insured or Uninsured beneficiary — qualifies for HIB, but requests only SMIB
T	Uninsured beneficiary — entitled to HIB under deemed insured provision **or** end stage renal disease (ESRD)
	Primary federal beneficiary not entitled to Title 11 or railroad monthly benefits (at time of filing)
TA	Same as B (1st claimant)
	Same as B3 (2nd claimant)
TB	Same as B7 (3rd claimant)
TG	Same as BK (4th claimant)
TH	Same as BL (5th claimant)
TJ	Disabled child (1st claimant)
TK	Same as TC (2nd - 9th claimant)
TC	Aged widow(er) (1st claimant)
T2 – T9	Same as TD (2nd claimant)
TD	Same as TD (3rd claimant)
TL	Same as TD (4th claimant)
TM	Same as TD (5th claimant)
TN	Disabled widow(er) (1st claimant)
TP	Same as TW (2nd claimant)
TW	Same as TW (3rd claimant)
TX	Same as TW (4th claimant)
TY	Same as TW (5th claimant)
TZ	Parent (1st claimant)

TV	Parent (2nd claimant)
TF	Young widow(er) (1st claimant)
TQ	Same as TE (2nd claimant)
TE	Same as TE (3rd claimant)
TR	Same as TE (4th claimant)
TS	Same as TE (5th claimant)
TT	Disabled widow (1st claimant)
TU	Disabled widower (1st claimant)
W	Disabled widow (2nd claimant)
W1	Disabled widower (2nd claimant)
W2	Disabled widow (3rd claimant)
W3	Disabled widower (3rd claimant)
W4	Disabled surviving divorced wife (1st claimant)
W5	Disabled surviving divorced wife (2nd claimant)
W6	Disabled surviving divorced wife (3rd claimant)
W7	Disabled widow (4th claimant)
W8	Disabled widower (4th claimant)
W9	Disabled surviving divorced wife (4th claimant)
WB	Disabled widow (5th claimant)
WC	Disabled widower (5th claimant)
WF	Disabled surviving divorced wife (5th claimant)
WG	Disabled surviving divorced husband (1st claimant)
WJ	Disabled surviving divorced husband (2nd claimant)
WR	
WT	

1 Youngest child is assigned suffix "1." When there are more than nine children in an Eligibility Determination Group (EDG), the 10th child is coded with an A rather than 10, the 11th child is coded with a B, etc.

2 Quarters of covered employment.

C—1430 SNAP Allotment Charts

Revision 12-4; Effective October 1, 2012

C—1431 Whole Monthly Allotments by Household Size

Revision 17-4; Effective October 1, 2017

SNAP Allotment Charts

The shaded portions on the table in this section indicate monthly (not prorated) allotments available to categorically eligible households, which can be $1 or more.

The minimum monthly (not prorated) Supplemental Nutrition Assistance Program (SNAP) allotment for a one- or two-person household is $15.

Related Policy
How to Determine Monthly SNAP Allotments, C-122

C—1432 Prorated SNAP Allotments by Application Date

Revision 11-3; Effective July 1, 2011

SNAP Allotment Charts

Do not issue prorated benefit allotments of less than $10.

Related Policy
How to Determine Monthly SNAP Allotments, C-122
How to Prorate Benefits, C-123
Whole Monthly Allotments by Household Size, A-2321

C—1440 Relationship Charts

Revision 08-1; Effective January 1, 2008

C—1441 Guide for Determining Relationship

Revision 13-3; Effective July 1, 2013

TANF and Medical Programs

This guide provides more detailed information about the eligibility requirements for relationship discussed in A-200, Household Composition, and A-520, Relationship. This guide is not all-inclusive.

A	B	C
When the child no longer lives with the relative listed below ...	**and the child now lives with ...**	**can the person listed in Column B be a caretaker/payee for the child?**
1. Mother	1. Stepfather	1. Yes
2. Father	2. Stepmother	2. Yes
3. Stepfather	3. Stepfather's Spouse	3. Yes
4. Stepmother	4. Stepmother's Spouse	4. Yes
5. Stepfather's Spouse	5. New Spouse	5. No
6. Stepmother's Spouse	6. New Spouse	6. No

A	B	C
When the child no longer lives with the relative listed below ...	**and the child now lives with ...**	**can the person listed in Column B be a caretaker/payee for the child?**
*7. Grandmother	7. Step Grandfather	7. Yes
*8. Grandfather	8. Step Grandmother	8. Yes
*9. Step Grandfather	9. New Spouse	9. No
*10. Step Grandmother	10. New Spouse	10. No
11. Brother	11. Sister-in-law	11. Yes
12. Sister	12. Brother-in-law	12. Yes
13. Brother-in-law	13. New Spouse	13. No
14. Sister-in-law	14. New Spouse	14. No
15. Stepbrother	15. Stepbrother's Spouse	15. Yes
16. Stepbrother's Spouse	16. New Spouse	16. No
17. Stepsister	17. Stepsister's Spouse	17. Yes
18. Stepsister's Spouse	18. New Spouse	18. No
*19. Aunt	19. Aunt's Spouse	19. Yes
*20. Uncle	20. Uncle's Spouse	20. Yes
21. Aunt's Spouse	21. New Spouse	21. No
22. Uncle's Spouse	22. New Spouse	22. No
**23. First Cousin	23. First Cousin's Spouse	23. Yes
**24. First Cousin's Spouse	24. New Spouse	24. No
*25. Niece	25. Niece's Spouse	25. Yes
26. Niece's Spouse	26. New Spouse	26. No
*27. Nephew	27. Nephew's Spouse	27. Yes
28. Nephew's Spouse	28. New Spouse	28. No

*Extends to the degree of "Great-great" for items 19, 20, 25, and 27 and to the degree of "Great-great-great" for items 7, 8, 9 and 10.

**Extends to the first cousin once removed.

C—1442 Guide for Determining Extended Relationships

Revision 06-1; Effective January 1, 2006

Extended Relationships Chart

C—1450 Guidelines for Clearing Quality Control (QC) Findings

Revision 12-2; Effective April 1, 2012

C—1451 Dropped – Subject to Review but Not Completed

Revision 15-4; Effective October 1, 2015

All Programs

Form H1025, Report of Quality Control Assessment Findings	Penalty	What to do ...
Not reviewed (reason): Refusal to Cooperate1	Yes2	Issue Form TF0001, Notice of Case Action, entering the comments for the appropriate program: "Your SNAP or TANF benefits are denied due to your refusal to cooperate with the Quality Control (QC) review. You will incur this penalty through February 2, yyyy,3 or until you decide to cooperate with the QC review process, whichever occurs first." Include the Texas Health and Human Services Commission's (HHSC's) Spanish translation: "Sus beneficios de SNAP o TANF se negaron porque usted se negó a cooperar con la revisión de Control de Calidad (QC). Esta sanción se le aplicaráá hasta el 2 de febrero de [YEAR] o hasta que decida cooperar con el proceso de revisión de la QC, lo que ocurra primero." Allow advance notice of adverse action and deny only the EDG for which Form H1025 was received. Do not deny associated EDGs. (See A-2343, Advance Notice.) Call the Texas Integrated Eligibility Redesign System (TIERS) helpdesk before disposing the denied EDG to ensure only the EDG the household refused to cooperate with is denied. **Notes:** • Refusal to cooperate with QC does not affect Medicaid. • The Temporary Assistance for Needy Families (TANF) denial cannot cause SNAP benefits to increase. Do not remove the TANF grant from an associated SNAP budget when denying a TANF EDG for refusal to cooperate with QC. Refer to policy in A-1324.18, Temporary Assistance for Needy Families (TANF). When the EDG is denied for any other reason by the time the advisor receives Form H1025 (for example, the individual failed to return pending information and the EDG is denied effective September 30, the QC review month was September, and the advisor receives Form H1025 in October), the advisor must still send Form TF0001 to the individual.
Not reviewed (reason): Failure to Cooperate4	No	The advisor needs to analyze any information provided by QC and adjust the EDG, if necessary.

Notes:

1 Refusal to cooperate indicates that the individual has refused to cooperate with the QC review process, that is, refused to provide information or refused to be interviewed.

2 Form H1025 contains a checkbox followed by the statement, "Impose a non-compliance penalty due to client refusal to cooperate if this box is checked. The penalty should be imposed through February 2, yyyy, [appropriate year inserted] or until the client agrees to cooperate with QCA, whichever occurs first."

3 The penalty period always expires 125 days after the reporting period. The reporting period ends September 30 each year. The penalty period for federal fiscal year (FFY) is October through September of the following year. QC refusal to cooperate penalties expire February 2, yyyy. **Example:** The individual's sample month is October 2011. The individual refuses to cooperate and is penalized. The penalty period expires February 2, 2013 (125 days after September 30, 2012).

4 Failure to cooperate indicates the individual has provided all of the information and cooperated with the QC review process; however, the QC analyst is unable to complete the review due to an aspect beyond the individual's control (for example, the employer or landlord refused to provide information).

C—1452 Dropped – Not Subject to Review

Revision 15-4; Effective October 1, 2015

All Programs

Form H1025, Report of Quality Control Assessment Findings	Penalty	What to do ...
Not reviewed (reason): Moved Out of State	No	If the individual reports in advance of moving, issue Form TF0001, Notice of Case Action, and deny the EDG simultaneously allowing adequate notice. See A-2344.1, Form TF0001 Required (Adequate Notice). Deny the EDG for which Form H1025 was received. When the individual reports after they move out of state or it is determined by QC, deny the EDG following A-2344.2, No Form TF0001 Required. Adjust/deny any other EDGs in which the individual/household members are included.
Not reviewed (reason): Referred to Fraud, Under Active Fraud Investigation or Intentional Program Violation (IPV) EDG	No	No action is required. If, as of the date the EDG is selected for QC sampling, the EDG meets one of the following: • has been referred for investigation to the state's fraud investigation unit, and the investigation is scheduled to begin within five months of sampling; • is under active fraud investigation; or • has a pending administrative or judicial IPV hearing, the IPV EDG is not subject to review.
Not reviewed (reason): Retroactive Benefits	No	No action is required. The sample month benefits were issued retroactively; therefore, the EDG is not subject to review. Example: The file date is November 15 and the certification date is December 15. Benefits for November are issued (retroactively) in December; if November is the sample month, the EDG is not subject to review.
Not reviewed (reason): Unable to Locate	No	When Form H1025 indicates that returned mail has been received by QC, the advisor must send Form TF0001 and deny the EDG simultaneously to allow adequate notice. (See A-2344.1.) When Form H1025 does not indicate that returned mail has been received but that the individual has not been located, advisors must send Form TF0001 to deny for unable to locate allowing advance notice of adverse action. (See A-2343, Advance Notice.) Adjust/deny any other EDGs in which the individual/household members are included.
Not reviewed (reason): All Individuals Who Could Be Interviewed Are Hospitalized, Incarcerated or Placed in a Mental Institution	No	Information discovered by QC is forwarded to the advisor via this format. The advisor needs to analyze the information and adjust the EDG appropriately, including denial. Adjust/deny any other EDGs in which the individual/household members are included.
Not reviewed (reason): EDG Pending a Hearing	No	No action is required.

Form H1025, Report of Quality Control Assessment Findings	Penalty	What to do ...
Not reviewed (reason):		
Household Did Not Receive Benefits for Sample Month	No	No action is required.

TANF

Form H1025 QC Findings	Penalty	What to do ...
Not reviewed (reason):		Deny the EDG, allow adequate notice and send Form TF0001 simultaneously. Adjust/deny any other EDGs in which the individual/household members are included. (See A-2344.1.)
Death of All Available Adult Household Members	No	The child(ren) may be certified as independent children on appropriate Medicaid EDGs (see A-241.1, Who Is Included) or they may be determined eligible in a new TANF household when all other eligibility requirements are met.
Not reviewed (reason):		
Dormant Electronic Benefit Transfer (EBT) Account	No	No action is required.

SNAP

Form H1025 QC Findings	Penalty	What to do ...
Not reviewed (reason):		
Death of All Household Members	No	Deny the EDG. Adjust/deny any other EDGs in which the individual/household members are included. (See A-2344.2.)
Not reviewed (reason):		
Dormant Account, No Activity in EBT Account, Sample Month and Two Following Months Up To and Including Transmission to Food and Nutrition Services	No	No action is required.

C—1453 Completed QC Reviews

Revision 15-4; Effective October 1, 2015

TANF and SNAP

Form H1025, Report of Quality Control Assessment Findings	Penalty	What to do ...

Form H1025, Report of Quality Control Assessment Findings	Penalty	What to do ...
		Issue Form TF0001, Notice of Case Action, with the following message: "Your SNAP/TANF benefits are denied due to your refusal to cooperate with the Quality Control (QC) review. You will incur this penalty through February 2, yyyy, or until you decide to cooperate with the QC review process, whichever occurs first." Include HHSC's Spanish translation: "Sus beneficios de SNAP o TANF se negaron porque usted se negó a cooperar con la revisión de Control de Calidad (QC). Esta sanción se le aplicará hasta el 2 de febrero de [YEAR] o hasta que decida cooperar con el proceso de revisión de la QC, lo que ocurra primero."
Completed – Individual Refused to Cooperate	Yes	Allow advance notice of adverse action and deny only the EDG for which Form H1025 was received. Do not deny associated EDGs. (See A-2343, Advance Notice.) **Notes:** • Refusal to cooperate with QC does not affect Medicaid. • The TANF denial cannot cause SNAP benefits to increase. Do not remove the TANF grant from an associated SNAP budget when denying a TANF EDG for refusal to cooperate with QC. Refer to policy in A-1324.18, Temporary Assistance for Needy Families (TANF).
Findings and Dollar Amounts of Error: Information(al) Only	No	Information discovered by the QC analyst is forwarded to the advisor via this format. The advisor needs to analyze the information and adjust the EDG appropriately, including denial, if necessary. The advisor must refer all SNAP overissuances identified during the QC review process to the Office of Inspector General (OIG), regardless of the dollar amount. See policy in B-720, When to File an Overpayment Referral, prior to sending the referral to OIG.
Amount Correct	No	No action is required.

Notes:

- "Refusal to cooperate" indicates the individual has refused to cooperate with the QC review process, that is, refused to provide information or refused to be interviewed.
- Form H1025 contains a checkbox followed by the statement, "Impose a non-compliance penalty due to client refusal to cooperate if this box is checked. The penalty should be imposed through February 2, yyyy, [appropriate year inserted] or until the client agrees to cooperate with QCA, whichever occurs first."
- The penalty period always expires 125 days after the reporting period. The reporting period ends September 30 each year. The penalty period for the FFY is October through September of the following year. QC reviews expire February 2, yyyy. **Example**: The individual's sample month is March 2012. The individual refuses to cooperate and is penalized. The penalty period expires February 2, 2013 (125 days after September 30, 2012).

TANF

Form H1025 QC Findings	Penalty	What to do ...

Form H1025 QC Findings	Penalty	What to do ...
		Note: The dollar amount listed is not necessarily the amount of the underpayment.
Findings and Dollar Amounts of Error: Underpayment — $xx.00	No	The advisor must adjust the EDG accordingly. (See B-800, Restored Benefits.) The advisor should issue supplemental benefits for the current month if the individual is currently eligible. **Note:** Consider all reported changes when determining the amount of supplemental or restored benefits. Adjust/deny any other EDGs in which the individual/household members are included.
		Note: The dollar amount listed is not necessarily the amount of the overpayment.
Findings and Dollar Amounts of Error: Overpayment — $xx.00	No	The advisor needs to adjust the EDG accordingly and enter the overpayment referral in TIERS. **Note:** Consider all reported changes when determining the amount of the overpayment claim, including changes reported to QC during the exclusionary period and any other information listed by QC as "information only." Adjust/deny any other EDGs in which the individual/household members are included.

SNAP

Form H1025 QC Findings	Penalty	What to do ...
Findings and Dollar Amounts of Error: Underissuance — $xx.00	No	**Note:** The dollar amount listed is not necessarily the amount of the underissuance. The advisor must adjust the EDG accordingly. (See B-800, Restored Benefits.) The advisor should issue supplemental benefits for the current month if the individual is currently eligible. For agency errors only, issue restored benefits for past months regardless of whether the individual is currently eligible. Do not restore benefits for unreported changes or household errors. **Note:** Consider all reported changes when determining the amount of supplemental or restored benefits. Adjust/deny any other EDGs in which the individual/household members are included.
Findings and Dollar Amounts of Error: Overissuance — $xx.00	No	**Note:** The dollar amount listed is not necessarily the amount of the overissuance. The advisor needs to adjust the EDG accordingly and enter the overissuance referral in TIERS. The advisor must refer all SNAP overissuances identified during the QC review process to OIG, regardless of the dollar amount. See policy in B-720, When to File an Overpayment Referral, prior to sending the referral to OIG. **Note:** Consider all reported changes when determining the amount of the overissuance claim, including changes reported to QC during the exclusionary period and any other information listed by QC as "information only." Adjust/deny any other EDGs in which the individual/household members are included.

C—1454 Reapplying for Benefits after a Quality Control Penalty

Revision 15-4; Effective October 1, 2015

All Programs

When the penalized individual comes in to reapply for benefits after the EDG is closed and the penalty period has ...	and the penalized individual is applying with ...	then the advisor ...
not expired,	the same household composition as was on the EDG reviewed by QC,	checks with the QC State Office staff who issued Form H1025, Report of Quality Control Assessment Findings. If the individual has cooperated with the QC review, the advisor proceeds with the application process. When the individual has not cooperated with the QC review, the advisor denies the application and informs the individual to reapply after they comply with the QC review process. Form TF0001, Notice of Case Action, must include the following: "You will need to contact (insert the QC contact designated by QC State Office) at (insert the QC contact designated by QC State Office) to complete the QC review process." Include HHSC's Spanish translation: "Para completar el trámite de revisión de la Valoración de Control de Calidad (QC), tiene que comunicarse con (insert QC contact designated by State Office) al (insert QC contact designated by State Office)."
not expired,	another household or moved into another household and is a required member of that household,	checks with the QC State Office staff who issued Form H1025. The penalty follows the penalized individual, and the new household is not eligible until the individual complies with QC. When the individual has cooperated with the QC review, the advisor proceeds with the application process. When the individual has not cooperated with the QC review, the advisor denies the application and imposes the disqualification until the individual cooperates or the penalty period expires, whichever comes first, informing the individual to reapply after they comply with the QC review process. Form TF0001 must include the following: "You will need to contact (insert the QC contact designated by QC State Office) at (insert the QC contact designated by QC State Office) to complete the QC review process." Include HHSC's Spanish translation: "Para completar el trámite de revisión de la Valoración de Control de Calidad (QC), tiene que comunicarse con (insert QC contact designated by State Office) al (insert QC contact designated by State Office)". Do not disqualify other adults or children who were members of the original penalized household when they apply with or enter another household and the penalized individual(s) is not applying with or entering the new household with them.

C—1455 Frequently Asked Questions

Revision 15-4; Effective October 1, 2015

All Programs

1. **Q: What is the difference between refusal to cooperate and failure to cooperate?**

- A: "Refusal to cooperate" is a QC response used when the individual has refused to cooperate with the QC review process, that is, refused to provide information or refused to be interviewed. "Failure to cooperate" is used when the individual has provided all of the information and cooperated with the QC review process; however, QC is unable to complete the review because of something beyond the individual's control, for example, employer or landlord refused to provide information. A penalty is incurred when the individual refuses to cooperate; a penalty is not incurred for failure to cooperate.

2. **Q: How do I know if a penalty has been imposed on a case?**

- A: QC maintains a list of sampled cases with imposed penalties. The list can be viewed from the Eligibility Services portal at https://ofsportal.hhsc.state.tx.us/. To view the list:

  - Enter your user name and password.
  - Select Report Manager.
  - Select QC/Case Review List in the Select Report Group.
  - A Drop Case Report will be displayed.
  - Select the appropriate Drop Case List Report.

- Enter the criteria for the report.

3. **Q: What is the "appropriate wording" to include when sending the individual Form TF0001, Notice of Case Action, for refusal to cooperate with QC?**

- A: Form TF0001 should contain the following information: "Your SNAP/TANF benefits are denied because of your refusal to cooperate with the Quality Control (QC) review. You will incur this penalty through February 2, yyyy, or until you decide to cooperate with the QC review process, whichever occurs first." Include HHSC's Spanish translation: "Sus beneficios de SNAP o TANF se negaron porque usted se negó a cooperar con la revisión de Control de Calidad (QC). Esta sanción se le aplicará hasta el 2 de febrero de [YEAR] o hasta que decida cooperar con el proceso de revisión de la QC, lo que ocurra primero."

4. **Q: Is the advisor required to send Form TF0001 with the appropriate penalty wording for individuals who are no longer receiving benefits by the time Form H1025, Report of Quality Control Assessment Findings, is received? Example: QC reviews and the EDG is denied in October. The advisor receives Form H1025 information December 2011. The individual is not receiving benefits when Form H1025 is received. The penalty period expires February 2, 2013.**

- A: Yes. The individual must be notified of the penalty period. Form TF0001 must advise the individual that the individual cannot receive benefits through February 2, 2013, or until the individual cooperates with the QC analyst, whichever is earlier as noted in #3 above.

5. **Q: Does the penalty period ever change? If so, how does it change?**

- A: The penalty period is always 125 days after the reporting period ends. The reporting period ends each federal fiscal year on September 30. One hundred twenty-five days from September 30 is February 2. These are for the prior federal fiscal year.

6. **Q: Do we deny the entire EDG or just the individual listed on Form H1025?**

- A: Deny the entire EDG reviewed by QC. **Note:** When denying a TANF EDG for refusal to cooperate, the associated SNAP benefits should not be increased (the TANF grant should not be removed from the budget) as the individual failed to cooperate with a QC review (see A-1324.18, Temporary Assistance for Needy Families [TANF]).

7. **Q: Can the individual appeal the denial of the EDG when it has been denied for refusal to cooperate?**

- A: Yes, the decision may be appealed. Refer to B-1000, Fair Hearings.

TANF

1. **Q: Is the individual entitled to restored benefits when QC discovers an underpayment?**

- A: When the household is currently eligible for and receiving TANF, then the answer is yes. See B-810, Entitlement to Restored Benefits.

2. **Q: What happens when we restore benefits and the individual has an overpayment claim filed?**

- A: The restored benefits must be used to offset the claim first. See B-810.

SNAP

1. **Q: Is the individual entitled to restored benefits when QC discovers an underissuance?**

- A: When the QC error was caused by the agency, then the answer is yes. When the QC error was caused by the individual due to unreported changes or other individual error, then the answer is no. See B-840, Notice to the Household.

2. **Q: What happens when we restore benefits and the individual has an overissuance claim filed?**

- A: The restored benefits must be used to offset the claim first. See B-810.

C—1460 Helpful Toll-Free Numbers

Revision 15-4; Effective October 1, 2015

All Programs

Use the following list of toll-free telephone numbers for reference purposes, or print the list and provide it to applicants.

Question or Concern	Organization	Telephone Number
Questions about social services or community resources in Texas, including the location and telephone number of local agency offices.	2-1-1 Texas Information and Referral Network	2-1-1 or 1-877-541-7905 (after selecting a language, press 1)
Provides households with information about EDG status such as active, on hold or denied; benefit amounts; and availability dates of current benefits.	Automated Voice Response (AVR) system hotline	2-1-1 or 1-877-541-7905 (after selecting a language, press 2)
Assists the public with issues or complaints about health and human services programs that have not been resolved under the agency's normal complaint process.	HHSC Office of the Ombudsman	1-877-787-8999
To report suspicions of the abuse or neglect of children, or the abuse, neglect or exploitation of persons age 65 or older or adults with disabilities.	Texas Department of Family and Protective Services	1-800-252-5400
Questions about Social Security Administration benefits or the maintenance of an individual's record.	Social Security Administration	1-800-772-1213 TTY number 1-800-325-0778
For claims of discrimination experienced by either individuals or applicants.	HHSC Civil Rights Office	1-888-388-6332 TTY number 1-877-432-7232
Concerns about fraud, waste or abuse of SNAP, Medicaid, TANF or Children's Health Insurance Program (CHIP) services or benefits.	Office of Inspector General	1-800-436-6184
The Children with Special Health Care Needs Services Program, within the Division for Family and Community Health Services, which provides services to children with extraordinary medical needs, disabilities and chronic health conditions.	Texas Department of State Health Services	1-800-252-8023
For child support services including the collection of court-ordered child support, information about the Crime Victims Compensation Fund and enforcement of the state's consumer protection laws.	Office of Attorney General	1-800-252-8011
For information on early intervention services for children with disabilities and developmental delays, vocational rehabilitation for persons with disabilities, services for people who are deaf or hard of hearing or people who are blind or visually impaired, and for information on disability determination services.	Texas Department of Assistive and Rehabilitative Services	1-800-628-5115 TTY number 1-866-581-9328

Question or Concern	Organization	Telephone Number
Information and assistance concerning family violence.	National Domestic Violence 24-hour hot line	1-800-799-SAFE (7233) TTY number 1-800-787-3224

Medicaid

Question or Concern	Organization	Telephone Number
Help finding or questions about a doctor, dentist or case manager for a person age 20 or younger.	Texas Health Steps	1-877-847-8377
For transportation assistance to a doctor's appointment.	Medical Transportation (HHSC)	1-877-633-8747
Helps individuals enrolled in STAR, STAR+PLUS or Primary Care Case Management (PCCM) with Medicaid managed care issues.	HHSC Medicaid Managed Care Helpline	1-866-566-8989
Questions about which services are covered by Medicaid, or help when a bill is received from a Medicaid provider, or questions about Medically Needy with Spend Down cases.	Statewide Medicaid help line	1-800-335-8957
Questions about enrolling in the STAR Managed Care Program or help changing a health plan.	State of Texas Access Reform (STAR)	1-800-964-2777

C—1470 Eligibility Environments

Revision 15-4; Effective October 1, 2015

All Programs

Texas Works serves applicants and recipients in Texas through a variety of eligibility environments. The following is a brief summary of each type.

Local eligibility offices: HHSC staff conduct business in a face-to-face environment with people seeking information or applying for health and human services programs. Interviewing tasks are performed at the local eligibility office either in person or by telephone.

The eligibility staff in local offices provide information and application assistance, receive applications, perform Data Broker and other third-party inquiries, collect data, assess missing information, determine eligibility, issue benefits, and perform other tasks associated with eligibility services operations. Work is processed by eligibility staff in local offices in TIERS. Individuals are assigned to specific offices and a single eligibility worker processes an EDG until it is disposed as approved or denied.

Eligibility staff in a local office process multiple types of assistance: SNAP, Medicaid, CHIP, and TANF. Eligibility staff in the offices work all types of EDGs/cases; however, some offices may have specialized staff based on workload. Clerical staff handle front desk and lobby-area tasks, telephones, mail, faxes, scheduling and other support duties.

Vendor staff creates and routes tasks for applications received via mail or fax to staff in the local eligibility offices or changes received via telephone, mail or fax to staff in the Customer Care Centers (CCCs). The vendor may register a new application or reschedule an

appointment, then route the interviewing tasks to local eligibility offices. Applications, redeterminations and changes submitted online through YourTexasBenefits.com are routed to the appropriate areas by the State Portal.

Centralized units: These units are able to specialize in certain programs or tasks and conduct eligibility work through the mail and by telephone without face-to-face contact. The centralized units help balance the workload of local eligibility offices. In a centralized unit, tasks are assigned based on due dates. Centralized functions have centralized mail, centralized telephone systems and do not require lobby space as eligibility offices do. Centers also have staff to answer telephones and provide status information, in addition to the staff working the cases.

C—1471 Specialized and Centralized Casework Units

Revision 18-1; Effective January 1, 2018

The following chart details various specialized and centralized casework units.

Centralized Units That Serve Both Texas Works (TW) Programs and Medicaid for the Elderly and People with Disabilities (MEPD) Programs

Unit Name	Description
Centralized Representation Unit (CRU)	The CRU files appeal requests and assembles EDG information in preparation for hearings for TIERS cases. The CRU represents the agency at fair hearings and implements all decisions for EDGs statewide. Members of this unit are housed across the state in local eligibility offices. HHSC created the unit in September 2007, and the unit initially processed EDG actions resulting from TIERS fair hearings for both Texas Works and MEPD. More details are available in the Eligibility Services State Processes document. Staff must file all appeal requests using the Hearings and Appeal — Create Appeal functionality in TIERS, accessed through the left navigation menu. Form H4800, Fair Hearing Request Summary, which is sent directly to the hearings division, will be returned to staff with instructions to enter the information in TIERS.
Customer Care Centers (CCCs)	The CCCs are located in Athens, Austin, El Paso, Houston and San Antonio. State staff, along with vendor staff, conduct business using the 2-1-1 Texas telephone system. CCC staff handle inquiries and concerns that vendor staff cannot resolve. The vendor creates tasks and routes non-interview changes received via telephone, mail, fax or the Self-Service Portal to state staff in the CCCs. The CCCs are supported by TIERS and by Eligibility Supporting Technologies, such as the Task List Manager and the State Portal. CCC state staff perform Data Broker and other third-party inquiries, collect data, assess missing information, determine eligibility, issue benefits, process individual- and agency-generated changes, perform other non-interview tasks, and process six-month income check task. CCC performs these functions, as applicable, for TW and MEPD. The CCC operates Monday to Friday from 8 a.m. to 6 p.m. Central time (excluding state holidays). Below are some helpful toll-free numbers: • 800-645-7164 — CHIP provider toll-free telephone line • 877-543-7669 (877-KIDS-NOW) — CHIP and Children's Medicaid toll-free telephone line • 800-735-2988 or 7-1-1 — TDD/TTY users (Relay Texas) Effective Jan. 15, 2013, HHSC centralized the clearance of Income Eligibility and Verification System (IEVS) Internal Revenue Service (IRS) data matches for TW and MEPD. Data matches that OIG identifies for each program are processed by CCC staff. HHSC set up CCCs with the Integrated Eligibility and Enrollment pilot rollout in January 2006.
Assistance Response Team (ART)	ART staff housed throughout the state serve as on-site support to regional staff. These state staff offer TIERS technical support for Texas Works and MEPD on-the-job trainings (OJT), conduct clerical OJTs, offer TIERS technical support to eligibility staff (offer pre-ticket support to all regions to mitigate unneeded tickets), process Texas Works cases based on MEPD email box referrals and Health Insurance Portability and Accountability Act of 1996 (HIPAA) referrals for all regions, and assist State Office Data Integrity with merging assignments. HHSC set up ART with the Integrated Eligibility and Enrollment pilot rollout in January 2006.

Centralized Units That Serve Only MEPD Programs

Unit Name	Description
MEPD	HHSC created a special statewide eligibility unit in January 2007 to process eligibility for MEPD programs. Statewide staff specialize in MEPD eligibility programs to help make sure MEPD casework is evenly distributed. Members of this unit are housed across the state in local eligibility offices.

Centralized Units That Serve Only Texas Works Programs

Unit Name	Description
Centralized Benefit Services (CBS)	Staff in this centralized Austin location process SNAP EDGs for households in which all members get Supplemental Security Income (SSI), using specialized automation that supports the modified eligibility requirements for these households. In addition, the unit also processes applications and redeterminations for: • SNAP Combined Application Project (SNAP-CAP) EDGs; • Medicaid for Breast and Cervical Cancer (MBCC); • Medicaid for children under the jurisdiction of the juvenile court and for youth under age 19 in non-secure facilities; • Medicaid for Transitioning Foster Care Youth (MTFCY); • Former Foster Care Children (FFCC); and • Medicaid for inmates of a public institution; and applications for: • Former Foster Care in Higher Education (FFCHE) health care benefits program.
Children's Medicaid Center (CMC)	Appointed staff process Medicaid requests for babies who are born to mothers incarcerated in Texas. Most babies receive ongoing Medicaid, but factors such as with whom the baby will reside or if the baby will remain in Texas may affect eligibility. When the baby cannot be certified for ongoing newborn Medicaid, the EDG is referred to Data Integrity to add coverage for the birth of the baby under a state-paid medical program. Centralized CMCs process applications and/or renewals for Children's Medicaid and CHIP, but do not process other associated-program case actions, to ensure a streamlined, timely approach. The CMCs are located in regions across the state: • Region 3 (Dallas Metroplex) • Region 6 (Houston) • Region 8 (San Antonio) • Region 11 (Rio Grande Valley) Currently, Regions 3, 6 and 8 have CMCs to process applications and renewals for Children's Medicaid and CHIP for their respective regions.
Region 8 Central Processing Unit	Staff in this centralized Region 8 location process applications and redeterminations for all SNAP-interviewed applications from the Community Partners Interviewer (CPI) Project. This single regional structure simplifies reporting and data gathering; centralizes EBT activities under one EBT coordinator, which streamlines record keeping and adds integrity to the EBT accounting and audit functions; adds efficiency to training activities since there is one location for staff; and enhances accountability as all regional activities will be under one management structure. The five CPI project food banks as of June 2011 were: • Houston Food Bank • North Texas Food Bank • San Antonio Food Bank • Tarrant Area Food Bank • South Plains Food Bank (limited to six counties in Region 1 — Bailey, Crosby, Floyd, Hockley, Lamb and Lubbock)
Healthy Texas Women (HTW)	This center, located in San Antonio, processes statewide HTW applications, changes and renewals. The HTW center also process Form H3038-P, CHIP Perinatal – Emergency Medical Services Certification, for CHIP perinatal mothers.

TWH, Part D, Children's Health Insurance Program (CHIP)

TWH, D-100, Overview

Revision 15-4; Effective October 1, 2015

D—110 General Policy

Revision 15-4; Effective October 1, 2015

CHIP

The Children's Health Insurance Program (CHIP) provides health care coverage for children under age 19 whose family income exceeds the Children's Medicaid income limit but is less than or equal to the applicable income limit for TA 84 (CHIP), defined in C-131.1, Federal Poverty Income Limits (FPIL). Children who qualify and enroll in CHIP receive up to 12 months of continuous coverage and are required to renew eligibility every 12 months. Families with net income above 151 percent of the FPIL are required to pay an enrollment fee. Families with income above 185 percent of the FPIL will have an income check during their sixth month of eligibility. Most families also have copayments for doctor visits, prescription drugs and emergency care.

When an application is received requesting Children's Insurance, the child is first tested for Medicaid eligibility. If ineligible for Medicaid, the child is then tested for CHIP eligibility.

CHIP eligibility is prospective. The effective date is based on whether the Eligibility Determination Group (EDG) is disposed before or after cutoff and when the enrollment process is completed. The Texas Integrated Eligibility Redesign System (TIERS) provides the potential eligibility begin date and Enrollment Broker provides the actual eligibility begin date.

CHIP appears as type of assistance *CI – CHIP (TA 84*) in TIERS.

CHIP Perinatal

CHIP perinatal provides services to unborn children of pregnant women, regardless of age. These pregnant women are ineligible for:

- Medicaid due to income exceeding the applicable income limit for TP 40 defined in C-131.1, Federal Poverty Income Limits (FPIL), but whose household income is at or below the applicable income limit for TA 85 (CHIP Perinatal) defined in C-131.1; or
- Medicaid or CHIP due to immigration status since the pregnant woman is not a citizen or qualified alien.

The unborn children of pregnant women eligible for CHIP perinatal are granted 12 months of continuous enrollment from the month the eligibility determination is made. The 12-month period includes the months of CHIP perinatal coverage before and after birth. The mother receives CHIP coverage related to the birth only; she does not receive personal health care coverage.

CHIP perinatal appears as type of assistance *CI – CHIP perinatal (TA 85*) in TIERS.

Receiving CHIP perinatal does not affect the mother's eligibility for:

- MA-MN with Spend Down (TP 56);
- MA-Pregnant Women – Emergency (TP 36),
- MA-Parents and Caretaker Relatives Medicaid – Emergency (TA 31);
- MA-MN with Spend Down – Emergency (TP 32); or
- MA-Children 6-18 – Emergency (TP 34).

Pregnant women may receive the program(s) above in the same month as CHIP perinatal. This is not considered dual coverage.

When a child is born to a CHIP perinatal mother whose household income is above the applicable income limit for Pregnant Women Medicaid, the child's coverage begins on the date of birth and the mother's coverage is terminated on the last day of the month the birth occurs. The mother is eligible to receive two postpartum visits that may occur after the mother's CHIP perinatal coverage ends. At birth, the child receives perinatal coverage for the remainder of the 12-month eligibility period. The child's CHIP perinatal enrollment is terminated at the end of the 12-month period.

When a child is born to a CHIP perinatal mother whose household income is at or below the applicable income limit for Pregnant Women Medicaid and the mother receives Emergency Medicaid to cover the labor with delivery charges, the advisor must enroll the child in TP 45 effective the child's date of birth. The mother's perinatal coverage ends the last day of the child's birth month or the pregnancy's termination month. The mother is eligible to receive two postpartum visits that may occur after her CHIP perinatal coverage ends.

Related Policy
Adding a New Child, D-1433.1

D—120 Eligibility Qualifications

Revision 08-1; Effective January 1, 2008

D—121 Children's Health Insurance Program (CHIP)

Revision 15-4; Effective October 1, 2015

CHIP

A child must:

- be ineligible for Children's Medicaid;
- not be on Medicare;
- reside in Texas;
- be under age 19;
- be a U.S. citizen or non-citizen with valid proof of immigration/alien status;
- have total household net income at or below the applicable income limit; and
- be uninsured for at least 90 days or claim one of the good cause exemptions to the waiting period explained in D-1723.6, Good Cause Exemptions for Children Subject to the 90-day Waiting Period.

D—122 CHIP Perinatal

Revision 15-4; Effective October 1, 2015

CHIP Perinatal

To be eligible for CHIP perinatal, a woman must:

- be pregnant;
- reside in Texas;
- have total household net income at or below the applicable income limit, depending on family size; and
- be ineligible for ongoing Medicaid and CHIP because of income or immigration status.

A pregnant woman is considered to be an adult the month of her 18th birthday.

A pregnant woman must be determined ineligible for Medicaid and CHIP before being tested for perinatal eligibility. CHIP perinatal coverage begins the first day of the month in which the eligibility determination is made.

The woman's age is calculated as of the month in which the proposed effective date of coverage will occur.

D—122.1 Post-Birth Eligibility Determination

Revision 15-4; Effective October 1, 2015

CHIP Perinatal

A woman is not eligible for perinatal coverage if she applies after the child is born. The advisor must deny the application upon becoming aware that the pregnant woman has delivered or had a miscarriage before the eligibility determination is made. The advisor must then determine whether the newborn is eligible for Medicaid or CHIP.

If the pregnant woman delivers or has a miscarriage before the eligibility determination and the advisor becomes aware of the delivery or miscarriage after the eligibility determination has been made, the woman's coverage is terminated. The woman will receive one month of CHIP perinatal coverage.

D—122.2 Notification of Birth

Revision 13-4; Effective October 1, 2013

CHIP Perinatal

Staff are notified of the perinatal child's birth via the:

- case authority who reports the child's birth by telephone or in writing;
- the newborn file; or
- birth notification from the health plan.

TWH, D-200, Application Processing

Revision 18-1; Effective January 1, 2018

D—210 Application Procedures

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Applications may be received in person, by telephone, fax, email, Internet or mail. Texas Health and Human Services Commission (HHSC) Benefits Offices are equipped with telephones, lobby computers and fax machines for applicants to submit applications.

Households can apply using any of the Medical Program application channels explained in A-113, Application Requests and Submissions.

If the applicant fails to provide a name, address or signature on a faxed or mailed application, consider it an invalid application.

No interview is required for the Children's Health Insurance Program (CHIP) or CHIP perinatal. Schedule an appointment only upon the household's request.

On the same day of the application receipt, advisors mail the applicant Form H0025, HHSC Application for Voter Registration. If the individual contacts HHSC to decline the opportunity to register to vote after receipt of Form H0025, the advisors mail Form H1350, Opportunity to Register to Vote, to the individual for a signature. Advisors send Form H1350 for imaging when the individual returns the form and retain the form for at least 22 months.

Related Policy

Application Processing, A-100
Registering to Vote, A-1521

D—211 Application Assistance

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

If an applicant needs help completing the application packet, a volunteer or staff member must help. The person helping the applicant complete an application must initial the part he/she completed, or sign the application showing that he/she helped complete it.

D—212 Applications Received by Fax, Email, Mail or Internet

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

The applicant's file date is the date the Texas Health and Human Services Commission (HHSC), the Texas Department of Aging and Disability Services (DADS) or an HHSC agent receives an application that contains, at a minimum, the applicant's name, address and signature. A faxed or electronic signature (if using the online application available through YourTexasBenefits.com) is acceptable. A typed signature is not valid if the application is received via fax, mail or in person. If the application does not contain a signature, return the application with Form H1020, Request for Information or Action, requesting a signature.

The file date is the date an application is received at an HHSC Benefits Office or online through YourTexasBenefits.com during state business hours. For applications received outside of state business hours, the file date is established as the next business day.

Once the initial application disposition occurs, requests for coverage for additional types of assistance are handled separately and a new application is required.

D—213 Applications Received by Telephone

Revision 17-1; Effective January 1, 2017

CHIP, CHIP Perinatal

The file date is the date the applicant submits the application by telephone through 2-1-1, and the telephonic application contains the applicant's:

- name;
- address; and
- signature by telephone.

An applicant may complete and sign an application by telephone following the policy for Medical Programs explained at A-122.1, Application Signature.

Related Policy
Application Signature, A-122.1

D—214 Withdrawal of an Application

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

A person with case authority may submit a request to voluntarily disenroll a member. The case authority person must sign and submit the request in writing.

D—215 Authorized Representatives (AR)

Revision 15-4; Effective October 1, 2015

A household may designate an individual or organization as an AR, following the policy explained in A-170, Authorized Representatives (AR).

D—220 Reopening an Application

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

When a household is denied for failure to provide information, the household has until the 60th day after the file date to provide the information without submitting a new application. The date the household submits all of the missing information becomes the new file date. Review the information provided by the household with the information listed on the application to ensure all information remains accurate.

If the household submits the missing information after the time frame, the household must reapply by submitting a new application.

D—230 Application Processing Time Frames

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

Provide Form TF0001, Notice of Case Action, by the:

- 45th day after the file date for an application requesting health care for children.
- 15th working day after the file date for an application requesting health care coverage for a pregnant woman.

D—231 CHIP Perinatal Application

Revision 18-1; Effective January 1, 2018

CHIP Perinatal

Pregnant women who apply for medical assistance are screened for Pregnant Women Medicaid (TP 40). If ineligible for Medicaid, pregnant women under age 19 are tested for CHIP. If ineligible for CHIP because of age, income, or immigration status, pregnant women are tested for CHIP perinatal.

Women certified on CHIP perinatal due to not meeting immigration status requirements and whose household income is at or below Medicaid for Pregnant Women income limits at the time of application must submit Form H3038, Emergency Medical Services Certification, or Form H3038-P, CHIP Perinatal – Emergency Medical Services Certification, to cover the costs of labor and delivery.

Accept the applicant’s (pregnant woman’s, case name’s or authorized representative’s) verbal or written statement of pregnancy, including the start month, number of children expected and the anticipated date of delivery, unless questionable. The woman’s statement would be considered questionable if the information provided regarding the due date is discrepant, such as the pregnancy start month and pregnancy end month are less than or more than nine months apart or if the woman reports a pregnancy with overlapping start and end months.

If questionable, verify the applicant's pregnancy by using:

- Form H3037, Report of Pregnancy; or

- other documentation containing the same information as Form H3037.

The verification must be from an acceptable source such as a physician, hospital, family planning agency, or social service agency.

A physician, nurse, advanced nurse practitioner or other medical professional must sign Form H3037 or another document for it to be considered verification from a medical source. If it is completed by another medical professional, ensure that the information about the supervising physician is provided.

The application contains a field for the number of children expected and the anticipated date of delivery, but does not contain a field for the applicant to enter the pregnancy start month. Staff must use the following procedures when certain information regarding pregnancy is left blank on any application for benefits:

- If the only item missing on the application form is the pregnancy start month, staff must count nine months back from the pregnancy end month to determine the pregnancy start month. The pregnancy end month is month zero.
- If the only item missing on the application form is the pregnancy end month, staff must count nine months from the pregnancy start date to determine the anticipated date of delivery. The pregnancy start month is month zero.
- If both the pregnancy start and end months are missing, attempt to obtain the information by phone. If unable to obtain the information by phone, send Form H1020, Request for Information or Action, to request the information.

If the pregnancy verification is not received by the 15th workday from the request, deny the application. See D-220, Reopening an Application, if the verification is provided after the application is denied.

Related Policy
Pregnancy, A-144.5

D—231.1 Minor Pregnant Women with Potential Medicaid Eligibility

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

If an application is received for a minor pregnant woman, request all missing information and test for potential Medicaid eligibility.

D—240 Missing Information Processing for Applications

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

If additional information is required, send the household Form H1020, Request for Information or Action. Upon receipt of the missing information, determine if the household is eligible.

Allow the household until the final due date to provide all the missing information. If the missing information is not provided by the final due date, deny the application.

If the missing information is received after the application is denied, but by the 60th day, reopen the application following the policy explained in D-220, Reopening an Application.

TWH, D-300, Household Composition

Revision 17-2; Effective April 1, 2017

D—310 Certified Group

Revision 17-2; Effective April 1, 2017

CHIP

A child may be eligible from birth through the month of the child's 19th birthday. Age is self-declared.

The certified group contains only the Children's Health Insurance Program (CHIP) eligible child. Only one child is certified per Eligibility Determination Group (EDG).

CHIP Perinatal

A pregnant woman of any age may qualify for perinatal coverage.

When the pregnant woman is age 18 and it is anticipated that she will turn age 19 before her CHIP enrollment start date, the CHIP coverage is denied. She is tested for Pregnant Women Medicaid (TP 40) and then for CHIP perinatal, if ineligible for Pregnant Women Medicaid (TP 40). If eligible for CHIP perinatal, her enrollment start date is the first day of the eligibility determination month.

Only one pregnant woman is certified per EDG.

If the mother's income is:

- **Above** the applicable income limit for Pregnant Women Medicaid (TP 40), as defined in C-131.1, Federal Poverty Income Limits (FPIL), the mother will be the only individual on the EDG for the majority of the certification period. During the month the child is born, the mother and the child are certified on the same EDG. After the month the child is born, the child is the only individual certified on the EDG.
- **At or below** the applicable income limit for Pregnant Women Medicaid (TP 40), as defined in C-131.1, and the mother receives Emergency Medicaid (TP 36) to cover the birth, the child will be certified on their own Medicaid for Newborn Children (TP 45) EDG.

CHIP, CHIP Perinatal

The following individuals are not eligible to receive CHIP or CHIP perinatal:

- Medicare recipients;
- inmates of a public institution; and
- residents of state supported living centers or institutions.

Exception: A child who is institutionalized (except for inmates of a public institution) during the child's continuous enrollment period remains eligible until the CHIP redetermination.

D—320 Budget Group

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Modified Adjusted Gross Income (MAGI) household composition is used to determine whose needs, income, and expenses are considered in determining an individual's eligibility for CHIP and CHIP perinatal. Each MAGI household composition is determined on the individual level. Individuals living at the same physical address may have a different MAGI household composition. MAGI household composition is based on federal income tax rules.

An individual does not have to file a federal income tax return to apply for CHIP or CHIP perinatal.

D—321 Who Is Included

Revision 16-4; Effective October 1, 2016

CHIP, CHIP Perinatal

Advisors must follow the policy described in A-240, Medical Programs, to determine who should be included in each individual's MAGI household composition.

CHIP

When determining eligibility for a pregnant child, the expected number of the pregnant child's unborn children are included in the pregnant child's MAGI household composition.

CHIP Perinatal

When determining eligibility for a pregnant woman, the expected number of unborn children are included in the pregnant woman's MAGI household composition.

If the CHIP perinatal MAGI household composition includes other pregnant women, the expected number of unborn children of the other pregnant women are also included in the CHIP perinatal MAGI household composition, regardless of whether the other pregnant women are certified on a medical program.

Related Policy

Inclusion of the Unborn, A-241.1.5

D—322 Who Is Not Included

Revision 16-4; Effective October 1, 2016

CHIP, CHIP Perinatal

Advisors must follow the policy described in A-240, Medical Programs, to determine who should be included in each individual's MAGI household composition.

CHIP

The expected number of unborn children are not included in a non-pregnant child's MAGI household composition for CHIP when a pregnant child is included in the household.

D—323 Minor Parent Situations

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Advisors must follow the policy described in A-240, Medical Programs, to determine who should be included in each individual's MAGI household composition.

D—330 Joint Custody

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Either parent may apply on behalf of the child(ren) if they meet the criteria explained in A-121, Receipt of Application for Medical Programs. A custodial parent is established based on the policy explained in A-240, Medical Programs, Living Arrangements.

D—340 Children in State Hospitals

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Children in state hospitals may be eligible as independent children for a 12-month period. In order to be admitted to a state hospital, the child must:

- be under age 19;
- be a U.S. citizen or Lawful Permanent Resident who entered the U.S. prior to Aug. 22, 1996;
- be a ward of HHSC via court civil commitment; or
- have or obtain a Social Security number (SSN).

A representative from the state hospital completes the application and attaches a cover sheet to specify the application is from the state hospital. In addition, the representative attaches copies of unpaid medical bills and, if applicable, Form H1113, Application for Prior Medicaid Coverage.

The application lists the:

- independent child's name as the head of household;
- SSN;
- date of birth;
- parents or UNKNOWN in other parent section;
- income and resources (if any);

Note: Resources are not considered as a factor in determining eligibility for CHIP or CHIP perinatal.

- insurance information;
- dates of service may be in the month of the child's 19th birthday or sooner;
- representative from the state hospital in the authorized representative section;
- signature of the representative from the state hospital who completed the application; and
- address of the state hospital in the residence and mailing address section, except for Terrell State Hospital (Terrell State Hospital lists the independent child's original residence address and the facility address in the mailing address).

If the independent child has no income, no other information is required to complete the application processing.

CHIP

An institutionalized child is not eligible to apply for CHIP. **Exception:** When a child is currently enrolled in CHIP and enters a state mental health facility, the child remains enrolled in CHIP until the end of the child's current enrollment segment.

TWH, D-400, Citizenship and Alien Status

Revision 15-4; Effective October 1, 2015

D—410 General Policy

Revision 15-4; Effective October 1, 2015

CHIP

An individual must be a U.S. citizen or alien with acceptable status to qualify for the Children’s Health Insurance Program (CHIP). The date of entry does not apply.

Review the alien status document from the U.S. Citizenship and Immigration Services (USCIS) and status code to determine the immigration/alien status. Refer to A-342, TANF and Medical Programs Alien Status Eligibility Charts.

CHIP Perinatal

A pregnant woman does not have to meet the citizenship or alien status requirements in order to be eligible for CHIP perinatal.

Applicants who possess temporary visas are eligible for CHIP perinatal as long as they meet residency eligibility requirements. See D-700, Residency.

Pregnant women potentially eligible for Medicaid who fail to provide verification of citizenship or alien status are not eligible for CHIP perinatal.

D—420 Citizenship

Revision 11-4; Effective October 1, 2011

CHIP, CHIP Perinatal

U.S. citizens meet the citizenship criteria for CHIP and CHIP perinatal. U.S. citizens are persons born:

- in the 50 states, District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, America Samoa, Swain's Island or Northern Marianna Islands; or
- abroad to at least one parent who is a U.S. citizen. The child may claim derivative citizenship.

D—430 Immigration/Alien Status

Revision 13-4; Effective October 1, 2013

CHIP

Qualifying immigrants and non-immigrants, as defined in A-311.1, Definition of Qualified Immigrant, are eligible for CHIP regardless of the date of entry. Review the alien status document and code to determine if the child meets the immigration/alien status requirements. Refer to A-342, TANF and Medical Programs Alien Status Eligibility Charts.

CHIP Perinatal

Immigration/alien status is not applicable to CHIP perinatal.

D—440 Verification

Revision 08-1; Effective January 1, 2008

D—441 Citizenship

Revision 11-4; Effective October 1, 2011

CHIP

CHIP applicants or recipients who declare that they are U.S. citizens must provide verification of citizenship.

Use Medicaid Programs proof/verification sources found in A-358.1, Citizenship, for citizenship and A-621, Verification Sources, for identity.

CHIP Perinatal

Citizenship is self-declared.

D—441.1 Reasonable Opportunity to Provide Citizenship and Alien Status Verification

Revision 15-4; Effective October 1, 2015

CHIP

CHIP applicants or recipients who declare themselves to be a U.S. citizen or declare an alien status, but for whom verification is unavailable, must be allowed a period of reasonable opportunity explained in A-351.1, Reasonable Opportunity.

D—441.2 Using State Online Query (SOLQ) or Wire Third-Party Query (WTPY) to Verify Citizenship

Revision 15-4; Effective October 1, 2015

CHIP

If an applicant has a Social Security number, use SOLQ or WTPY to verify citizenship. See A-351.2, Using State Online Query (SOLQ) or Wire Third-Party Query (WTPY) to Verify Citizenship.

D—442 Using Systematic Alien Verification for Entitlements (SAVE) Program to Verify Alien Status

Revision 15-4; Effective October 1, 2015

CHIP

Access the Verification Information System (VIS) through the USCIS using the Department of Homeland Security's SAVE program for verification validity.

Do not reverify an alien's documents if the non-citizen status was previously verified and documented, and the documents have not expired. If the USCIS document is expired, and the alien wants to continue receiving or reapplies for benefits, then request updated documents. If the family fails to provide the updated documents, the child cannot receive benefits.

CHIP Perinatal

Immigration status is self-declared. The pregnant woman may be:

- a U.S. citizen,
- a lawful permanent resident, or
- an undocumented alien.

Do not trigger missing information for immigration status or date of entry.

CHIP, CHIP Perinatal

If the applicant provides documents other than those listed in A-358.2, Alien Status, take the following action to request additional verification:

- complete Form G-845, Document Verification Request;
- attach fully readable photocopies (front and back) of original immigration documents containing the alien's registration number; and
- mail one set of copies to the USCIS office serving the county of application (see the instructions to Form G-845).

If the applicant's name changed since the alien registration card was issued, the applicant must provide verification of the change.

If the alien is otherwise eligible, do not delay or deny the child's eligibility while waiting for a response from USCIS. When USCIS returns Form G-845, follow these procedures:

If the response indicates that the alien's document is...	then ...
valid,	document the detailed information and send the documents for imaging.
not valid and the child is enrolled,	• take adverse action to disqualify the child or deny the case, as appropriate; and • process a fraud referral.

TWH, D-500, Social Security Number

Revision 15-4; Effective October 1, 2015

D—510 Social Security Enumeration

Revision 15-4; Effective October 1, 2015

CHIP

All Children's Health Insurance Program (CHIP) applicants must provide a Social Security number (SSN), and advisors must verify citizenship and SSN at application using State Online Query (SOLQ) or Wire Third-Party Query (WTPY) and the process explained in A-351.2, Using State Online Query (SOLQ) or Wire Third-Party Query (WTPY) to Verify Citizenship.

If an applicant cannot provide an SSN, the advisor must verify that the applicant has applied for an SSN.

If an applicant does not have an SSN and does not meet a good cause reason for Medical Programs as explained in A-410, General Policy, the agency must follow the process explained in A-411, Determining Advisor Action at Application.

Non-applicants are not required to provide an SSN or proof of an application for an SSN. When non-applicants provide an SSN, advisors may attempt to verify the SSN using the procedures explained in A-440, Verification Requirements. If verification is not available through electronic data sources, verification must not be requested from the applicant.

CHIP Perinatal

A pregnant woman is not required to provide or apply for an SSN.

The applicant is not required to provide SSNs for other members included in the budget group. If SSNs are provided, they shall be recorded and the advisor may attempt to verify the SSN using the procedures explained in A-440, Verification Requirements. If verification is not available through electronic data sources, verification of the SSN must not be requested from the applicant.

D—520 Verification Sources

Revision 15-4; Effective October 1, 2015

CHIP

For SSN discrepancies or SSNs that cannot be verified through SOLQ or WTPY, the family must provide one of the following:

- Copy of the child's SSN card; or
- Social Security Administration letter confirming the child's SSN.

Acceptable proof of application of an SSN includes:

- Form SSA-5028, Receipt for Application for an SSN, less than 30 days old;
- Form SSA-2853, Message From Social Security, less than 180 days old; or
- Form H1106, Enumeration Referral.

TWH, D-600, Identity

Revision 15-4; Effective October 1, 2015

D—610 General Policy

Revision 10-2; Effective April 1, 2010

D—611 Application

Revision 15-4; Effective October 1, 2015

CHIP

Advisors must verify the identity of all individuals applying for Medical coverage. Once identity has been verified for an individual, advisors do not re-verify.

CHIP Perinatal

Identity is self-declared.

D—612 Renewals

Revision 15-4; Effective October 1, 2015

CHIP

Advisors must verify the identity of the certified individual if identity has not been previously verified.

D—620 Verification Requirements

Revision 15-4; Effective October 1, 2015

CHIP

Birth records and other official records are preferred sources of verification.

Advisors use proof/verification sources from the list under Medical Programs in A-621, Verification Sources. Once identity has been verified for an individual, advisors do not re-verify.

Note: If an applicant/recipient receives reasonable opportunity, verification of identity will be required when the reasonable opportunity period expires.

D—630 Documentation Requirements

Revision 10-2; Effective April 1, 2010

CHIP

Document the source of identity proof/verification.

TWH, D-700, Residency

Revision 11-4; Effective October 1, 2011

D—710 General Policy

Revision 11-4; Effective October 1, 2011

CHIP, CHIP Perinatal

An eligible applicant must be a Texas resident. Residency in Texas is self-declared. An applying person does not lose resident status when out of state for less than a 12-month period.

Applicants meet the residency requirement if they live in Texas and intend to make Texas their home. The household is not required to have a permanent dwelling or fixed residence. A Texas residence address listed on the application meets the "intent to make Texas their home" rule.

People who live in Texas for a temporary purpose do not meet the residency requirement.

Migrant and itinerant workers meet the residency requirement when applying if they:

- live in Texas,
- entered Texas with a job commitment or an intention to seek employment (regardless of current employment status), and
- do not receive assistance from another state.

TWH, D-800, Child Support

Revision 11-4; Effective October 1, 2011

D—810 General Policy

Revision 11-4; Effective October 1, 2011

CHIP, CHIP Perinatal

Child support requirements do not apply to CHIP. Applicants may obtain child and medical support assistance by contacting the Office of Attorney General.

TWH, D-900, Resources

Revision 15-4; Effective October 1, 2015

D—910 General Policy

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Resources are not considered as a factor in determining eligibility for the Children's Health Insurance Program (CHIP) or CHIP perinatal.

TWH, D-1000, Income

Revision 15-4; Effective October 1, 2015

D—1010 General Policy

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Income is any type of payment that is of gain or benefit to a household. Income is either counted or exempted from the budgeting process. Earned income is related to employment and entitles a household to deductions not allowed for unearned income. Unearned income is income received without performing work-related activities. It includes benefits from other programs. To determine the date income can reasonably be anticipated, the advisor should use factors specific to the source of income, distance it has to travel through the mail, weekends and holidays.

Advisors must use Modified Adjusted Gross Income (MAGI) rules to determine financial eligibility for the Children's Health Insurance Program (CHIP) and CHIP perinatal following the Medical Programs policy, explained in A-1300, Income.

D—1020 Income Limits

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Income limits for CHIP and CHIP perinatal are defined in C-131.1, Federal Poverty Income Limits (FPIL).

D—1030 Types of Income

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Use the Medical Programs policy, explained in A-1320, Types of Income, to determine the countable and exempt income types for CHIP and CHIP perinatal.

D—1040 Reserved

Revision 15-4; Effective October 1, 2015

D—1050 Calculating Household Income

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

For CHIP and CHIP perinatal, each individual's MAGI household income is calculated following the Medical Programs policy explained in A-1341, Income Limits and Eligibility Tests.

D—1051 Income Frequency

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Income received must be converted to a monthly amount, unless received monthly. Advisors must use the following conversion factors. (Monthly pay means that the employee is paid once a month.)

Income Frequency	Conversion Factor
Weekly (paid once every week)	Multiply by 4.33
Bi-weekly (paid every other week)	Multiply by 2.17
Semi-monthly (paid twice a month)	Multiply by 2.0
Annually (paid once a year)	Divide by 12

If the income frequency cannot be determined based on the information listed on the application or from the verification, the advisor must generate Form H1020, Request for Information or Action, to request the income frequency.

D—1052 Terminated Income

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Count terminated income in the month received. Use actual income and do not use conversion factors if terminated income is less than a full month's income. If the income terminated in the application month, the advisor must request missing information to verify the termination. Self-declaration is not acceptable verification.

D—1053 Budget Months

Revision 15-4; Effective October 1, 2015

CHIP

The system will determine CHIP eligibility for the following months:

At Application

- Application month
- Process month

At Redetermination

The month following the last month of CHIP coverage.

D—1060 Verification Requirements

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Income verification requirements for CHIP and CHIP perinatal align with the Medical Programs policy explained in A-1370, Verification Requirements.

D—1061 Verification Sources

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Determining whether client-reported income is reasonably compatible with electronic data sources is the preferred method of wage verification for CHIP and CHIP perinatal. Reasonable compatibility is explained in A-1370, Verification Requirements, Medical Programs.

Other income verification sources for CHIP and CHIP perinatal align with the Children’s Medicaid (TP 33, TP 34, TP 35, TP 43, TP 44 and TP 48) policy explained in A-1371, Verification Sources.

D—1070 Documentation Requirements

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Exempt Income

Document:

- why it is exempt, and
- the name and address or telephone number of the income source.

Terminated Income

Document:

- the name and address or telephone number of the income source, and
- vacation pay received before or after termination, including the dates received.

Income

Document the:

- date of each income statement or stub used;
- date income is actually received;
- date income is anticipated using factors such as time it has to travel via mail, weekends and holidays;
- name and address or telephone number of the income source;
- gross amount of income;
- frequency of receipt (such as weekly, every two weeks, semi-monthly, monthly); and
- calculations used.

Income Computations

Document verification and computation of household income at the initial application, when a change is reported and at each subsequent application/redetermination. Record all sources, amounts, dates and computations.

Other Income

Document the method used to verify income other than earned income. This documentation includes the type of income, the check or document seen, the date on the check or document, the amount recorded on the check or document, the date the income was verified and any computations performed to determine the total income.

Self-Employment

Document:

- the method for averaging income;
- deductions for the cost of doing business;
- the number of hours engaged in the enterprise;
- other factors used to determine the amount of income;
- that the individual was informed to keep self-employment records and receipts for verification purposes for future recertifications; and
- when using Form H1049, Client's Statement of Self-Employment Income, as the only source of verification, the reason Form H1049 is the only source of income.

TWH, D-1100, Deductions

Revision 15-4; Effective October 1, 2015

D—1110 General Policy

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Households may be allowed the Modified Adjusted Gross Income (MAGI) deductions explained in A-1410, General Policy, for Medical Programs.

D—1120 Reserved

Revision 15-4; Effective October 1, 2015

D—1130 Verification Requirements

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

The deduction verification requirements for the Children's Health Insurance Program (CHIP) and CHIP perinatal align with the Medical Programs policy explained in A-1440, Verification Requirements.

D—1131 Verification Sources

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

The deduction verification sources for CHIP and CHIP perinatal align with those for Medical Programs explained in A-1441, Verification Sources.

D—1140 Documentation Requirements

Revision 11-4; Effective October 1, 2011

CHIP, CHIP Perinatal

Document:

- amount of expense,
- who pays the expense,
- how often the expense is paid,
- to whom the expense is paid,
- calculations used to determine monthly amounts, and
- justification for not allowing the deduction.

TWH, D-1200, Third-Party Resources

Revision 15-4; Effective October 1, 2015

D—1210 Health Insurance

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Third-party resources (TPR) are sources of payment for medical expenses other than the recipient or Medicaid. TPR includes payments from private and public health insurance and from other liable third parties that can be applied toward the recipient's medical expenses. **Note:** Separate dental or vision plans, auto, workers' compensation, county medical discount cards, student accident, travel insurance or sports-related insurance are not considered TPRs.

Consider Medicare a TPR. Do not certify a Medicare recipient for the Children's Health Insurance Program (CHIP) or CHIP perinatal.

CHIP

Households that have health insurance in which the monthly premium amount for the child(ren) costs:

- less than 5 percent of the household's net income in the application month are not eligible for CHIP coverage.
- 5 percent or more of the household's net income in the application month are eligible for CHIP coverage. However, the household must drop the insurance before CHIP coverage begins. Children cannot be covered by CHIP and health insurance at the same time. These children are not subject to the 90-day waiting period, as explained in D-1723.6, Good Cause Exemptions for Children Subject to the 90-Day Waiting Period.

Households that have health insurance in which the monthly premium amount for the family's coverage that includes the child(ren) costs:

- less than 9.5 percent of the household's net income in the application month are not eligible for CHIP coverage.
- 9.5 percent or more of the household's net income in the application month are eligible for CHIP coverage. However, the household must drop the insurance before CHIP coverage begins. Children cannot be covered by CHIP and health insurance at the same time. These children are not subject to the 90-day waiting period, as explained in D-1723.6.

When the family reports TPR at application or redetermination, send Form H1020, Request for Information or Action, to request:

- a coverage end date,
- the monthly premium amount for the child(ren) or for family coverage that includes the child(ren), and
- information that will verify the insurance policy.

Deny the CHIP Eligibility Determination Group (EDG) if the household does not provide the verification by the due date and the verification is required for all certified group members. If the verification is not required for all individuals, the affected individual will be disqualified.

Acceptable verification of the private health insurance end date includes:

- health insurance ID card indicating the end date,
- letter from the employer indicating the end date, or
- the individual's statement by phone or in writing.

At any time during the child's enrollment segment, if the Texas Health and Human Services Commission (HHSC) is notified that the child remains on health insurance or that the child has Medicare (the household did not drop the TPR at application or redetermination), the child is denied and disenrolled.

If a household reports that it has obtained health insurance during the continuous enrollment period, document the change and process the change at the next redetermination.

The Texas Integrated Eligibility Redesign System (TIERS) will pend the TPR logical unit of work at redetermination when HHSC receives TPR information via the TPR interface for a child currently eligible or enrolled in CHIP.

Related Policy
Third Party Resources Changes, D-1437
Health Insurance, D-1632.2
Exceptions to the Continuous Enrollment Period, D-1731

CHIP Perinatal

Pregnant women with any type of private health insurance are not eligible for perinatal coverage, even if the current health insurance does not provide maternity coverage. Pregnant women cannot be covered by perinatal and private health insurance at the same time.

The 5 percent and 9.5 percent rules regarding monthly premium costs compared to the household's monthly net income that apply to CHIP do not apply to CHIP perinatal.

Related Policy
Third Party Resources Changes, D-1437
Exceptions to the Continuous Enrollment Period, D-1731

TWH, D-1300, Case Disposition

Revision 15-4; Effective October 1, 2015

D—1310 General Policy

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Case disposition is the result of the eligibility determination once all required information is obtained and an individual's notice of eligibility status is generated.

The notice explains if the case/application is pended, certified, sustained or denied.
The household must submit all missing information by the 45th calendar day from the file date. If the family fails to submit the required information timely, the application is denied.

When an eligibility determination is made, the household is notified of the child's eligibility status in writing. In addition, households must be informed in the denial and disenrollment letter of:

- their rights and responsibilities;
- right to request a review of the case decision; and
- commercial insurance options through a referral to the Texas Department of Insurance toll-free telephone number at 1-800-252-3439 and the website at www.texashealthoptions.com.

The system automatically sends individuals determined ineligible for Medicaid and the Children's Health Insurance Program (CHIP) at application, redetermination or when processing a change to the Marketplace for an eligibility determination for federal health care coverage programs.

To qualify for the federal health care coverage programs, all individuals must first be determined ineligible for Medicaid and CHIP. Advisors must test whether an individual is eligible for all Medical Programs. The Texas Works Medical Programs Hierarchy, explained in A-132.1, Medical Programs Hierarchy, does this automatically for most clients.

Note: Advisors must follow a manual process when retesting eligibility for a minor parent aging out of CHIP, as explained in A-2342.1, Retesting Eligibility.

D—1320 Notice of Decision

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

Form TF0001, Notice of Case Action, advises the household of the:

- potential household eligibility and who is potentially eligible;
- need for the household to return a health plan selection and enrollment fee, if required;
- reason the application was denied, terminated or reinstated;
- effective date of the denial, termination or reinstatement; and
- right to request a review.

D—1330 Correspondence Processing

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

CHIP correspondence refers to written documents or a request for review from a household or applicant for enrollment into CHIP. Correspondence may be submitted online at YourTexasBenefits.com, by fax, or through the mail. Uploaded, faxed, or hard copy correspondence documents are linked with the appropriate case. Types of correspondence may include:

- provider claims;
- plan transfer form or letter;
- letter requesting address or name change;
- missing information requested by CHIP through application processing;
- requests for disenrollment;
- enrollment requests;
- request for review of an eligibility or enrollment decision; and
- cost share updates.

TWH, D-1400, Changes

Revision 17-2; Effective April 1, 2017

D—1410 General Policy

Revision 17-2; Effective April 1, 2017

CHIP, CHIP Perinatal

Changes are situations in a household that may affect eligibility. Action must be taken on reported changes to ensure program integrity.

Cost share adjustments are handled by the Enrollment Broker at application, redetermination and the six-month income check.

When a change is processed that is missing required information, send Form H1020, Request for Information or Action, within one business day from the report date. Allow the household 10 full days to provide the requested information or verification. Action must be taken on the change within one business day of receipt of the missing information.

D—1420 Reporting Requirements

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Households must report the following changes to:

- address;
- intent to reside in Texas;
- the individuals living in the home;
- income, including sources of income, regular hours worked, and pay rate;
- Modified Adjusted Gross Income (MAGI) expenses;
- pregnancy termination;
- a child being institutionalized or dying; and
- medical insurance coverage.

Exceptions: A child is disenrolled if the child reapplies and becomes eligible for Medicaid or at the end of the month of the child's 19th birthday.

Process all other changes, including agency-generated changes, at the time of report.

D—1421 How to Report

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Persons with case authority may report changes by one of the following means:

- online through YourTexasBenefits.com;
- in person at a Texas Health and Human Services Commission Benefits Office;
- telephone;
- mail;
- fax;
- Form H1019, Report of Change, and;
- signed Form H1028, Employment Verification.

A person with case authority is an individual who has the authority to apply on the child's behalf, as explained in A-121, Receipt of Application, for Medical Programs.

D—1422 Receipts for Reported Changes

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

Households may request a receipt to acknowledge the change report. The receipt includes the type of change(s) and the date reported. If an individual requests a receipt, issue Form H1800, Receipt for Application/Medicaid Report/Verification/Report of Change.

D—1430 Processing Requirements

Revision 08-1; Effective January 1, 2008

D—1431 Address Change Processing

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

The case address is updated when the household reports an address change.

If the household reports a change of address, the individual is mailed Form H0025, HHSC Application for Voter Registration, to register to vote based on the new address. If the individual declines the opportunity to register to vote after receipt of Form H0025, mail Form H1350, Opportunity to Register to Vote, to the individual for their signature. Send Form H1350 for imaging when the individual returns Form and retain Form for at least 22 months.

Related Policy
Registering to Vote, A-1521

D—1432 Moves

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

For moves within Texas, the case is updated to reflect the newly reported address.

For moves outside of Texas, the case is updated to reflect the:

- temporary address, if the move is temporary.
- address and disenrolls the child as soon as possible, if the move is permanent.

D—1433 Household Composition Changes

Revision 15-4; Effective October 1, 2015

CHIP Perinatal

No action is taken on a request to add or remove a non-certified person from an existing perinatal Eligibility Determination Group (EDG).

D—1433.1 Adding a New Child

Revision 17-2; Effective April 1, 2017

CHIP, CHIP Perinatal

A separate application is required to initiate benefits for a new child being added if there is not an existing Medicaid or Children's Health Insurance Program (CHIP) EDG on the case. A separate application is also required if a household requests benefits for a sibling of a child released from a juvenile facility whose TP 44 eligibility is reinstated to a denied or newly created case. See policy in A-121, Receipt of Application, for TP 43, TP 44, and TP 48.

CHIP

When a household reports a new child in the household, determine if the child meets Medicaid eligibility criteria. If the child is eligible, only the new child is certified for Medicaid and the remaining children remain on CHIP through the end of the continuous eligibility period.

Note: If the Texas Juvenile Justice Department (TJJD) or Juvenile Probation Department (JPD) reports via the TJJD/JPD Released Logical Unit of Work that a child was released from a juvenile facility and is now living in the household, TIERS automatically tests the child's eligibility for Medicaid.

If the child is ineligible for Medicaid but eligible for CHIP and has siblings or a parent currently enrolled in the program, they are considered to meet good cause. TIERS calculates the child's effective date of coverage for the next possible month following cutoff. The child will receive the remaining months of coverage with the siblings or parent. The coverage end date is the same date as the child's currently enrolled siblings or parent. The new child may not receive the full 12 months of coverage and is required to renew coverage along with the child’s siblings or parent on the scheduled renewal date.

Once the child is determined eligible for CHIP, TIERS notifies the Enrollment Broker via an interface. The Enrollment Broker generates and mails a welcome letter to the household.

CHIP Perinatal

Income Above the Limit for Medicaid for Pregnant Women (TP 40)

A child born to a CHIP perinatal mother whose household income is above the income limit for Pregnant Women Medicaid (TP 40), defined in C-131.1, Federal Poverty Income Limits (FPIL), will have an effective date beginning with the date of birth and continuing through the remainder of the 12-month CHIP perinatal enrollment segment. The mother's perinatal coverage ends the last day of the child's birth month or the pregnancy's termination month. The mother will receive two postpartum visits even if they are beyond the birth month.

Example: A pregnant mother is approved for CHIP perinatal effective June 1. The child is born on October 4. The newborn's effective date of coverage is October 4, and the end date is May 30. The mother's perinatal coverage ends October 31.

A perinatal child whose coverage ends, and who has siblings currently enrolled in CHIP, meets good cause upon determination of CHIP eligibility. The child's enrollment start date is the first day of the month following the perinatal end date. The child's CHIP end date is the end date of the existing CHIP enrollment segment. The child may not receive the 12 months of CHIP coverage and must renew eligibility in accordance with the existing CHIP redetermination date.

Income at or Below the Limit for Medicaid for Pregnant Women (TP 40)

A child born to a CHIP perinatal mother whose household income is at or below the income limit for Pregnant Women Medicaid (TP 40), defined in C-131.1, Federal Poverty Income Limits (FPIL), and who receives Emergency Medicaid to cover the labor with delivery charges will be enrolled in TP 45 coverage effective the date of birth. The mother's perinatal coverage ends the last day of the child's birth month or the pregnancy's termination month. The mother will receive two postpartum visits even if they are beyond the birth month.

Related Policy
CHIP Perinatal Application Process, A-128.3
Neonatal Intensive Care Unit (NICU) Newborn Process, A-126.3.1

D—1433.2 Child Leaves the Home

Revision 17-2; Effective April 1, 2017

CHIP

Under MAGI household composition rules, explained in A-240, Medical Programs, a certified child leaving the home may or may not affect their continued eligibility for CHIP based on their tax status, tax relationships, and family relationships.

When a child dies, terminate the child’s eligibility effective the last day of the month the child died.

When the Texas Juvenile Justice Department (TJJD) or Juvenile Probation Department (JPD) reports that a child was placed in a juvenile facility via the TJJD/JPD Placement Logical Unit of Work in TIERS, the child's eligibility is terminated effective the day after the report of the placement. If the report of a child's placement is received from another source, terminate the child's eligibility following cutoff rules.

D—1433.3 Child Institutionalized

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

When a certified child enters a state hospital or institution for a temporary absence, the child remains enrolled for the remainder of the 12-month period. See A-920, Temporary Absence From the Home, to determine if stay is considered a temporary absence.

D—1433.4 Head of Household

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Under MAGI household composition rules, explained in A-240, Medical Programs, a head of household leaving the home may or may not affect eligibility depending on that person's tax status, tax relationships, and family relationships.

Related Policy
Who Is Included, D-321
New Head of Household, D-1632.1

D—1434 Demographic Changes

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

A demographic change is a change to a person's identifying information, such as date of birth, Social Security number (SSN), gender or name.

Process these changes and do not interrupt the child's continuous coverage.

D—1435 Pregnancy Reports

Revision 15-4; Effective October 1, 2015

CHIP

When a household reports a CHIP child's pregnancy before her CHIP end date, the child is tested for Pregnant Women Medicaid (TP 40) and verification of the pregnancy is requested. A verbal or written statement of pregnancy from the pregnant child, case name or authorized representative that includes the pregnancy start month, number of children expected and the anticipated date of delivery is an acceptable verification source. If potentially eligible and the household provides the pregnancy verification, the child is terminated from CHIP and certified for Medicaid.

If the pregnant child is determined ineligible for Pregnant Women Medicaid (TP 40), she remains in CHIP up to two months beyond the original CHIP end date if the pregnancy due date is in the 11th or 12th month of her CHIP coverage, unless the:

- pregnant child reports pregnancy termination,
- household reports she has other insurance,
- pregnant child no longer lives in Texas, or
- pregnant child turns age 19.

Before the pregnancy ends, extend coverage for:

- one month if the pregnancy due date is in the 11th month of the CHIP certification; or
- two months if the pregnancy due date is in the 12th month of the CHIP certification.

If the household does not report a CHIP child's pregnancy until she gives birth or later, the child remains in CHIP, and the CHIP child's newborn is tested for Medicaid eligibility. If eligible, the newborn is certified for Children Under Age One Medicaid (TP 43). If not eligible, the newborn is enrolled in the mother's CHIP health plan. The effective date of CHIP coverage is the next possible month following cutoff. The newborn's CHIP coverage ends with the household's current enrollment segment.

Related Policy
Adding a New Child, D-1433.1

D—1436 Income and Deduction Changes

Revision 13-4; Effective October 1, 2013

CHIP

If the household reports a change in income and requests that its cost share responsibilities be recalculated, refer the household to the Enrollment Broker.

D—1437 Third Party Resources Changes

Revision 15-4; Effective October 1, 2015

CHIP

If a household reports that they have obtained health insurance during the continuous enrollment period, document the change and process the change at the next redetermination.

Related Policy
Health Insurance, D-1632.2

CHIP Perinatal

Do not take any action if a woman reports private health insurance coverage during her certification period.

TWH, D-1500, Six-Month Income Check

Revision 15-4; Effective October 1, 2015

D—1510 General Information

Revision 15-4; Effective October 1, 2015

CHIP

Children certified on the Children's Health Insurance Program (CHIP) with income above 185 percent of the Federal Poverty Income Level (FPIL) will have a six-month income check to determine whether the child remains financially eligible.

An automated income check, explained in B-637, Periodic Income Checks, for CHIP, is run in the fifth month of the certification period when the following conditions have been met:

- The client's income at application was above 185 percent of FPIL;
- The individual will not age out before or during the fifth month;
- Any of the following is true for at least one individual in the Modified Adjusted Gross Income (MAGI) household for at least one countable income or expense source:
  - An income or expense is not verified;
  - One of the following income types uses "Verified by Reasonable Compatibility" as the verification source:
    - Employment income;
    - Unemployment compensation income; or
    - Retirement, Survivors, and Disability Insurance (RSDI) income; or
  - The verification source is anything other than "Verified by Reasonable Compatibility" and the verification received date is more than 60 days old;
- The case is in Approved Ongoing Mode; and

- There are no pending Task List Manager (TLM) tasks for the case.

The result of the income check may impact eligibility in the seventh month.

The household is provided at least 30 days advance notice prior to disenrollment. The household is entitled to a request for review and continued enrollment based on actions related to the six-month income check. **Exception**: The household is not eligible for continued enrollment if the denial is because the household failed to provide the information requested during the six-month income check.

If the household's income is at or below the applicable income limit for CHIP, the household remains on CHIP.

At the six-month income check, the Texas Integrated Eligibility Redesign System (TIERS) will send updated eligibility status or cost share details to the CHIP enrollment broker.

Note: CHIP perinatal households are not subject to the income check.

Related Policy
Periodic Income Checks, B-637
Exceptions to the Continuous Enrollment Period, D-1731
Request for Review, D-1920

TWH, D-1600, Redeterminations

Revision 15-4; Effective October 1, 2015

D—1610 General Policy

Revision 15-4; Effective October 1, 2015

CHIP

Individuals enrolled in the Children's Health Insurance Program (CHIP) must complete the administrative renewal process explained in B-122.4, Medical Program Administrative Renewals.

Depending on the renewal status outcome and client action, final eligibility determinations for CHIP may be made manually by advisors processing renewal documents or automatically by the system.

For individuals required to return a renewal packet, advisors must process the manual renewal as explained in B-122.4.2, Processing a Manual Renewal, while following the timelines explained in D-1630, Timely Redeterminations, and D-1631, Redetermination Processing Time Frames.

CHIP Perinatal

There is no redetermination of CHIP perinatal coverage. The household is mailed a packet during the ninth month of eligibility, allowing the household to apply for medical coverage for the child.

D—1620 Notice of Expiration

Revision 15-4; Effective October 1, 2015

CHIP

The system generates and sends renewal correspondence to individuals enrolled in CHIP following the process explained in B-121, Notice of Redetermination/Certification Expiration, for TP 08 and Children's Medicaid (TP 43, TP 44 and TP 48).

CHIP Perinatal

A packet is mailed to the household after cutoff in the ninth month of coverage. This mailing occurs over a five-day period. The household is instructed to complete the application, attach verification and return the application within seven days.

In the 10th month of the perinatal enrollment segment, TIERS determines if the case has both a CHIP and a CHIP perinatal Eligibility Determination Group (EDG). If the CHIP perinatal enrollment segment ends before the end of the CHIP enrollment segment, the perinatal child is added to the CHIP EDG if the child is not eligible for Medicaid.

D—1621 Redetermination Reminder Notifications

Revision 15-4; Effective October 1, 2015

CHIP

Form H1014-A, Children's Health Care Benefits – Final Reminder, is mailed to individuals who are required to return a signed renewal form as part of the administrative renewal process, as explained in B-122.4, Medical Program Administrative Renewals, and have not returned the packet. Form H1014-A is sent to individuals who have not responded by the first calendar day of the 11th month of coverage.

The letter reminds households that coverage will end if the completed redetermination form is not received.

D—1630 Timely Redeterminations

Revision 15-4; Effective October 1, 2015

CHIP

A CHIP redetermination is considered received timely when received by cutoff of the 11th month of the certification period. This allows time for the enrollment process to be completed by the cutoff of the 12th month to avoid the client having a break in coverage.

D—1631 Redetermination Processing Time Frames

Revision 15-4; Effective October 1, 2015

CHIP

For individuals required to return a renewal form for CHIP, staff must process renewals, received timely or untimely, by the 30th day from the date the renewal form is received or by cutoff of the 11th month of the certification period, whichever is later.

When an acceptable Medical Programs renewal form is not returned, the system automatically makes an eligibility determination through a mass update based on the eligibility outcome from the automated renewal process. This does not require the advisor to run eligibility or dispose the EDG.

If the renewal form is received after the date of denial, advisors follow the policy for TP 08, TP 43, TP 44 and TP 48 explained in B-124, Processing Untimely Redeterminations.

D—1632 Changes Reported at Redetermination

Revision 13-4; Effective October 1, 2013

D—1632.1 New Head of Household

Revision 15-4; Effective October 1, 2015

CHIP

Accept a renewal form as valid when it is received reflecting a new head of household who is not someone with existing case authority.

Take the following action:

- accept the application and link it to the existing case,
- create a new case number for the household, and
- certify the new case to begin the month after the old case coverage ends.

D—1632.2 Health Insurance

Revision 15-4; Effective October 1, 2015

CHIP

When a household reports that it has acquired health insurance, determine if:

- The monthly premium amount for the child(ren) is less than 5 percent of the household's net income; or
- The monthly premium amount for the family's health insurance that includes the child(ren) is less than 9.5 percent of the household's net income.

If the health insurance coverage meets one of the scenarios above, deny the CHIP EDG.

If the health insurance coverage does not meet either of the scenarios above, the child(ren) is(are) still eligible for CHIP, but the household must drop the insurance in order to continue to receive CHIP. Send Form H1020, Request for Information or Action, to the household requesting proof of the insurance end date. If the household does not provide proof, the child(ren) is(are) no longer eligible for CHIP. Deny the CHIP EDG.

Acceptable verification of the private health insurance end date includes:

- health insurance identification card indicating the end date,
- letter from the employer indicating the end date, or
- individual's statement by phone or in writing.

Related Policy
Health Insurance, D-1210
Third Party Resources Changes, D-1437
Exceptions to Continuous Enrollment Period, D-1731

D—1633 Missing Information

Revision 15-4; Effective October 1, 2015

CHIP

During the automated renewal process, electronic data is used to automatically verify the following required verifications for CHIP:

- Income and expenses, and
- Immigration status.

Depending on the outcome of the automated renewal process, the system generates and sends renewal correspondence, including Form H1020, Request for Information or Action, if more information is needed, to individuals enrolled in CHIP following the process explained

in B-121, Notice of Redetermination/Certification Expiration, for TP 08 and Children's Medicaid (TP 43, TP 44 and TP 48).

All missing information must be received before cutoff of the 11th month of the coverage period to receive continuous coverage. If the missing information is received before cutoff of the child's 11th month of coverage, update the EDG with the new information. If the information is received after cutoff of the 11th month of coverage, there may be a break in CHIP coverage.

When a renewal is denied due to failure to provide information or verification, advisors follow the policy for TP 08, TP 43, TP 44 and TP 48 explained in B-122.3.2, Denied for Failure to Provide Information/Verification.

Households that complete the redetermination process (eligibility and enrollment) by cutoff in the 11th month of the eligibility period and remain eligible will be enrolled for a new 12-month period. If the individual fails to pay the enrollment fee by cutoff of the first month of the new 12-month period, the EDG is placed in a Pending Enrollment Fee and/or Plan Selection and/or TPR Delay status for up to three months. If the household pays the enrollment fee within the three months, the EDG is reinstated and the child(ren) receive the remainder of the 12-month enrollment segment beginning with the month of reinstatement.

D—1634 Redetermination Application Complete

Revision 13-4; Effective October 1, 2013

CHIP

Once the household completes the redetermination and is eligible for CHIP, health care coverage begins the first of the next possible month after the household pays the applicable enrollment fee.

Households that complete the redetermination process receive a Form TF0001, Notice of Case Action, indicating the potential outcome for each child. If an enrollment fee is due, the Enrollment Broker sends the household a payment coupon and return envelope. The enrollment fee due date is set to 10 calendar days.

D—1634.1 Missing Enrollment Fee

Revision 15-4; Effective October 1, 2015

CHIP

If a household completes the redetermination process, but does not pay the applicable enrollment fee by the cutoff date of the 12th month, the child receives a one-month extension of CHIP coverage. The Enrollment Broker mails the family a letter to inform the family of the one-month extension and the requirement to pay the enrollment fee by cutoff in the first month of the new 12-month period, in order to continue coverage. The extended month of coverage is counted as month one in the new 12-month enrollment segment.

The Enrollment Fee Extension (EFX) letter is mailed the first week of the first month of the new 12-month enrollment segment. The letter advises households that the household must pay the enrollment fee to continue the child(ren)'s coverage.

If the household:

- pays the enrollment fee by cutoff of the first month of its new 12-month period, then the child remains enrolled for the remainder of the 12-month period.
- does not pay the enrollment fee by cutoff of the first month of the new 12-month period, then the child is disenrolled. The EDG is placed in Pending Enrollment Fee and/or Plan Selection and/or TPR Delay status starting the second month, for a period of up to three months.

If the household pays the enrollment fee after the:

- cutoff of the first month in the new 12-month period, but before the cutoff of what would have been the second month, then the child is suspended for one month and reinstated the following month for the remainder of the 12-month enrollment segment.
- second month's cutoff and before the third month's cutoff, then the child is suspended for two months and reinstated the following month for the remainder of the 12-month enrollment segment.
- third month's cutoff and before the fourth month's cutoff, then the child is suspended for three months and reinstated the following month for the remainder of the 12-month enrollment segment.
- cutoff of the fourth month, the application is denied and the household must reapply.

Note: If the payment is returned with non-sufficient funds (NSF), an NSF letter is mailed to the household as if the household had not paid the enrollment fee, and the EDG is placed on Pending Enrollment Fee and/or Plan Selection and/or TPR Delay status the following month.

D—1635 Redetermination Applications Eligible for Medicaid

Revision 14-3; Effective July 1, 2014

CHIP

When processing a redetermination application, test the application for Medicaid eligibility. If a child in the CHIP household is eligible for Medicaid and the action is processed:

- before cutoff, CHIP coverage ends the last day of the current month. Medicaid coverage begins the first day of the next month.
- after cutoff, CHIP coverage ends the last day of the following month. Medicaid coverage begins the first day of the month following the next month.

Any children in the household who are ineligible for Medicaid remain on CHIP through the end of the current CHIP certification period. They are then certified with a new CHIP certification period if they continue to be eligible for CHIP.

A child who is eligible for Medicaid based on income, and who has reported that she is pregnant, is denied at the end of the next possible month and certified for Medicaid. If the pregnancy due date is later than the end date of her CHIP coverage month and she is not eligible for Medicaid, she continues on CHIP through the end of the current certification period. Certify her with a new certification period if she continues to be eligible for CHIP.

If the household no longer qualifies for CHIP, deny the CHIP EDG at the end of the CHIP certification period. Send the household Form TF0001, Notice of Case Action, notifying the household that the child is no longer eligible for CHIP.

Related Policy
Advisor Action for Determining Eligibility for Children, A-126.3

TWH, D-1700, Enrollment

Revision 17-2; Effective April 1, 2017

D—1710 General Information

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Once determined eligible for the Children's Health Insurance Program (CHIP) or CHIP perinatal, households must complete the enrollment process in order to receive benefits. The enrollment process includes choosing a health and dental plan and paying an enrollment fee, if applicable.

CHIP

CHIP eligibility is prospective. TIERS provides the potential eligibility begin date and the Enrollment Broker provides the actual eligibility begin date.

The earliest a child can be eligible for CHIP is based on cutoff rules. When the Eligibility Determination Group (EDG) is disposed on or before the cutoff date, the potential eligibility begin date is the first of the month following the disposition month. When the EDG is disposed after cutoff, the potential eligibility begin date is the first of the second month following the disposition month.

Example 1 – Disposed on or before cutoff:

Disposed May 1, 2015; eligible June 1, 2015

Example 2 – Disposed after cutoff:

Disposed May 23, 2015; eligible July 1, 2015

D—1711 Expedited CHIP Enrollment

Revision 17-2; Effective April 1, 2017

Individuals who transfer during their non-continuous eligibility period to CHIP before their Medicaid certification period ends and who owe a CHIP enrollment fee may be eligible for expedited CHIP enrollment, with no gap in coverage if they are certified for one of the following Medicaid types of assistance:

- MA-Pregnant Women (TP 40);
- MA-Children Under 1 (TP 43);
- MA-Children 6-18 (TP 44); and
- MA-Children 1-5 (TP 48).

Individuals who meet the criteria may be enrolled in CHIP beginning the first of the month following their last month on Medicaid even when an enrollment fee is due but not yet paid.

The following case actions are eligible for expedited CHIP enrollment:

- Periodic Income Check (PIC) (except TP 40);
- change;
- appeal and reactivation due to change or PIC; and
- renewal processed by an advisor resulting in a shortened Medicaid certification period (except TP 40).

The following case actions are **not** eligible for expedited CHIP enrollment:

- application;
- appeal and reactivation due to reason other than change or PIC;
- retesting eligibility; and
- third party resources.

If determined eligible for CHIP, the Enrollment Broker will send an enrollment packet to households with eligible members. The enrollment packet will indicate the enrollment fee and options for selecting a health and dental plan.

Expedited CHIP enrollment is only applicable when transferring from Medicaid to CHIP when an enrollment fee is owed to ensure health coverage is maintained with no gap in coverage. Once the enrollment fee is paid in full, the household follows normal CHIP policy and procedure. If the enrollment fee is not paid by the deadline, the household is disenrolled.

Households who do not owe an enrollment fee do not qualify for Expedited CHIP Enrollment and are enrolled in CHIP and defaulted into a plan following current policies and procedures and cutoff rules if a health and/or dental plan is not selected.

Related Policy
Medicaid Termination, A-825
Enrollment Fees at Application, D-1821
Expedited CHIP Enrollment Process, D-1720.1
Involuntary Disenrollment, D-1761
Denial at Redetermination, A-2342
Eligibility Transition from Medicaid to CHIP, B-123.4
Actions on Changes, B-631
Periodic Income Checks, B-637

D—1720 Enrollment Process

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

The Enrollment Broker receives an enrollment request that consists of member information for the eligible members on a daily basis. The Enrollment Broker sends an enrollment packet or confirmation notice to households with eligible members within three business days of

receipt of the eligibility information. The household completes the enrollment process by choosing a health plan and dental plan and by paying a fee, if applicable.

Once the enrollment process is complete, the household is mailed an enrollment confirmation letter confirming the child's enrollment start date.

Related Policy
Dental Providers, D-1751

D—1720.1 Enrollment Packets

Revision 17-2; Effective April 1, 2017

CHIP

Households eligible for expedited CHIP enrollment are enrolled in CHIP beginning the first of the month following their last month on Medicaid. This occurs even when a fee is due but not yet paid, with no gap in coverage. The household is given at least 90 days to pay the enrollment fee and remains enrolled pending payment of the enrollment fee.

For households determined eligible for expedited CHIP enrollment, the length of the expedited CHIP enrollment period depends upon when HHSC completes the action:

When action is processed during the classification period ...	Length of Expedited CHIP Enrollment period is ...
Before or on cutoff of the 5th month	Up to three months.
After cutoff of the 5th month Note: This includes changes completed in the 6th, 7th, 8th, 9th, 10th, and 11th month.	Up to four months.

If the fee is not paid by the due date, all individuals in the household enrolled in CHIP are disenrolled. The household must reapply for benefits and would follow normal CHIP processing. In reapplying for benefits, the household would not be eligible for expedited CHIP enrollment.

If the fee is paid by the due date, all individuals in the household remain enrolled in CHIP and receive the remainder of the 12-month CHIP certification period. The months a household received CHIP coverage through expedited CHIP enrollment count towards the 12-month CHIP certification period.

Notes:

- The six-month continuous eligibility period of Medicaid is **not** impacted regardless of when HHSC completes the change.
- Households that transfer to CHIP and do not owe an enrollment fee follow current policies and procedures and are enrolled in CHIP and defaulted into a plan following cutoff rules. These households are not eligible for expedited enrollment.

Related Policy
Expedited CHIP Enrollment, D-1711
Enrollment and Non-Sufficient Funds, D-1723.4
Involuntary Disenrollment, D-1761

D—1721 Enrollment Packets

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

The enrollment packet includes a variety of information including a Welcome Letter, cost share requirement information, and health and dental plan choice information.

CHIP

Enrollment packets are mailed to all households. The enrollment packet includes the:

- enrollment/transfer form;
- enrollment return envelope;
- comparison chart of the value-added services provided by the health plans;
- explanation of CHIP benefits;
- Welcome Letter that includes –
    - cost sharing information, if applicable, specific to the income level of the household receiving the enrollment packet; and
    - cost share limit amount for households required to pay cost sharing. This amount is a percentage of the household's net income and reflects the maximum amount of health care expenses and cost sharing payments that a household is obligated to pay during a term of coverage.
- flier summarizing the importance of the health plan selection;
- CHIP member guide; and
- enrollment fee invoice and envelope, if applicable.

Households that are not required to pay an enrollment fee, or that paid the enrollment fee but did not select a health plan, are defaulted into the available health plan and sent an enrollment confirmation notice.

CHIP Perinatal

CHIP perinatal members are not subject to cost sharing. All members receive an enrollment packet. The enrollment packet includes the:

- enrollment/transfer form;
- enrollment return envelope;
- comparison chart of the value-added services provided by the health plans;
- explanation of benefits;
- flier summarizing the importance of the health plan selection; and
- CHIP perinatal member guide.

D—1722 Children with Special Health Care Needs

Revision 15-4; Effective October 1, 2015

CHIP

The enrollment packet includes a list of questions as determined by the Texas Health and Human Services Commission (HHSC) to identify Children with Special Health Care Needs (CSHCN).

Health plans evaluate and confirm whether a child meets the CSHCN criteria by contacting the self-identified families. If the plan determines the child does not meet the CSHCN criteria, the plan sends the CSHCN status determination to the Enrollment Broker.

The Enrollment Broker reports the number of CSHCN monthly.

D—1723 Selecting a Health Plan

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Households can make a health plan selection by telephone, online, or by submitting a completed Enrollment Transfer Form (ETF) by mail or fax. If the selection is made by telephone, the requirement for a signed enrollment form is waived.

Households that do not choose a health plan are automatically defaulted into a health plan. Families are notified that they have been defaulted and are given 90 days to choose a new health plan.

CHIP

Individuals with case authority select the health plan for CHIP-eligible children. Households that fail to choose a health plan are defaulted into a health plan.

Information concerning CHIP health plans and the areas covered is available at yourtexasbenefits.hhsc.texas.gov/programs/health/child/childrens-medicaid.

Upon completion of the enrollment process, the system triggers an Enrollment Confirmation Notice (ECN) that informs the household of each CHIP-eligible child's:

- unique identification number;
- enrollment start date;
- selected or assigned health plan;
- applicable copays; and
- cost share limit, if applicable.

The ECN includes a Medical Payments Form (MPF). The MPF helps the household track expenditures by date, event and amount. See D-1800, Cost Sharing.

If a child is subsequently added to a CHIP-enrolled case, the Enrollment Broker mails the household an ECN.

CHIP Perinatal

Individuals with case authority select a health plan for CHIP perinatal eligible children. Households that do not select a health plan are defaulted into a health plan.

Information concerning CHIP perinatal health plans and the areas covered is available at www.hhsc.state.tx.us/chip/perinatal/CHIPPerinatalHMOsbyServiceArea.pdf.

Upon completion of the enrollment process, the system triggers an ECN that includes the pregnant woman's:

- unique identification number,
- enrollment start date, and
- selected or assigned health plan.

Related Policy
Health Plan Change, D-1740

D—1723.1 Enrollment Reminder Notification

Revision 13-4; Effective October 1, 2013

CHIP

Fifteen calendar days after the enrollment packets are mailed, an enrollment reminder notification is mailed to households that fail to select a health plan and/or pay the enrollment fee.

If the household does not respond within 90 calendar days of mailing the enrollment packet and the household fails to pay any required enrollment fee, the EDG is denied and the household must submit a new application.

D—1723.2 Missing Information Processing for Enrollment Forms

Revision 15-4; Effective October 1, 2015

CHIP

Missing information for an enrollment form must be received within 90 calendar days of the date the Welcome Packet is mailed.

When all missing information is received before cutoff of the month before the member's enrollment start date (and within 90 calendar days of the date the Welcome Packet is mailed), the Enrollment Broker updates the enrollment information and the child's/children's enrollment start date is recalculated to the first day of the next possible month.

After 90 calendar days from the day the Welcome Packet is mailed, if the enrollment fee is not received, the Enrollment Broker sends an eligibility request to deny for non-payment. The denial letter informs the household that the enrollment missing information was not received or was received beyond the required period, and the household must submit a new application and reapply.

D—1723.3 Address Change While Pending Enrollment

Revision 15-4; Effective October 1, 2015

CHIP

At initial application, health plan changes are allowed when the household moves to a new coverage service area and enrollment is complete, but pending a future enrollment start date due to the 90-day waiting period or cutoff.

D—1723.4 Enrollment and Non-Sufficient Funds

Revision 17-2; Effective April 1, 2017

CHIP

Households with children in a pended status, determined to have paid the enrollment fee with non-sufficient funds (NSF), do not receive health care coverage until the enrollment fee is received and processed. The household must submit the enrollment fee in full so that the child(ren) can be moved to a CHIP-eligible status. Households have 90 calendar days to submit the enrollment fee. If the household's payment is received before the due date, the child(ren) is (are) enrolled, based on the scheduled coverage date or the first month thereafter, and receives a new enrollment segment of 12 months.

If a child has an active enrollment segment and the Enrollment Broker determines the enrollment fee as NSF, the child is disenrolled at the next possible month, and the household must submit payment via money order, cashier's check, or debit or credit card via YourTexasBenefits.com. Once the household submits an acceptable payment, the Enrollment Broker re-establishes the child's enrollment the next possible month and provides the remaining months of coverage.

The following chart shows NSF situations and the action taken by the Enrollment Broker in each situation.

If the enrollment fee is...	then the Enrollment Broker...
returned with NSF before cutoff of the first month of a new 12-month enrollment period,	disenrolls the child and places the case in suspension starting in the second month for a period of up to three months.
submitted by a replacement payment after the extension month cutoff but before renewal month four cutoff,	reopens the case in the following month for the remainder of the 12-month period.
returned with NSF before the extension month cutoff and no replacement payment is made by renewal month four cutoff (the end of the suspension period),	does not reopen the case. The household must submit a new application.
returned with NSF after the extension month cutoff and a replacement payment is made before renewal month two cutoff,	continues enrollment for the remainder of the 12-month period.
returned with NSF after the extension month cutoff and a replacement payment is received after renewal month two cutoff but before renewal month three cutoff,	disenrolls the child and suspends the case for one month. The case is reinstated for the remainder of the 12-month period (nine more months).
returned with NSF after the extension month cutoff and a replacement payment is received after renewal month three cutoff but before renewal month four cutoff,	disenrolls the child and suspends the case for two months. The case is reinstated for the remainder of the 12-month period (eight more months).
returned with NSF after the extension month cutoff and a replacement payment is not made before renewal month four cutoff,	does not reopen the case. The household must submit a new application.

Related Policy
Missing Enrollment Fee, D-1634.1

Expedited CHIP Enrollment

Households whose enrollment fee returns with NSF will be disenrolled and must reapply for benefits.

Related Policy
Expedited CHIP Enrollment, D-1711
Expedited CHIP Enrollment Process, D-1720.1

D—1723.5 Coverage Start Dates

Revision 15-4; Effective October 1, 2015

CHIP

If the enrollment process is completed prior to cutoff, the coverage start date begins the first of the following month, unless the household is subject to the 90-day waiting period or has a future Medicaid end date.

If the enrollment process is completed after cutoff, the coverage start date begins the first of the second month following the disposition month, unless the household is subject to the 90-day waiting period or has a future Medicaid end date.

Example 1 – Enrollment completed on or before cutoff:

Enrollment completed May 1, 2015; coverage starts June 1, 2015

Example 2 – Enrollment completed after cutoff:

Enrollment completed May 23, 2015; coverage starts July 1, 2015

For children subject to the 90-day waiting period, the coverage start date is 90 days (three calendar months) after the last month in which the child was covered by a third-party health benefits plan, as long as the enrollment fee is paid.

The waiting period only applies to children who were covered by a third-party health benefits plan (private health insurance) at any time during the 90 days (three calendar months) before the date of application for CHIP. The good cause exemptions apply to children subject to the waiting period. See D-1723.6, Good Cause Exemptions for Children Subject to the 90-day Waiting Period.

CHIP Perinatal

The coverage start date begins the first day of the month in which eligibility is determined. When the child is born, the child begins coverage on the date of birth. The mother may receive two postpartum visits.

D—1723.5.1 Coverage Start Date for Adding a Child

Revision 15-4; Effective October 1, 2015

CHIP

The CHIP coverage start date is coordinated with the Medicaid end date, if applicable.

D—1723.6 Good Cause Exemptions for Children Subject to the 90-day Waiting Period

Revision 15-4; Effective October 1, 2015

CHIP

The waiting period for CHIP enrollment may be waived if the household claims one of the following good cause exemptions:

- A parent's insurance benefit under the Consolidated Omnibus Budget Reconciliation Act of 1984 (COBRA) is terminated;
- A change in a parent's marital status;
- The child is no longer covered by the Texas Employee Retirement System;
- Loss of CHIP eligibility from another state;
- Involuntary loss of insurance coverage;
- The employer stops offering health insurance coverage for dependents (or any coverage);
- A change in employment, including involuntary separation, resulting in the child's loss of coverage (other than through full payment of the premium by the parent under COBRA);
- Loss of Medicaid coverage for any reason;
- Loss of coverage in any insurance affordability program, including Advanced Premium Tax Credits (APTCs), Cost Sharing Reductions (CSRs), Medicaid, and CHIP;
- The premium paid by the family for coverage of the child under the group health plan is more than 5 percent of the Modified Adjusted Gross Income (MAGI) household income;
- The premium that a family pays for the family's coverage that includes the child is more than 9.5 percent of the MAGI household income;
- Death of a parent;
- The child has special health care needs;
- HHSC determines that good cause exists based on information provided by the applicant or information otherwise obtained by the agency; or
- HHSC Directive — other reasons for an exemption that have not yet been defined by HHSC.

An applicant may declare good cause at any point during the application processing or after eligibility is determined. An applicant may claim a good cause exemption as follows:

- On Form H1010, Texas Works Application for Assistance — Your Texas Benefits:
  - Addendum, Section 5 – Insurance Offered Through Your Job; and
  - Appendix A, Health Coverage From Jobs;
- On Form H1010-M, Applying for or Renewing Medicaid or CHIP?:
  - Addendum, Section 5 – Insurance Offered Through Your Job; and
  - Appendix A, Health Coverage From Jobs;
- On Form H1205, Texas Streamlined Application:
  - Step 5 – Your Family's Health Coverage; and
  - Appendix A, Health Coverage From Jobs;
- Online at YourTexasBenefits.com;
- By telephone; or
- In writing.

Staff must accept the client's self-declaration of a good cause exemption to the CHIP 90-day waiting period, except as follows.

Staff must not grant the applicant or client a good cause exemption to the CHIP 90-day waiting period if:

- the applicant selects "other" as the reason the insurance from a job ended;
- the end date of the health insurance coverage from a job is left blank; or
- the cost of the insurance coverage from a job is left blank.

Children exempt from the 90-day waiting period whose households subsequently report a change that nullifies the exemption become subject to the 90-day waiting period. The child(ren)'s scheduled coverage date is determined from the date the eligibility determination is made.

CHIP Perinatal

There is no 90-day waiting period for CHIP perinatal. Good cause exemptions do not apply.

Note: A perinatal child whose coverage ends, and who has siblings currently enrolled in CHIP, meets good cause upon determination of CHIP eligibility. The system calculates the child's enrollment start date as the first day of the month following the perinatal end date. The child's CHIP end date is the end date of the existing CHIP enrollment segment.

D—1723.6.1 CHIP Good Cause and Account Transfers

Revision 15-4; Effective October 1, 2015

CHIP

If a client is determined eligible for CHIP but is subject to the 90-day waiting period, HHSC will transfer that individual's account information to the Marketplace to be assessed for eligibility for other health care coverage programs. This allows the individual access to coverage during the 90-day waiting period and to avoid sanctions for failing to acquire health coverage.

D—1730 Continuous Enrollment Period

Revision 15-4; Effective October 1, 2015

CHIP

Children are granted 12 months of continuous coverage. **Note:** Households with income above 185 percent of the Federal Poverty Income Limit (FPIL) are subject to the six-month income check. See D-1510, General Information.

CHIP Perinatal

CHIP perinatal recipients are granted 12 months of continuous enrollment from the first day of the eligibility determination month. The 12-month period includes the months of CHIP perinatal coverage before and subsequent to birth. When the child is born, if the household's income was above the income limit for TP 40, defined in C-131.1, Federal Poverty Income Limits (FPIL), the child's coverage begins on the date of birth. The pregnant woman's coverage ends on the last day of the month that the child is born. The child's enrollment ends at the end of the original 12-month segment.

The child receives full CHIP benefits from the date of birth through the end of the continuous perinatal enrollment segment. Subsequent to delivery, the mother of the perinatal child qualifies for two postpartum care visits.

If a household reports a change in household size or income that would otherwise impact the household's eligibility, there is no disruption to the child's active enrollment segment.

D—1731 Exceptions to the Continuous Enrollment Period

Revision 17-2; Effective April 1, 2017

CHIP

The following are exceptions to the period of continuous enrollment:

- a child who is determined eligible for coverage on a date subsequent to the beginning of coverage for at least one sibling;
- a child age 19;
- a pregnant child who is eligible for Medicaid;
- current Children's Medicaid coverage;
- confirmation that the child remains on health insurance (the household did not drop the third-party resource [TPR] at application or redetermination);
- the household submits a new application and the child is eligible for Medicaid;
- the household submitted a request for review because the household failed to provide information requested during the six-month income check;
- the household did not submit a redetermination packet;
- confirmation that the child no longer lives in the state;
- the case authority requests disenrollment in writing; or
- a child becomes an inmate of a public institution.

Note: Households with income above 185 percent of the FPIL are subject to the six-month income check. See D-1510, General Information.

CHIP Perinatal

The following are exceptions to the period of continuous enrollment:

- current Medicaid coverage;
- confirmation of current health insurance coverage;
- confirmation that the woman or newborn no longer lives in the state;
- the case authority requests disenrollment in writing;
- termination of pregnancy with no live birth;
- the birth is not reported by two months after the expected due date; or
- the mother was determined eligible after the birth month of the child.

Related Policy
Health Insurance, D-1210
Third Party Resources Changes, D-1437
Health Insurance, D-1632.2

D—1732 Pregnant Members Aging Out of CHIP

Revision 15-4; Effective October 1, 2015

CHIP

A pregnant CHIP member who ages out of CHIP before her expected due date and who is determined eligible for CHIP perinatal is enrolled in perinatal beginning the first day of the month following her CHIP end date.

D—1740 Health Plan Change

Revision 15-4; Effective October 1, 2015

CHIP

Households are eligible to change health plans for any reason up to 90 calendar days after the enrollment start date. There is no limit to the number of times a household may change plans within that time frame. In addition, households may change health plans once per year at redetermination for any reason or during the child's enrollment segment for specific reasons.

The household may request and complete a health plan transfer:

- by phone,
- in writing using the Enrollment/Transfer form submitted by fax or mailed to:

HHSC
PO Box 149023
Austin, TX 78714-9023

- by Interactive Voice Response (IVR), or
- online using YourTexasBenefits.com.

CHIP Perinatal

Households are eligible to change health plans for any reason up to 120 calendar days after the enrollment start date. There is no limit to the number of times a household may change plans within that time frame. Households may change health plans during the enrollment segment for specific reasons.

The household may request and complete a health plan transfer:

- by phone,

- in writing using the Enrollment/Transfer form submitted by fax or mailed to:

HHSC
PO Box 149023
Austin, TX 78714-9023

- by IVR, or
- online using YourTexasBenefits.com.

Related Policy
Plan Change During Current Enrollment Segment, D-1741

D—1741 Plan Change During Current Enrollment Segment

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Following the first 90 days of CHIP enrollment or 120 days for CHIP perinatal, a household is allowed to change health plans during the child's enrollment segment if the household:

- permanently relocates to a different health maintenance organization service delivery area.
- permanently relocates to a different location within a service area and this relocation would necessitate a change in primary care provider.
- has good cause to request a plan change. A household's request to change health plans on the basis of good cause can be approved in limited situations, and HHSC determines the situations that constitute good cause.
- is unable to receive the service the member is seeking because the plan does not cover the service because of moral or religious objections.
- needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.
- has other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs.

A household may submit a request for a health plan change or disenrollment to the Enrollment Broker, who reviews and considers each request on an individual basis. If the household disagrees with the decision, the household may request a review. The household, health plan and Enrollment Broker receive notification from HHSC regarding disposition of the review.

D—1742 Plan Change at Redetermination

Revision 15-4; Effective October 1, 2015

Households can change health plans once per year during redetermination.

If the household’s request for a health plan change is received by the cutoff date of the last month of the child's certification period, the ECN letter is sent to inform the household of the new health plan selection.

For a household with health plan change information processed after the cutoff date of its last month of certification, a grace period extends to the cutoff date of the first month of the child's new certification period. The household's CHIP coverage continues under the original health plan through the end of the first month of the child's new certification period. Coverage under the new health plan begins the first day of the following month. The household is sent the Health Plan Transfer (HCC) letter informing the household of the new health plan selection.

Health plan change requests received by the Enrollment Broker as part of the redetermination process are applied to the new certification period and do not affect the current certification period, unless the requests are submitted due to a change of address or other good cause reason.

Once the health plan change form is received and processed, additional enrollment health plan changes are granted for address changes and other good cause reasons only.

D—1743 Redetermination Indicates a Change of Address

Revision 15-4; Effective October 1, 2015

CHIP

If the redetermination form indicates a household moved and now has different health plan options, a Health Plan Change (HPC) letter is mailed to the household and includes:

- a health plan change form;
- a comparison chart that includes a value-added service matrix;
- the health plan change/redetermination instruction letter; and
- a self-addressed stamped envelope.

The health plan change/redetermination instruction letter informs the household they may change health plans:

- by phone,
- in writing using the Enrollment/Transfer form submitted by fax or mailed to:

  HHSC
  PO Box 149023
  Austin, TX 78714-9023

- by IVR, or
- online using YourTexasBenefits.com.

The Enrollment Broker must receive the completed health plan change form before enrolling a household in a new health plan. A household that moves to an area of choice remains with its current health plan until the Enrollment Broker receives the completed health plan change form or the health plan transfer is completed by phone. If the household reports the change of address online, the household is also able to make a health plan change online. If the household does not return its completed health plan change form by the cutoff of its last month of certification, the household is enrolled in the next available health plan using a default process. The household is sent the ECN informing the household of the new health plan selection.

The child is enrolled in the designated health plan during the next certification period.

D—1750 Dental Benefits

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

All children enrolled in CHIP are eligible to receive dental benefits. Dental benefits include both therapeutic and preventive services. CHIP perinatal pregnant women do not receive dental benefits. However, upon birth, the newborn is eligible for dental benefits. The dental benefit is for a 12-month period that is the same as the child's 12-month enrollment period. **Note:** Children with private dental insurance still qualify for CHIP.

Households are required to pay copayments for dental services. Dental office visit copays are assessed at the office visit copay rate. The applicable copayment requirements are:

Coverage Description	Up to 151% FPIL	Greater than (>) 151% to (<=) 186% FPIL	Greater Than (>) 186% to (<=) 201% FPIL
Office visit	$5	$20	$25
Non-emergency ER visit	$5	$75	$75

Coverage Description	Up to 151% FPIL	Greater than (>) 151% to (<=) 186% FPIL	Greater Than (>) 186% to (<=) 201% FPIL
Generic prescription	$0	$10	$10
Name-brand prescription	$5	$35	$35
Inpatient hospital care (per admission)	$35	$75	$125

D—1751 Dental Providers

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

DentaQuest and Managed Care of North America (MCNA) Dental are the dental managed care organizations (DMOs) for dental benefits. Eligible CHIP households receive an enrollment packet that provides information on the DMOs available in their area and how to choose a dental plan. The packet contains plan comparison charts, an enrollment form and a business reply envelope. A 30-day reminder letter is sent to households that have not made a dental plan selection. CHIP households make a dental plan selection through the following options:

- by phone,
- in writing using the Enrollment/Transfer form submitted by fax or mailed to:

HHSC
PO Box 149023
Austin, TX 78714-9023

- by IVR, or
- online using YourTexasBenefits.com.

Related Policy
Enrollment Process, D-1720

D—1760 Disenrollment

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

The applicant or someone with case authority may request disenrollment at any time. Disenrollment requests received and processed before the current month's cutoff are effective at the end of the current month unless the applicant requests a specific date. Disenrollment requests received after cutoff of the current month are effective the next possible month. When the request is due to death, the member is disenrolled effective the last day of the month the member died.

Upon completion of processing the disenrollment request, Form TF0001, Notice of Case Action, is sent to the household. Form TF0001 informs the household of the reason the member's coverage is ending.

Once eligibility has been terminated, members will be disenrolled.

Regardless of the disenrollment reason or month, if a member has received at least one month of CHIP coverage, the household is not eligible for a refund of the enrollment fee.

D—1761 Involuntary Disenrollment

Revision 17-2; Effective April 1, 2017

CHIP

Verbal notification is sufficient to generate an involuntary disenrollment for a CHIP-enrolled child. Reasons for involuntary disenrollment include:

- aging out when the child turns age 19;
- the household moves out of state;
- the death of a child;
- a child is certified for Medicaid;
- notification of pregnancy;
- if a household is eligible for expedited CHIP enrollment while owing an enrollment fee and does not pay the fee by the due date;
- self-disclosure of the child's non-lawful permanent resident, non-qualified alien or non-U.S. citizen status; and
- direction by HHSC based on evidence that the child's original eligibility determination was incorrect.

CHIP Perinatal

Verbal notification is sufficient to generate an involuntary disenrollment for women enrolled in CHIP perinatal. Reasons for involuntary disenrollment include:

- the pregnant woman is enrolled in Medicaid;
- a household submits a new application and specifically requests Medicaid in writing once the perinatal child is born;
- the confirmation is received that the pregnant woman has private health insurance;
- the woman is disenrolled on the last day of the month in which the pregnancy terminates without a live birth, and the EDG is denied;
- no birth is reported by two months after the expected due date;
- a child with special needs (who requires neonatal intensive care) is retroactively disenrolled back to the child's date of birth; and
- a household moves out of state.

D—1762 Health Plan Request to Disenroll a Member

Revision 15-4; Effective October 1, 2015

CHIP, CHIP Perinatal

Based on Texas Department of Insurance guidelines, a limited number of situations exist when a health plan may request the disenrollment of a member from its plan.

The situations in which a health plan may request the disenrollment of a member are limited to one or more of the following:

- fraud or intentional material misrepresentation (coverage may be cancelled after not less than 15 days written notice from the Enrollment Broker to the member).
- fraud in the use of services or facilities (coverage may be cancelled after not less than 15 days written notice from the Enrollment Broker to the member).
- misconduct detrimental to safe plan operations and the delivery of services (coverage may be cancelled by the Enrollment Broker immediately).
- failure of the enrollee and a plan physician to establish a satisfactory patient/physician relationship if it is shown that the plan has, in good faith, provided the enrollee with the opportunity to select an alternative plan physician. The enrollee is notified in writing that the plan considers the patient/physician relationship to be unsatisfactory and specifies the changes that are necessary in order to avoid disenrollment, and the enrollee has failed to make such changes (coverage may be cancelled 30 days following written notice from the Enrollment Broker to the member).

The Enrollment Broker has the option of enrolling the member in another health plan and notifies the second plan of the reason for disenrollment from the first.

TWH, D-1800, Cost Sharing

Revision 17-2; Effective April 1, 2017

D—1810 General Information

Revision 13-4; Effective October 1, 2013

CHIP

There are two types of cost share obligations – enrollment fees and copayments. Most CHIP eligible households are subject to cost share obligations. **Exceptions:**

- households with gross income at or below 150% of the Federal Poverty Income Limit (FPIL) are not subject to an enrollment fee;
- American Indians and Alaska Natives are exempt from all cost sharing. American Indian or Alaska Native status is self-declared on the application. If one child within the household is an American Indian or Alaska Native, the entire household application has American Indian or Alaska Native status; and
- unaccompanied refugee minors are exempt from all cost sharing.

Cost sharing is processed by the Enrollment Broker.

CHIP Perinatal

CHIP perinatal recipients are not subject to cost share obligations. Perinatal recipients do not pay enrollment fees or copayments.

D—1820 Enrollment Fees

Revision 13-4; Effective October 1, 2013

CHIP

An enrollment fee is assessed before initial enrollment and at redetermination. The enrollment fee is money submitted by a family for CHIP coverage to the Enrollment Broker. The amount of the enrollment fee is based on the household's FPIL and covers the continuous enrollment period. All enrollment fee requirements are assessed on a per-household basis, not on a per-child basis.

Enrollment fees are:

- $0 for households with net income at or below 150% FPIL;
- $35 for households with net income above 150% up to and including 185% FPIL; and
- $50 for households with net income above 185% up to and including 200% FPIL.

Related Policy
General Information, D-1810

D—1821 Enrollment Fees at Application

Revision 17-2; Effective April 1, 2017

CHIP

Eligible children cannot enroll and receive covered benefits before receipt of the enrollment fee.

Exception: Children determined eligible for expedited CHIP enrollment can enroll and receive covered benefits before receipt of the enrollment fee. See D-1711, Expedited CHIP Enrollment.

D—1821.1 Change During the Enrollment Process

Revision 13-4; Effective October 1, 2013

CHIP

If during the enrollment process, a reported change alters the cost share obligation, the child or children begin health care coverage based on the payment requirement of the current eligibility determination. The household is charged or credited the difference and a letter is sent to the household explaining the change.

D—1822 Enrollment Fees at Redetermination

Revision 13-4; Effective October 1, 2013

CHIP

Households must pay the enrollment fee at redetermination before continuing coverage.

D—1822.1 Request for Review and Continued Benefits

Revision 13-4; Effective October 1, 2013

CHIP

If the redetermination is denied due to income and the household requests a review and continued enrollment coverage in a timely manner, the enrollment fee is waived until the request for review staff reviews the eligibility. If the household is determined eligible for CHIP, the Enrollment Broker will send the household an enrollment packet to request the enrollment fees. See D-1920, Request for Review.

D—1823 Enrollment Fee Payment Processing

Revision 13-4; Effective October 1, 2013

CHIP

Enrollment fee payments can be submitted in one of the following ways.

Method of Payment at Initial Enrollment:

- money order,
- personal check (not valid if original payment is non-sufficient funds),
- cashier's check, or
- credit card via www.yourtexasbenefits.com.

Method of Payment at Redetermination:

- money order,
- personal check,
- cashier's check, or
- credit card via www.yourtexasbenefits.com.

Payment for enrollment must be received and processed before cutoff prior to the last month of current CHIP certification.

The vendor receives all payments made to the program via money order, personal check or cashier's check. The vendor scans images and processes the payments. If the household mistakenly sends the payment to the Document Processing Center (DPC), the DPC logs the receipt of the payment and forwards the payment to the vendor for normal processing.

Enrollment fees submitted via www.yourtexasbenefits.com are charged a $2 non-refundable convenience fee. The household is mailed an electronic receipt.

D—1824 Refunds

Revision 13-4; Effective October 1, 2013

CHIP

Households that overpay the enrollment fee can request a refund. In addition, refunds are sent to households that submit the enrollment fee, but are never enrolled or have credit balances due at the time of disenrollment from the program. **Note:** Households enrolled in CHIP are not eligible for a refund if the household received at least one month of CHIP coverage and was required to pay an enrollment fee.

The Enrollment Broker issues a refund in Form of an individual check to the household, regardless of how the household made the payment. If the household pays by credit card, the $2 convenience fee is not refunded. Undeliverable refund checks are returned and voided. The vendor annotates the CHIP case and makes the necessary adjustment to the case to reflect the returned and voided refund. Once a refund is voided and processed, households may request reissuance of a voided refund. The vendor confirms the correct address with the individual before reissuing the previously voided refund.

D—1830 Copayment Requirements

Revision 13-4; Effective October 1, 2013

CHIP

Households are required to pay copayments for medical services or prescription drugs at the time of the service. The applicable copayment requirements are:

Coverage Description	At or Below (<=)100% FPIL	Greater Than (>) 100% to (<=) 150% FPIL	Greater than (>) 150% to (<=) 185% FPIL	Greater Than (>)185% to (<=) 200% FPIL
Preventative health care and shots	$0	$0	$0	$0
Non-emergency ER visit	$3	$5	$75	$75
Generic prescription	$0	$0	$10	$10
Name-brand prescription	$3	$5	$35	$35
Inpatient hospital care (per admission)	$15	$35	$75	$125
Outpatient hospital care	$0	$0	$0	$0
Other doctor visits	$3	$5	$20	$25

D—1840 Cost Sharing Cap Amounts

Revision 13-4; Effective October 1, 2013

CHIP

The cost sharing cap is the maximum amount of out-of-pocket expenses a household is required to pay during the certification period. When a household reaches its cost sharing cap during the certification period, the household is not required to make copayments for the remainder of the certification period. Households are assigned a cost sharing cap and a reporting threshold at application and at each redetermination. The reporting threshold is the amount in expenditures the household must report to the Enrollment Broker. The threshold is a cushion to ensure that additional cost sharing expenditures are not made during the period the documentation is being processed by the Enrollment Broker and the health plan.

The cost sharing cap amount and reporting threshold are based on the household's net income as it relates to the FPIL amount. For households with net income:

- at or below 150% FPIL, the cost sharing cap is 5.0% of the total net income for the term of coverage. The reporting threshold is 4.75%.
- above 150% FPIL, the cost sharing cap is 5.0% of the total net income for the term of coverage. The reporting threshold is 4.75%.

The household is informed of the reporting threshold and sent a Medical Payments Form (MPF) with the Welcome Letter and enrollment packet. The MPF helps the family track medical expenditures by type, date and amount.

D—1841 Cost Sharing Processing

Revision 13-4; Effective October 1, 2013

CHIP

The household must complete and submit the MPF to report that they meet the cost sharing cap.

When the MPF is submitted, the Enrollment Broker reviews the types of expenses listed on Form. The household is not required to provide receipts. Valid medical expenses include:

- enrollment fees, if applicable;
- office visit copayments;
- prescription medicines;
- emergency room visits;
- inpatient or outpatient hospital care; and
- out-of-pocket expenses, such as dental or vision.

The Enrollment Broker reviews the amounts and dates of the expenses to ensure that the family incurred the expenses during the current certification period.

If the household meets the cost sharing cap, a Cost Share Met (CSM) letter is sent to inform the household that it is exempt from copayments for the remainder of the current certification period. The Enrollment Broker notifies the affected health plan within two business days. The health plan is responsible for issuing a new identification card reflecting the absence of copayments.

If the household does not meet the cost sharing cap, the Enrollment Broker triggers a Cost Share Not Met (CSN) letter to inform the household that the cost sharing limit was not met. The following situations may cause the household not to meet the cost sharing cap:

- invalid expenses;
- expenses incurred outside the current certification period;
- valid expenses, but the dates and amounts are blank; or
- the total amount listed on the form is less that the cost sharing cap/threshold.

The CSN includes the cost sharing limit and the total amount of valid expenses submitted. An MPF is included with the CSN.

D—1842 Cost Sharing Re-Evaluation

Revision 13-4; Effective October 1, 2013

CHIP

The household's cost sharing is re-evaluated at redetermination and the six-month income check.

For children who are currently enrolled, the Enrollment Broker does not use new income for eligibility determination.

The Enrollment Broker determines if all information is present to complete the evaluation at the six-month income check. If the income verification is not received and the reported income:

- increases, the Enrollment Broker recalculates the cost sharing for the household. A Cost Sharing Recalculation (CSC) letter is sent to inform the household that the change was complete and provides the household with the new cost sharing amount.
- decreases, a cost sharing re-evaluation is not processed. The Enrollment Broker sends a CSC No Change letter to inform the household that there is no change to the family's cost sharing obligation.

When no information is missing, the Enrollment Broker uses the new income reported during the six-month income check to determine if there has been a change in the household's cost sharing amount.

TWH, D-1900, Complaints and Request for Review

Revision 18-1; Effective January 1, 2018

D—1910 CHIP Complaint Process

Revision 16-2; Effective April 1, 2016

CHIP, CHIP Perinatal

Households may call 2-1-1 to report complaints regarding:

- a delay in processing a CHIP application,
- rude treatment by customer service staff,
- a gap in coverage after Medicaid denial, or
- the income used to determine the household's enrollment fee.

To report a delay in the CHIP enrollment process or complaints regarding plan selection, cost sharing and/or amount of the enrollment fee, households may contact the Enrollment Broker at 1-800-964-2777.

If a household is not satisfied with the response it received, the household must submit the issues in writing to:

Health and Human Services Commission
Attention: Complaint Department
P.O. Box 149027
Austin, TX 78714-9027

D—1920 Request for Review

Revision 18-1; Effective January 1, 2018

CHIP, CHIP Perinatal

A request for review is any expression of dissatisfaction with an adverse action. HHSC defines "adverse action" as denial of eligibility, an untimely eligibility determination or termination of enrollment. Following an adverse action taken on a CHIP Eligibility Determination Group (EDG), HHSC sends a disenrollment or denial letter to the family. The letter informs the CHIP household of its right to request a review.

Households have 30 business days from the date of Form TF0001, Notice of Case Action, to submit a request for review concerning the decision that resulted in an adverse action. Households can either submit the request for review in writing or fax the written request. To

submit in writing send to:

Health and Human Services Commission
P.O. Box 149027
Austin, TX 78714-9027

Fax the written request for review to 866-559-9628.

The request must come from a person with case authority, or the child's provider or health plan (for expedited situations). If the child's physician or health plan determines that a suspension or termination of enrollment could seriously jeopardize the child's life, health or the child's ability to attain, maintain or regain maximum function, the household is entitled to an expedited review process. When disenrolled at the six-month income check, the household has 30 buisness days from the date of Form TF0001 to submit a request for review.

Allow continued enrollment for all individuals when HHSC receives the request for review anytime from the first day of the last benefit month through cutoff of the last benefit month.

Related Policy
Six-Month Income Check, D-1500
Exceptions to the Continuous Enrollment Period, D-1731

D—1921 Request for Review Processing

Revision 18-1; Effective January 1, 2018

CHIP, CHIP Perinatal

If any member of a household or the household's representative expresses dissatisfaction with a decision regarding benefits or services, the advisor takes the following action:

- explain the basis for the decision and the applicable policies;
- provide the household an opportunity to have a conference with the supervisor;
- provide the household an opportunity to request a review;
- consult with the supervisor if the individual requests information the advisor considers confidential.

Note: The member is entitled to any information used to determine suspension, reduction or termination of benefits. See B-1210, Disclosure of Information, for information considered confidential.

Upon receipt of the request for review, HHSC reviews the adverse action and sends the household Form H1063, Request for Review Outcome Letter, within 10 business days from the date of receipt of the request. The response letter contains information addressing the answer to the request for review. HHSC staff document the final decision.

When the request for review is received, HHSC validates that the individual requesting the review has case authority.

- If someone with case authority requests the review in writing, HHSC request for review staff review all case information and supporting evidence that the household provides. HHSC staff make a determination and send Form H1063 informing the household of the decision.
- If the person requesting the review does not have case authority, the request is denied and Form H1063 is sent to the household informing it of the request for review denial.

HHSC staff review all case information and supporting evidence the household provides. If HHSC determines the case was processed accurately, the request for review is denied. Form H1063 is sent informing the household of the request for review outcome.

If the EDG was not processed accurately, or the applicant submitted additional information with the request for review that changes the eligibility outcome, the request for review is approved and staff takes the necessary action to re-establish eligibility and/or enrollment. The household is sent Form H1063 and Form TF0001 informing the household of its eligibility.

When the request for review is approved and the reason for the request is related to a disenrollment decision, HHSC reviews the child's current status to determine if the child is currently enrolled. If the child is:

- currently enrolled, HHSC tells the Enrollment Broker to cancel the disenrollment for the future month to ensure the child's enrollment continues through the end of the current enrollment period and generates Form H1063. In addition, the household receives an Enrollment Confirmation Notice from the Enrollment Broker.
- not enrolled due to renewal period ending adversely, request for review staff process the CHIP eligibility and send Form H1063 and Form TF0001 informing the household of CHIP eligibility. The Enrollment Broker re-enrolls the child for another 12-month period and once enrollment is re-established, the household receives an Enrollment Confirmation Notice.

When HHSC receives a request for review after 30 business days from the date of Form TF0001, or determines that the request for review is not for an adverse action, HHSC denies the request and generates Form H1063 that informs the household of the denial reason.

TWH, D-2000, Confidentiality

Revision 13-4; Effective October 1, 2013

D—2010 General Policy

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

Eligibility Determination Group (EDG) information may be released to individuals who have case authority.

A CHIP or CHIP perinatal household member may give verbal permission to discuss their case with a third party. Staff must authenticate the CHIP or CHIP perinatal household member before discussing the case with a third party.

Limited information may be released to contracted organizations, providers and their contractors, public officials and other state agencies. Reasonable efforts must be made to limit the use, request or disclosure of individually identifiable health information to the minimum necessary to determine eligibility and operate the program. The disclosure of individual medical information from agency records must be limited to the minimum necessary to accomplish the requested disclosure.

It is acceptable to release the following general denial or disenrollment reasons.

- Failure to provide missing Information
- Voluntary withdrawal

It is unacceptable to provide specific EDG details, such as the specific reason for denial (excess assets, excess income).

D—2011 Community Based Organizations

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

Limited information may be released to contracted or sub-contracted community-based organization (CBO) representatives. The CBO representative must provide the CBO identification number in order to receive EDG information. In addition, the CBO representative must provide the:

- name of the head of household,
- address, and
- child's Social Security number (SSN).

Staff may then release the following CHIP EDG information to the CBO:

- status of the application or EDG (denied, disenrolled, enrolled, missing information),
- missing information on an EDG (types of information needed to complete eligibility determination),
- enrollment coverage dates (start and end dates), and
- enrollment fee amount.

Do not release specific EDG details, such as:

- the reason for denial,
- sources or amounts of income,
- types of assets,
- household size, and

- citizenship/alien status.

D—2012 Providers and Health Plans

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

Limited information may be released to providers and health plans. Health care providers must give their provider identification number. If a provider participates with more than one CHIP health plan, the provider may have multiple identification numbers. Accept and document any identification number the provider gives.

The provider or health plan must confirm the:

- name of the head of household,
- address, and
- child's Social Security number (SSN).

Staff may then release the following EDG information to the provider or health plan:

- status of the application or EDG (denied, disenrolled, enrolled, missing information);
- missing information on an EDG (types of information needed to complete eligibility determination);
- enrollment coverage dates (start and end dates); and
- other EDG information as requested (enrollment fee, cost share limit, copayments).

D—2013 Federal and State Executive and Legislative Officials

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

Limited information may be released to federal and state executive and legislative branch members and their staff. Managers and supervisors may release to State of Texas legislators and legislative staff members the following information:

- Case or EDG eligibility status
- Missing information on an application or EDG
- Enrollment coverage dates
- Enrollment status
- Enrollment fee amount

D—2014 Teacher Retirement System (TRS)

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

Limited information may be released to TRS representatives. In order to obtain any EDG information, the representative must provide the assigned TRS personal identification number and any of the following CHIP EDG information:

- Case or EDG number
- Name of the person with case authority
- Home telephone number
- Child's name
- Child's Social Security number

Staff may then release the following EDG information to the TRS representative:

- status of the application or EDG (denied, disenrolled, enrolled, missing information);
- missing information on a EDG (types of information needed to complete eligibility determination);
- enrollment coverage dates (start and end dates); and
- other EDG information as requested (enrollment fee, cost share limit, copayments).

D—2020 Health Insurance and Portability Accountability Act (HIPAA)

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

Policies and procedures have been established for the secure communication of Protected Health Information (PHI) or confidential information to ensure employees do not use or share any PHI in violation of HIPAA laws and standards. Unauthorized disclosure of PHI is grounds for disciplinary action.

When sharing information is appropriate, HIPAA allows staff to speak to the individual or others with case authority about PHI.

Calls received by the Customer Care Center staff are recorded, which safeguards PHI. These records keep track of who has accessed a recipient's information. Requests from recipients for copies of their records, corrections to mistakes in records and information pertaining to who has accessed the records are forwarded to HHSC.

TWH, D-2100, Reserved for Future Use

TWH, D-2200, Reserved for Future Use

TWH, D-2300, Forms

Revision 15-4; Effective: October 1, 2015

CHIP, CHIP Perinatal

The Enrollment Broker must ensure that individual correspondence is clear, concise and has been approved by the Texas Health and Human Services Commission (HHSC).

Acronym/Form	Title	Description
CBL	Charge Back Letter	Sent to notify an individual that the individual's credit card was charged more than once for the enrollment fees and that the individual will need to contact the credit card company or bank to get a refund.
CSC	Cost Share Recalculation	Sent when a household submits new income information and its cost share is re-evaluated.
CSM	Cost Share Met	Sent to notify an applicant that the cost share has been met.
CSN	Cost Share Not Met	Sent to notify a household that the cost share has not been met.
DTF	Dental Enrollment Transfer Form	Captures dental plan selections.
E1R	Enrollment Reminder	Sent to remind the applicant that the enrollment form and/or enrollment fee has not been received.
ECN	Enrollment Confirmation Notice	Sent to confirm enrollment for new enrollees and at redetermination. It also informs the applicant of their cost share amount.

Acronym/Form	Title	Description
EFX	Enrollment Fee Extension Letter	Sent to households who have completed their Children's Health Insurance Program (CHIP) redetermination process completely by cutoff of the 12th month of their current coverage, but who have not paid the enrollment fee. The letter tells the household they have until cutoff of their first month of new coverage to pay this fee.
EMI	Enrollment Missing Information	Sent to notify the applicant that the enrollment form was either missing, incomplete or was received without the entire enrollment fee amount due.
EPM	Welcome Letter	Sent with the new enrollment packet. The child is pending eligibility for enrollment and enrollment fee, if not entered.
ETF	Enrollment Transfer Form	Captures health plan and primary care physician (PCP) selections along with special health care needs.
FEF	Form Request – Enrollment Transfer Form (medical and dental)	Sent when an individual requests a new ETF and/or DTF.
FPB	Form Request – Medical Payment Form (blank)	Sent when an individual requests a blank Medical Payments Form (MPF).
FPC	Form Request – Medical Payment Coupon	Sent when an individual requests a new Payment Coupon (MPC).
FPF	Form Request – Medical Payment Form (prepopulated)	Sent when an individual requests a new prepopulated MPF.
FPR	Form Request – All Forms (ETF, DTF, MPC, Blank MPC)	Sent when an individual requests a new copy of any combination of ETF, DTF, MPC, prepopulated MPF and/or blank MPF.
HCC	Health Plan Transfer Letter	Sent to notify the applicant of the completion of either a forced or requested plan transfer.
HPC	Health/Dental Plan Transfer Approval Letter	Sent to notify the applicant of the individual's authorization to make a plan transfer.
HPD	Health Plan Change Denial Letter	Sent to notify the applicant that the individual's transfer request was denied.
LPD	Last Payment Due Reminder Letter	Sent to inform the applicant their enrollment fee has not been received, and the final day it can be paid
MPC	Payment Coupon	Coupon requesting that the household pay its enrollment fee.
MPF	Medical Payments Form	Used by the individual to track all copay cost sharing so that the individual can report it.
NSF	Non-Sufficient Funds	Sent to notify an individual that a payment was returned for non-sufficient funds. The letter instructs the individual on how to make a new payment.
PHL	Payment History Letter	Letter that provides a listing of payments made during a specified time period. The letter is manually printed and mailed to the individual by the Enrollment Broker Funds team.
PNL	Payment Not Needed	Sent to inform an individual that a payment is being returned to the household because the household does not owe any payments at this time or the payment is unable to be processed.
POD Cover Letter	Print on Demand Cover Letter	Cover letter sent when a client requests a copy of the letter that had previously been sent to the individual.

Acronym/Form	Title	Description
RAC	Refund Address Confirmation	Sent to a CHIP household that qualifies for a refund in order to confirm the household's current mailing address. The letter is generated when the household is owed a refund and a current phone number does not exist in the case or when the customer care representative is unable to reach the household using the existing phone listed in the case.
RNL	Retro Notification Letter	Sent to inform an individual that the enrollment start date for their children has changed.
UPR	Unclaimed Property Letter	Sent to a participant of CHIP or the Medicaid Buy-In (MBI) program who is owed a refund of $250 or more for a closed Eligibility Determination Group (EDG) and who has had no account activity for at least three years. The letter is generated on a yearly basis.

TWH, D-2400, Glossary

Revision 13-4; Effective October 1, 2013

D–2410 Glossary Listing

Revision 13-4; Effective October 1, 2013

CHIP, CHIP Perinatal

Advance Notice — A notice of adverse action that expires 13 days after it is sent, with the exception of a six-month income check. Households denied at a six-month income check are given a 30-day advance notice of adverse action.

Adverse Action — An action resulting in denial or termination of assistance.

Applicant — An individual who submits an application to apply for assistance.

Case Authority — An individual who has the authority to act on behalf of the child. Examples include parents who live with the child, grandparents who live with the child, spouse, independent child, payee or authorized representative.

Children's Insurance — Includes Children's Medicaid and Children's Health Insurance Program (CHIP).

Community Based Organization (CBO) — Organization providing assistance to an applicant applying for and enrolling in state-funded programs by aiding in the application process and seeking answers to case inquiries.

Disenrollment — The process by which a child's CHIP coverage is removed.

Enrollment — The process by which a child's CHIP coverage begins.

Enrollment Broker – Entity that enrolls an eligible child into CHIP or an eligible pregnant woman into CHIP perinatal once health and dental plan selections have been made and any required enrollment fees have been paid.

Enrollment Missing Information — Required information needed to complete the enrollment process that includes choosing a health plan and paying an enrollment fee.

Net Income — Gross income less the allowable child care deduction.

Perinate — An individual from the period of conception to birth. The unborn child.

Plan Partners — Organizations contracted through HHSC to provide health, dental or vision care services to CHIP enrolled children.

Request for Review — A written expression of dissatisfaction of an adverse action taken on a CHIP case. CHIP recipients are not allowed fair hearings.

TWH, Part E, Former Foster Care Children (FFCC)

TWH, E-100, Application Processing

Revision 17-1; Effective January 1, 2017

E—110 Medicaid for Former Foster Care Children (FFCC)

Revision 15-4; Effective October 1, 2015

The Patient Protection and Affordable Care Act (Public Law 111-148) and the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), commonly referred to together as the Affordable Care Act (ACA), requires states to extend Medicaid coverage to the population of youth who are between ages 18 and 26 and aged out of foster care at age 18 or older.

The process to cover these individuals is coordinated between the Texas Department of Family and Protective Services (DFPS), which administers the foster care program, and the Texas Health and Human Services Commission (HHSC). When a child ages out of foster care, Medicaid eligibility for these youths is transferred from Foster Care Medicaid to FFCC. DFPS certifies initial FFCC eligibility for youths aging out of foster care and HHSC is then responsible for determining their future Medicaid eligibility.

Note: There may be situations in which HHSC processes the initial certification.

E—111 Type of Assistance (TA) 82 – Medical Assistance – FFCC

Revision 15-4; Effective October 1, 2015

In order to be eligible for FFCC, individuals must:

- have aged out of foster care or the Unaccompanied Refugee Minor Resettlement Program in the state of Texas at age 18 or older;
- be ages 18 up to 26;
- have received federally funded Medicaid when they aged out of foster care; and
- meet all other Medicaid eligibility criteria such as U.S. citizenship, alien status, and Texas residency.

Centralized Benefit Services (CBS) staff is responsible for processing all FFCC applications and redeterminations, along with any other associated active Eligibility Determination Groups (EDGs). The FFCC program is identified in the Texas Integrated Eligibility Redesign System (TIERS) as TA 82, Medicaid for Former Foster Care Children.

Customer Care Center (CCC) staff is responsible for processing changes for FFCC.

Note: Federal regulations require states to provide Unaccompanied Refugee Minors (URMs) with the same range of medical benefits and services as those available to children who were in foster care. CBS is responsible for ensuring URMs continue to receive medical services through the end of their 26th birthday if they meet all eligibility criteria.

E—112 Application Processing

Revision 17-1; Effective January 1, 2017

Centralized Benefit Services (CBS) receives:

- a new FFCC case/Eligibility Determination Group (EDG) via an interface with the Texas Department of Family and Protective Services (DFPS); or
- an application completed by an individual who aged out of foster care.

Note: DFPS provides a notice of eligibility to each individual.

CBS staff are notified by DFPS or HHSC Quality Assurance when a referral/interface is not completed. In cases where a DFPS referral/interface is not completed or processed, CBS staff must contact DFPS to determine the reason why the individual was not sent to HHSC via the interface and confirm whether eligibility criteria is met for FFCC. If the individual meets the eligibility criteria in Section E-111 , Type of Assistance (TA) 82 - Medical Assistance - FFCC, CBS staff certify the individual for FFCC without requiring an application.

There are instances when an individual is denied ongoing FFCC coverage and must submit a new application for benefits. An individual may be denied ongoing FFCC coverage if the individual:

- voluntary withdraws;
- moves out of state; or
- fails to return verification during a renewal.

Individuals denied ongoing FFCC benefits may experience gaps in coverage. When there is a gap in coverage, individuals must apply using any of the Medical Programs application channels explained in A-113, Application Requests and Submissions.

One of the following questions must be marked **Yes** on the application for eligibility to be considered for FFCC.

- Were you in foster care at age 18 or older?
- Were you in an approved Unaccompanied Refugee Minor's Resettlement Program at age 18 or older?

If ineligible for FFCC, the individual will be considered for eligibility under other Medical Programs.

E—113 Requesting an Application

Revision 15-4; Effective October 1, 2015

Applicants may request to apply for FFCC as explained in A-113, Application Requests and Submissions.

Related Policy
Registering to Vote, A-1521

E—114 Authorized Representatives (AR)

Revision 15-4; Effective October 1, 2015

An individual may designate an individual or organization as an AR, following the policy explained in A-170, Authorized Representatives (AR).

E—120 Office Procedures

Revision 15-4; Effective October 1, 2015

E—121 Filing an Application

Revision 17-1; Effective January 1, 2017

individuals who wish to apply for FFCC, can;

- submit an application as explained in A-113, Application Requests and Submissions; and
- sign an application as explained in A-121, Application Signature.

E—122 File Date

Revision 17-1; Effective January 1, 2017

The file date is the day an application is received in one of the following ways:

- by an HHSC eligibility determination office;
- online through YourTexasBenefits.com;
- by telephone through 2-1-1; or
- through an account transfer from the Marketplace.

The file date for cases received through the DFPS interface is the date the interface is received. To be a valid application, it must contain the applicant's name, address, and appropriate signature/electronic signature. This is day zero in the application process.

Advisors must document why a certain file date was used to determine eligibility when:

- The file date used differs from the received date on the application, or
- The application has two received dates (stamp dates).

Note: For applications received outside of normal business hours, the file date is the next business day.

Related Policy
Application Signature, A-122.1

E—130 Interviews

Revision 15-4; Effective October 1, 2015

E—131 General Policy

Revision 15-4; Effective October 1, 2015

An interview is not required when applying for or renewing an application for the FFCC program. Schedule a phone interview only if the individual requests an interview. The State Portal Scheduler does not support scheduling for the FFCC program. Any requests for an interview must be scheduled manually.

Note: Advisors must continue determining eligibility, rather than denying the application, if the applicant misses the interview.

TWH, E-200, Household Composition

Revision 15-4; Effective October 1, 2015

E—210 General Policy

Revision 15-4; Effective October 1, 2015

The certified group consists of only the individual.

E—220 Verification Requirements

Revision 15-4; Effective October 1, 2015

There are no verification requirements for household composition. Advisors must accept the individual's statement as verification.

TWH, E-300, Citizenship

Revision 15-4; Effective October 1, 2015

E—310 General Policy

Revision 15-4; Effective October 1, 2015

Verify citizenship and alien status following the Medical Programs policy for citizenship and alien status eligibility in A-300, Citizenship. Applicants who are U.S. citizens and certain legally admitted alien residents are eligible for Medicaid for Former Foster Care Children (FFCC) if they meet all other eligibility criteria.

The alien status policy for FFCC follows Chart D in Section A-342, TANF and Medical Programs Alien Status Eligibility Charts. Individuals are no longer eligible for FFCC the month after their 21st birthday if they no longer qualify under Chart D. For individuals age 21 and older, continue eligibility if they are otherwise eligible based on Charts A, B, and C.

Allow applicants and recipients a period of reasonable opportunity, if applicable, to verify their citizenship or alien status, as explained in A-351.1, Reasonable Opportunity.

E—320 Verification Requirements

Revision 15-4; Effective October 1, 2015

The Texas Department of Family and Protective Services (DFPS) interface provides the following information pre-populated into the Texas Integrated Eligibility Redesign System (TIERS) for individuals with an alien status:

- Document Type — I-551 orI-94
- Annotation/Category (conditionally based on documenttype)
- U.S. Citizenship and Immigration Services (USCIS) Documented US EntryDate
- Alien Status ExpirationDate
- Alien Registration Number (the “A”number)

Verification of alien status is required when the information received via the interface does not match the information in TIERS or when the document type is marked "other." Do not request verification from the individual until efforts to verify alien status through DFPS have been attempted. Staff must request an image of the alien status documentation from DFPS to verify the alien status.

Within 10 days of receiving the task, staff must email the DFPS FC-ADO mailbox at fcadomedex@dfps.state.tx.us and copy tonya.eason@dfps.state.tx.us to request the image of the alien documentation. The email must include the individual's name, date of birth, and Social Security number (SSN) and must be encrypted. **Do not** include any client information in the subject line of the email. DFPS should reply to this request within five workdays.

If the DFPS image does not provide sufficient information to verify alien status, then FFCC applicants must receive a period of reasonable opportunity, explained in A-351.1, Reasonable Opportunity, to verify their alien status.

TWH, E-400, Social Security Number (SSN)

Revision 15-4; Effective October 1, 2015

E—410 General Policy

Revision 15-4; Effective October 1, 2015

Applicants must provide an SSN or apply for one through the Social Security Administration (SSA) before certification. Advisors use policy in A-411, Determining Advisor Action at Application, listed under the All Programs heading when an applicant does not have an SSN.

TWH, E-500, Age

Revision 15-4; Effective October 1, 2015

E—510 General Policy

Revision 15-4; Effective October 1, 2015

Applicants are eligible to receive Medicaid for Former Foster Care Children (FFCC) benefits from age 18 through the month of their 26th birthday.

Exception: An individual is no longer eligible for FFCC the month after the individual's 21st birthday if the individual no longer qualifies due to alien status, as explained in E-310, General Policy.

E—520 Verification Requirements

Revision 15-4; Effective October 1, 2015

Advisors accept self-declaration as verification of age.

E—530 Documentation Requirements

Revision 15-4; Effective October 1, 2015

Document the individual's self-declaration establishing the age.

TWH, E-600, Relationship

Revision 15-4; Effective October 1, 2015

Relationship requirements are not applicable in the Former Foster Care Children (FFCC) program.

TWH, E-700, Identity

Revision 15-4; Effective October 1, 2015

E—710 General Policy

To establish identity, follow Medical Programs policy in A-600, Identity.

TWH, E-800, Residence

Revision 15-4; Effective October 1, 2015

E—810 General Policy

Revision 15-4; Effective October 1, 2015

To determine residence eligibility, follow the Medical Programs policy in A-700, Residence.

TWH, E-900, Adequate Health Coverage (Third-Party Resource)

Revision 15-4; Effective October 1, 2015

E—910 General Policy

Revision 15-4; Effective October 1, 2015

Former Foster Care Children (FFCC) recipients may have adequate health coverage. Adequate health coverage is also known as a third-party resource (TPR). FFCC follows TPR policy in A-860, Third-Party Resources (TPR). FFCC recipients with TPR must cooperate in providing details of the TPR.

E—920 Verification Requirements

Revision 15-4; Effective October 1, 2015

The TPR information has been verified when the “NHIC” box is checked and greyed out. Staff cannot end/terminate the coverage. If the individual has TPR and the “NHIC” box is greyed out, this information has already been verified by the Office of Inspector General – Third Party Liability area.

Request verification if:

- the individual indicates the individual has TPR, and
- required TPR information has not been verified.

Some former foster care individuals’ parents may have TPR coverage for the applicant without the individual being aware of this coverage. If the individual states they are not aware of the TPR or do not know the details of the TPR, but the TPR has been verified by the claims

administrator, advise the applicant to call the claims administrator's Third Party Liability Customer Service Line at 1-800-846-7307 and select option 2. This will allow the individual to obtain information regarding the TPR.

If the TPR information in the Texas Integrated Eligibility Redesign System (TIERS) has been verified by the claims administrator but needs to be updated, fax the completed Form H1039, Medical Insurance Input, to the claims administrator at 512-514-4215.

TWH, E-1000, Medicaid Eligibility

Revision 18-1; Effective January 1, 2018

E—1010 General Policy

Revision 15-4; Effective October 1, 2015

To determine the correct eligibility begin dates, follow policy in A-820, Regular Medicaid Coverage. The applicant is continuously eligible the first day of the application month if all eligibility criteria are met. Certified applicants are eligible to receive benefits beginning the month of their 18th birthday through the end of the month of their 26th birthday.

The Medical Effective Date (MED) cannot precede:

- January 1, 2014, the program effective date; or
- the month of the individual's 18th birthday.

E—1011 Three Months Prior Coverage

Revision 15-4; Effective October 1, 2015

Applicants for Medicaid for Former Foster Care Children (FFCC) are eligible for three months prior coverage.

Three months prior coverage under FFCC cannot precede January 1, 2014. If eligible under another Medicaid program, an individual can receive three months prior coverage for months requested prior to January 1, 2014, on the Medicaid program for which the individual would have qualified prior to January 1, 2014. Coverage from January 1, 2014, forward will be under the FFCC program.

E—1012 Types of Coverage

Revision 18-1; Effective January 1, 2018

FFCC recipients are automatically enrolled in STAR Health through the month of their 21st birthday. STAR Health provides a full range of Medicaid-covered medical and behavioral health services for Texas Department of Family and Protective Services (DFPS) individuals. Individuals may opt out of STAR Health for STAR, which allows for a choice of health plans.

People under age 21 who receive Supplemental Security Income (SSI) or reside in a nursing facility have the choice of staying in STAR Health or opting into STAR Kids if they meet one of the following criteria:

- receive Medicaid and Medicare; or
- receive services under one of the following 1915(c) waiver programs:
  - Home and Community-based Services (HCS);
  - Community Living Assistance and Support Services (CLASS);
  - Texas Home Living (TxHmL);
  - Deaf Blind with Multiple Disabilities (DBMD);
  - Medically Dependent Children Program (MDCP); or
  - Youth Empowerment Services (YES).

Once an FFCC recipient attains age 21, coverage will transfer to STAR. STAR provides a full range of Medicaid-covered medical and other services for many children and adults. **Exception**: Individuals ages 21 up to age 26 who meet the STAR+PLUS criteria must enroll in the STAR+PLUS managed care program.

Related Policy
Managed Care, A-821.2
Managed Care Plans, C-1116

TWH, E-1100, Domicile

Revision 15-4; Effective October 1, 2015

Domicile requirements do not apply to the Former Foster Care Children (FFCC) program.

TWH, E-1200, Deprivation

Revision 15-4; Effective October 1, 2015

Deprivation requirements do not apply to the Former Foster Care Children (FFCC) program.

TWH, E-1300, Child Support

Revision 15-4; Effective October 1, 2015

Child and medical support requirements do not apply to the Former Foster Care Children (FFCC) program.

TWH, E-1400, Resources

Revision 15-4; Effective October 1, 2015

Resources are not considered as a factor in determining eligibility for the Former Foster Care Children (FFCC) program.

TWH, E-1500, Income

Revision 15-4; Effective October 1, 2015

Income is not considered as a factor in determining eligibility for the Former Foster Care Children (FFCC) program.

TWH, E-1600, Deductions

Revision 15-4; Effective October 1, 2015

Since there is no income test, deductions are not considered as a factor in determining eligibility for the Former Foster Care Children (FFCC) program.

TWH, E-1700, School Enrollment

Revision 15-4; Effective October 1, 2015

School attendance requirements do not apply to the Former Foster Care Children (FFCC) program.

TWH, E-1800, Management

Revision 15-4; Effective October 1, 2015

Management requirements do not apply to the Former Foster Care Children (FFCC) program.

TWH, E-1900, Reminders

Revision 15-4; Effective October 1, 2015

E—1910 General Policy

Revision 15-4; Effective October 1, 2015

Before certifying applicants and recertifying recipients, advisors must:

- Ensure the applicant completes each question and signs and dates the application.
- Give the applicant Form H1019, Report of Change. Explain that changes must be reported within 10 days after knowing about the change. Indicate the appropriate reporting requirement on Page 1.
- Refer the applicant to other programs the individual might be eligible for such as the Supplemental Nutrition Assistance Program (SNAP); Temporary Assistance for Needy Families (TANF); Medicaid; Supplemental Security Income (SSI); or Retirement, Survivors and Disability Insurance (RSDI). Refer individuals with a disability who are ineligible for Medical Programs for families and children to the Texas Health and Human Services Commission (HHSC) Medicaid for the Elderly and People with Disabilities (MEPD) programs.
- Inform the applicant of the right to appeal any HHSC action that affects the individual's eligibility.
- Inform the applicant that the information the applicant provides is subject to verification by third parties.

E—1920 Documentation Requirements

Revision 15-4; Effective October 1, 2015

Advisors must document that Form H0025, HHSC Application for Voter Registration, was given to the applicant, authorized representative or representative payee in the Agency Use Only section of the application.

Related Policy
Registering to Vote, A-1521

TWH, E-2000, Case Disposition

Revision 15-4; Effective October 1, 2015

E—2010 Notice to Applicants

Revision 15-4; Effective October 1, 2015

When processing an application, redetermination or change, advisors are required to inform the individual if their request is pended, certified, sustained, or denied. Eligibility Determination Group (EDG) disposition is the end result of processing the request for assistance and will generate Form TF0001, Notice of Case Action. However, if the EDG cannot be disposed because it is pending for additional information/verification, the advisor must provide the individual with Form H1020, Request for Information or Action.

Form H1020, Request for Information or Action

Form H1020 informs the individual the:

- reason the case is pending;
- action the individual or advisor must take;
- date by which the individual or advisor must take action; and
- date the advisor must deny the application/case if the individual does not take action, if applicable.

Note: For Spanish-speaking only individuals, ensure that all comments provided are in Spanish.

Form TF0001, Notice of Case Action

Form TF0001 informs the individual:

- the date benefits begin,
- the date of denial and right to a fair hearing to appeal a case action, and
- address and telephone number of free legal services available in the area.

Note: For Spanish-speaking only individuals, ensure that all comments provided are in Spanish.

E—2020 Length of Certification

Revision 15-4; Effective October 1, 2015

The Texas Integrated Eligibility Redesign System (TIERS) calculates the eligibility end date from the date the advisor disposes the EDG as follows:

- Applications — initial certification month plus 11 months.
- Renewals — 12 months from the last certification month.

Individuals are continuously eligible for Former Foster Care Children (FFCC) benefits for 12 months or through the month of their 26th birthday, whichever is earlier.

Exception: An individual is not eligible to receive 12 months of continuous eligibility if the individual:

- reaches age 26,
- dies,
- voluntarily withdraws, or
- moves out-of-state.

E—2030 Setting Special Reviews

Revision 15-4; Effective October 1, 2015

Use Medical Programs policy in A-2330, Setting Special Reviews, to set special reviews.

E—2040 Adverse Action

Revision 15-4; Effective October 1, 2015

Any household receiving a notice of adverse action has the right to request a fair hearing. In some situations, households may continue receiving benefits pending an appeal. After certification, advisors give households advance notice of adverse actions to deny benefits except for reasons listed in A-2344.1, Form TF0001 Required (Adequate Notice), and A-2344.2, No Form TF0001 Required.

For adverse action, advisors use current policy in A-2340, Adverse Action.

TWH, E-2100, Processing Time Frames

Revision 15-4; Effective October 1, 2015

E—2110 Applications

Revision 15-4; Effective October 1, 2015

Advisors must make an eligibility determination by the 45th day from the file date.

Reopen an application denied for failing to furnish information/verification if the missing information is provided by the 60th day from the file date. Use the date the missing information/verification was provided as the new file date.

Use the original application, until it is 60 days old.

If the information on the form has changed or is more than 45 days old, the individual and advisor must update the form.

E—2120 Deadlines

Revision 15-4; Effective October 1, 2015

Provide Form TF0001, Notice of Case Action, the same day eligibility is determined for an application but no later than 45 days from the file date.

E—2130 Missed Interviews

Revision 15-4; Effective October 1, 2015

No interview is required to process an application or renewal unless requested by the applicant/individual. If an interview is requested, advisors provide the applicant/individual a telephone interview. If the individual fails to keep the interview, advisors must not deny the application or renewal but continue to process the request for assistance.

E—2140 Pending Information on Applications

Revision 15-4; Effective October 1, 2015

Advisors may not request additional information or documentation from clients unless such information is not available electronically or the information obtained electronically is not consistent with the information provided by the client.

If additional information is needed, advisors must request documents that are readily available to the household and are considered to be sufficient verification. Each handbook section lists potential verification sources. C-900, Verification and Documentation, gives information on verification procedures.

In determining eligibility, advisors must consider any information the individual reports between the application date and the decision date. Include any information the individual reports during the application decision process.

E—2150 Notice of Renewal/Expiration

Revision 15-4; Effective October 1, 2015

The system generates and sends renewal correspondence to individuals enrolled in Medicaid for Former Foster Care Children (FFCC) following the process explained in B-121, Notice of Redetermination/Certification Expiration, for TP 08 and Children's Medicaid (TP 43, TP 44 and TP 48).

Note: The system will generate Form H1206, Health Care Benefits Renewal - FFCC, rather than Form H1206, Health Care Benefits Renewal - MA, for individuals renewing FFCC.

E—2160 Processing Renewals

Revision 15-4; Effective October 1, 2015

E—2161 How to Process a Renewal

Revision 15-4; Effective October 1, 2015

FFCC completes an administrative renewal process. An administrative renewal is initiated by the system and requires no advisor action. The administrative renewal process uses the automated renewal process, explained in E-2161.1, Automated Renewal Process, to gather information from a client’s existing case and from electronic data sources to determine whether the client remains potentially eligible for Medical Programs.

E—2161.1 Automated Renewal Process

Revision 15-4; Effective October 1, 2015

The automated renewal process is the first step in an administrative renewal. The automated renewal process runs the weekend before cutoff in the ninth month of the certification period and does not require advisor action.

The process uses electronic data to automatically:

- assess the verifications required by type program for renewals;
- determine the eligibility outcome; and
- send the renewal correspondence to the client.

E—2161.1.1 Verifications Required for Renewals

Revision 15-4; Effective October 1, 2015

During the automated renewal process, the system verifies:

- Residency
- Immigration status

E—2161.1.2 Eligibility Outcomes

Revision 15-4; Effective October 1, 2015

Once available verifications are assessed during the automated renewal process, the system runs eligibility. The following chart lists the possible eligibility outcomes of the automated renewal process.

Automated Renewal Process: Eligibility Outcomes

Eligibility Potentially Approved	• All required eligibility information **can** be verified during the automated renewal process and no additional verification is needed from the client. • Clients must review the information used to determine their eligibility. • Clients are only required to return a signed renewal Form H1206, Health Care Benefits Renewal - FFCC, if the information on the renewal form is incorrect or there are changes to the client's case.
Additional Information Needed	• All required eligibility information **cannot** be verified during the automated renewal process and additional verification is needed from the client. • The client must return a signed renewal form, Form H1206-FFCC, and all requested verification(s).

E—2161.1.3 Renewal Correspondence

Revision 15-4; Effective October 1, 2015

The system generates client correspondence according to the eligibility outcome of the automated renewal process and the action needed by the client.

The following chart lists the correspondence generated for each eligibility outcome of the automated renewal process and the required client response.

Automated Renewal Process: Renewal Correspondence

Eligibility Outcomes	Correspondence and Required Client Response
Eligibility Potentially Approved	• Form H1211, It's Time to Renew Your Health-Care Benefits Cover Letter, notifies the client that they must review the information used to determine their eligibility on Form H1206, Health Care Benefits Renewal - FFCC. • The client is only required to return a signed renewal form, Form H1206 - FFCC, if the information on the form is incorrect or there are changes to the client's case. • Form M5017, Documents to Send with Your Renewal Application, is included with Form H1206. • No additional forms are sent with Form H1211.

Additional Information Needed	• Form H1211, It's Time to Renew Your Health-Care Benefits Cover Letter, and Form H1020, Request for Information or Action, are sent to the client.
	• Form H1211 notifies the client that they must return the following:
	  ○ Signed renewal form, Form H1206 - FFCC; and
	  ○ Required verification(s).
	• Form H1020 identifies all the required verification(s) needed to complete the renewal and a statement that the signed renewal form is required.

- Form M5017, Documents to Send with Your Renewal Application, is included with Form H1206 - FFCC.

Form TF0001, Notice of Case Action, is sent when a final eligibility determination has been made. Depending on the renewal status outcome and client action, final eligibility determinations may be made by advisors manually processing renewal documents or by the system automatically. Form TF0001 identifies the dates of the new certification period for Medicaid benefits or the denial reason for not recertifying the case.

E—2161.2 Processing a Manual Renewal

Revision 15-4; Effective October 1, 2015

If an individual is required to return a renewal form and returns a paper Form H1206, Health Care Benefits Renewal - FFCC, the form is routed to Centralized Benefit Services (CBS) for processing. If an FFCC renewal is submitted to a local office, it may be processed by the local office advisor but only CBS advisors may dispose the FFCC Eligibility Determination Group (EDG). If an FFCC renewal needs to be disposed, a Task List Manager (TLM) task will be generated for CBS instructing them to dispose the renewal.

The file date is the day that any local eligibility determination office receives an acceptable FFCC renewal form. The following are considered acceptable FFCC forms:

- Form H1206, Health Care Benefits Renewal - FFCC
- Form H1010-R, Your Texas Works Benefits: Renewal Form

A redetermination is considered timely if a renewal form is received by the first calendar day of the 11th month of the certification period. A redetermination is considered untimely if a renewal form is received after the first calendar day of the 11th month of the certification period and through the last day of the 12th month.

Note: If the first calendar day of the 11th benefit month falls on a weekend or a holiday and the redetermination is received on the following business day, the redetermination is considered timely.

Advisors must process redeterminations (received timely or untimely) by the 30th day from the date the renewal form is received **or** by cutoff of the 12th month of the certification period, whichever is later.

When the Texas Health and Human Services Commission (HHSC) receives an acceptable FFCC renewal form, the advisor must review the information provided and determine whether the case needs to be updated to reflect the most recent information reported by the client on the form.

The advisor may only request information and verification needed to determine eligibility from the client when it is not available through electronic data sources. Verification previously provided must be used to renew eligibility when the verification is still valid. The advisor must determine whether there is any verification that can be used before requesting verification from the client. The household must be allowed at least 10 days to provide missing information, and the due date must fall on a workday.

E—2161.2.1 When a Renewal Form Is Not Returned

Revision 15-4; Effective October 1, 2015

When an acceptable FFCC renewal form is not returned, the system automatically makes an eligibility determination through a mass update based on the eligibility outcome from the automated renewal process. This does not require the CBS advisor to run eligibility or dispose the EDG.

Below are the eligibility outcomes during the automated process:

- Eligibility Potentially Approved – the client is auto-disposed and approved without advisor action. The file date is the date the EDG is auto-disposed approved, and the client is granted a new 12-month certification period.
- Additional Information Needed – the client is auto-disposed and denied without advisor action.

E—2161.2.2 Information or Renewal Form Returned After Termination

Revision 15-4; Effective October 1, 2015

When a renewal is denied due to failure to provide information or verification and the information or verification is provided after the date of denial but by the 90th day after the last day of the last benefit month, CBS staff must reopen the EDG. The date the information or verification is provided is the new file date.

If a renewal form is not received by the date of denial in the 12th month of the certification period, the EDG is denied for failure to return a renewal packet. A renewal form received after the last day of the 12-month certification period must be treated as an application using application processing time frames. The file date is the day that any local eligibility determination office receives the FFCC renewal form.

Note: If the renewal form is received after the date of denial but before the last day of the 12th month of the certification period, reopen the EDG and process as a renewal.

E—2170 Renewal Time Frames

Revision 15-4; Effective October 1, 2015

For individuals required to return a renewal packet, CBS advisors must process the manual renewal following the time frames explained in E-2161.2, Processing a Manual Renewal.

E—2180 Pending Information

Revision 15-4; Effective October 1, 2015

Advisors must allow the household at least 10 days to provide missing information/verification. The due date must be a workday. Advisors must request documents that are readily available to the household if the documents are anticipated to be sufficient verification. If the applicant has any active or inactive EDGs, check to see if any verification previously provided for the other EDGs can be used to determine eligibility for FFCC.

Advisors use verifications accepted for the Temporary Assistance for Needy Families (TANF) program, Medical Programs or the Supplemental Nutrition Assistance Program (SNAP).

Exception: Only Medical Programs sources of verification of U.S. citizenship for applicants can be used.

Note: Advisors must not use verification that is over 90 days old from the FFCC file date.

E—2181 Summary of Due Dates for Form H1020, Request for Information or Action

Revision 15-4; Effective October 1, 2015

Case Action	Due Date	Final Due Date
Application	10 days	• 30th day, or • 10th day if the household's Form H1020 due date extends beyond the 30th day
Renewal	10 days	• 30th day or by cutoff in the last benefit month of certification, whichever is later; or • 10th day if the household's Form H1020 due date extends beyond the last day of the last benefit month
Incomplete	10 days	10th day

review

Note: Staff have until the 45th day from the file date to determine eligibility for applications.

TWH, E-2200, Changes

Revision 16-4; Effective October 1, 2016

E—2210 How to Report a Change

Revision 15-4; Effective October 1, 2015

Customer Care Center (CCC) staff process all changes for Former Foster Care Children (FFCC) recipients. FFCC recipients can report changes:

- online through YourTexasBenefits.com;
- by visiting a local eligibility office;
- in writing by mail or fax;
- by completing Form H1019, Report of Change; or
- by calling 2-1-1.

Note: When a change is reported by telephone, staff must verify that the person speaking is the individual or an authorized representative as explained in A-2000, Identifying Applicants Interviewed by Phone and Prevention of Duplicate Participation.

An individual must report the following changes:

- if the individual moves out state,
- an address change, or
- enrollment in health insurance.

Advisors process all other changes, including agency-generated changes, at the next renewal.

Exception: If the individual failed to report required information at the time of the application that causes the individual to be ineligible for FFCC, advisors must deny the benefits and send a fraud referral to the Office of the Inspector General.

E—2220 Action on Changes

Revision 15-4; Effective October 1, 2015

If an individual reports a change or the advisor receives an agency-generated change during the 12-month continuous eligibility period and has:

- no associated Eligibility Determination Group (EDG) — the advisor documents the change and handles at renewal, unless it is a change of address, the certified individual dies, a voluntary withdrawal, receipt of health insurance, or the individual moves out of Texas;
- an associated EDG — the advisor documents the change and handles at renewal, unless it is a change of address, the certified individual dies, a voluntary withdrawal, receipt of health insurance, or the individual moves out of Texas; or
- a change of address — the advisor mails the individual Form H0025, HHSC Application for Voter Registration, to register to vote based on the new address. If the individual contacts Centralized Benefit Services (CBS) or 2-1-1 to decline the opportunity to register to vote after receipt of Form H0025, the advisor mails Form H1350, Opportunity to Register to Vote, to the individual for a signature, files Form H1350 in the case record when the individual returns the form, and retains the form for at least 22 months.

Advisors follow Medical Programs policy in B-600, Changes, for verification and documentation requirements.

Related Policy
Registering to Vote, A-1521

E—2221 Returned Mail

Revision 16-4; Effective October 1, 2016

When returned mail is received, the vendor creates and assigns a Returned Mail (RTML) task to Centralized Benefit Services (CBS) staff for processing.

Upon receipt of the RTML task, CBS staff must take the following actions:

1. Review the address on the returned mail, the case record, and the State Portal to determine whether the household has reported a new address. If a new address has been reported, process the address change and, if there is a Supplemental Nutrition Assistance Program (SNAP) Eligibility Determination Group (EDG), any related changes in shelter expenses.

2. If a new address has not been reported and a forwarding address was not provided, attempt to contact the household via telephone to obtain an updated address and document the attempt. If the household provides a new address, process the address change and, if there is a SNAP EDG, any related changes in shelter expenses. Otherwise go to Step 3.

3. If there is an individual(s) in the household who receives Retirement, Survivor's and Disability Insurance (RSDI) or Supplemental Security Income (SSI), use the State Online Query (SOLQ) to verify the household's address. Use the address in SOLQ to update the address if the address in SOLQ differs from the address on file and, if there is a SNAP EDG, explore shelter expenses.

If the address in SOLQ matches the address in the TIERS record, document in TIERS Case Comments that the SOLQ inquiry address matches the TIERS address and take no further action.

If unable to contact the individual by phone and there is not an individual(s) in the household who receives RSDI or SSI for the:

- FFCC EDG, go to Step 4; or
- SNAP EDG, follow Step 5 under the process for a case that includes a SNAP EDG in B-638 , Returned Mail.

4. If unable to update the address, simultaneously send emails using the following CBS email box to:

- Health Plan Operations (HPO) using the following email box:
  - cbs_ffche-mtfcy@hhsc.state.tx.us; and
- Preparation for Adult Living (PAL) using the following email box:
  - OES_FFCC@hhsc.state.tx.us

HPO Process

- Send an email to the Medicaid CHIP Division (MCD) Health Plan Operations (HPO) at HPO_Star_Plus@hhsc.state.tx.us .
- Include in the subject line **Returned Mail – [last four digits of the client's case number]**.
- Include the following information in the email:

- case name;
- case number;
- individual’s date of birth (DOB), Social Security Number (SSN), and Medicaid Individual Identification Number; and
- date the response is needed.
  - Leave the RTML task pending.

PAL Process

- Use the link below to identify the Lead Regional PAL staff covering the region of the client's last known address.
  - http://www.dfps.state.tx.us/Child_Protection/Youth_and_Young_Adults/Preparation_For_Adult_Living/PAL_coordinators.asp
- Send an email to the identified Lead Regional PAL staff.
- Include in the subject line **Returned Mail -- [last four digits of the client's case number].**
- Include the following information in the email:
  - case name;

    - case number;
    - individual's DOB, SSN, and Medicaid Individual Identification Number; and
    - date the response is needed.
- Leave the RTML task Pending.

Note:

For an individual who aged out of the Unaccompanied Refugee Minor (URM) Resettlement program, contact the following agencies and individuals to determine if the agency or individual has an updated address for the former URM:

- the URM's former Voluntary Agency (VolAg); and
- the two agencies in Texas that have URM programs:
    - Catholic Charities Diocese of Fort Worth
        - Jennifer Frazier, URM Director, at jfrazier@ccdofw.org
    - Catholic Charities Diocese of Galveston-Houston
        - Debbie Sandberg, URM Coordinator, at 713-874-6505 or dsandberg@catholiccharities.org
        - Raj Kendrick, URM Director, at 281-874-6530 or rkendrick@catholiccharities.org

5. The MCD HPO and DFPS PAL staff have ten calendar days to respond. It is important that staff make the request as soon as possible. The response will include either:

- the known address on file for the individual; or
- no known address on file for the individual.

MCD HPO responds to the CBS email mailbox (cbs_ffche-mtfcy@hhsc.state.tx.us) and copies the original requestor with information from the plan by the tenth calendar day from when the email is sent, either confirming or denying that they have an address on file for the client. If they confirm, the response will include the address on file.

The **DFPS PAL** program responds to the email box (OES_FFCC@hhsc.state.tx.us) and copies the original requestor with information from the Lead Regional PAL staff by the tenth calendar day from when the email is sent, either confirming or denying that they have an address on file for the client. If they confirm, the response will include the address on file.

Note: If the MCD HPO and DFPS PAL both respond and provide different addresses, use the address received from the MCD HPO (unless the individual has already provided an address).

6. For cases with a SNAP EDG, if by the Form H1020 due date, the household:

- provides the requested information, process the address change for all active EDGs, including the FFCC EDG, and address any related changes in shelter expenses for the SNAP EDG; or
- fails to provide the requested information, deny the SNAP EDG for failure to provide information. Send Form TF0001, Notice of Case Action, using the denial reason, "Failed to Provide Information".

For the FFCC EDG, if by the 10th calendar day due date the HPO/PAL information:

- is provided, use the information to update the address in the TIERS record;
- is not provided, use the following steps to deny the EDG(s) using the denial reason "Unable to Locate" as stated in A-2344.1 , Form TF0001 Required (Adequate Notice).
    - In Change Action Mode, go to "Household Information" and select "Yes" for the question "is the worker unable to locate the household?"
    - Run eligibility.

Note: The HPO/PAL information cannot be used to verify residence for SNAP EDGs.

7. If MCD HPO or DFPS PAL provide an updated address within 30 days of the EDG's denial due to "Unable to Locate," reopen the EDG.

For the SNAP EDG, if the household is denied for failure to provide information and provides a correct address within the advance notice adverse action period, reopen the EDG using the original certification period and process any related changes in shelter expenses. Please refer to the TIERS Advance Notice of Adverse Action Reference Guide in the ASK iT Knowledge Base for instructions.

Notes:

- If an address provided by MCD HPO or the DFPS PAL program differs from an address provided by the household, contact the household to resolve the discrepancy.
- For SNAP EDGs, if the household provides verification of residence, but does not provide information regarding shelter expenses, re-budget eligibility without the shelter expense and notify the household, according to policy in A-631, Actions on Changes.

Related Policy

Actions on Changes, B-631
Returned Mail, B-638

TWH, E-2300 Fair Hearings

Revision 15-4; Effective October 1, 2015

E—2310 Appeals Procedures

Revision 15-4; Effective October 1, 2015

Individuals on Medicaid for Former Foster Care Children (FFCC) have the right to appeal within 90 days from the effective date of any Texas Health and Human Services Commission (HHSC) action. The individual's request may be oral or in writing.
See B-1000, Fair Hearings, for specific appeals policy and procedures.

TWH, E-2400, Automated Support

Revision 15-4; Effective October 1, 2015

E—2410 Electronic Data Sources (ELDS) and Data Broker

Revision 15-4; Effective October 1, 2015

Advisors must follow the policy explained in C-817, Electronic Data Sources (ELDS), and C-820, Data Broker.

Exception: The consent policy explained in C-817 does not apply to individuals who are transferred to the Texas Health and Human Services Commission (HHSC) via the Texas Department of Family and Protective Services (DFPS) interface.

TWH, Part F, Former Foster Care in Higher Education (FFCHE)

TWH, F-100, Application Processing

F—110 Application Procedures

Revision 15-4; Effective October 1, 2015

Section 17, Senate Bill 10, passed by the 80th Texas Legislature, Regular Session, 2007, requires the Texas Health and Human Services Commission (HHSC) to provide Medicaid coverage to certain former foster care youth attending school.

HHSC uses state funds to pay for the Former Foster Care in Higher Education (FFCHE) program. Since this program is funded entirely by the state, it is not considered Medicaid and is identified as a Health Care Benefits program instead of Medicaid or medical assistance.

Effective January 1, 2014, new individuals will not be certified for FFCHE. Individuals receiving FFCHE as of December 2013 and eligible for Former Foster Care Children (FFCC) transitioned to FFCC January 1, 2014. Applications and redeterminations for FFCHE disposed on or after January 1, 2014, will be reviewed for FFCC eligibility. Those individuals not eligible for FFCC will continue to receive FFCHE until they age out of the program or are no longer eligible, whichever comes first.

Exception: HHSC received federal approval to provide health care coverage for individuals living in Texas who aged out of foster care under an Interstate Compact on the Placement of Children (ICPC) agreement. These individuals may be eligible for FFCHE or Medicaid for Transitioning Foster Care Youth (MTFCY), explained in Part M, Medicaid for Transitioning Foster Care Youth (MTFCY).

F—111 Type of Assistance (TA) 77 – Health Care – FFCHE

Revision 15-4; Effective October 1, 2015

In order to be eligible for FFCHE benefits, individuals must:

- have had an ICPC agreement*,
- currently reside in Texas,
- be ages 21 up to 23,
- have been in any state's conservatorship or voluntary agency (VolAg) conservatorship on their 18th birthday,
- be enrolled in an institution of higher education located in Texas,
- not have adequate health coverage as defined by HHSC, and
- meet all other Medical Programs eligibility criteria such as citizenship or alien eligibility.

* Centralized Benefit Services (CBS) staff must contact the Texas Department of Family and Protective Services (DFPS) to determine whether the individual had an ICPC agreement. DFPS has three business days to respond.

Exception: For individuals receiving FFCHE as of December 2013 who are not eligible for FFCC, income and deductions will continue to be factors in eligibility, following Medical Programs policy in A-1300, Income, and A-1400, Deductions, and the income limit for FFCHE (TA 77) in C-131.1, Federal Poverty Income Limits (FPIL).

CBS advisors are responsible for processing this caseload (applications, renewals, changes, etc.). This type of assistance is identified in the Texas Integrated Eligibility Redesign System (TIERS) as TA 77.

Note: Federal regulations require states to provide Unaccompanied Refugee Minors (URMs) with the same range of medical benefits and services as those available to children who were in foster care. CBS is responsible for ensuring that URMs continue to receive medical services through the end of their 23rd birthday.

F—112 Application Processing

Revision 15-4; Effective October 1, 2015

Individuals who have had an ICPC agreement may apply by completing Form H1868, Application for Health Care Benefits. The Spanish version of the FFCHE application is Form H1868-S. Staff must determine whether the applicant is in need of the English or Spanish version when a request for an application is received.

Note: Advisors must also accept any of the applications explained in A-113, Application Requests and Submissions. CBS advisors must request any additional information needed to make an eligibility determination.

F—113 Requesting an Application

Revision 15-4; Effective October 1, 2015

Individuals who have had an ICPC agreement may request an FFCHE application by calling 2-1-1.

Note: If an individual requests an application at a local eligibility determination office, the advisor must refer the applicant to CBS and provide appropriate contact information.

On the same day the request is received, the advisor provides the applicant an application packet that includes:

- Form H1868, Application for Health Care Benefits;
- Form H1870, School Enrollment Verification Form;
- Form H0025, HHSC Application for Voter Registration; and
- a business reply envelope addressed to the HHSC Document Processing Center (DPC).

CBS advisors will send individuals who have had an ICPC agreement and are enrolled in MTFCY the following forms two months prior to aging out of MTFCY:

- Forms H1868/H1868-S, Application for Health Care Benefits;
- Forms H1870/H1870-S, School Enrollment Verification Form; and
- a business reply envelope.

CBS advisors must document in TIERS Case Comments, "Special Review completed; Forms H1868 and H1870 mailed to client."

If an applicant requests help completing an application, a volunteer or staff member must provide assistance. Anyone assisting the applicant in completing a paper application must initial the part completed, or sign the form indicating assistance was provided.

Related Policy
Registering to Vote, A-1521

F—114 Authorized Representatives (AR)

Revision 15-4; Effective October 1, 2015

An individual may designate an individual or organization as an AR, following the policy explained in A-170, Authorized Representatives (AR).

F—120 Office Procedures

Revision 10-2; Effective April 1, 2010

F—121 Filing an Application

Revision 15-4; Effective October 1, 2015

Individuals who have had an ICPC agreement may submit Form H1868/H1868-S:

- by mail to the HHSC DPC at:

  HHSC
  P.O. Box 149024
  Austin, TX 78714-9024

or

- by toll-free fax to 1-877-447-2839.

Note: Applicants cannot submit Form H1868/H1868-S via telephone or online through YourTexasBenefits.com.

If a local eligibility determination office receives an application, staff must date stamp and fax the application to the DPC non-expedited fax line (1-877-447-2839) no later than the next business day.

Note: Advisors follow policy found in A-121, Receipt of Application, regarding what constitutes a valid application and what to do when the agency receives an incomplete application.

F—122 File Date

Revision 15-4; Effective October 1, 2015

The file date is the day any local eligibility determination office, call center vendor, or other HHSC-contracted entity accepts an application containing the applicant's name, address and an appropriate signature. The file date is considered day zero in the application process.

Advisors must document why a certain file date was used to determine eligibility when:

- the file date used differs from the received date on the application, or
- the application has two received dates (stamp dates).

Note: For applications received outside of normal business hours, the file date is the next business day.

F—130 Interviews

Revision 10-2; Effective April 1, 2010

F—131 General Policy

Revision 15-4; Effective October 1, 2015

An interview is not required when applying for or renewing an application for the FFCHE program. Advisors must schedule a phone interview only if the individual requests an interview. The State Portal Scheduler does not support scheduling an interview for the FFCHE program. Any requests for an interview must be scheduled manually.

Note: An application must not be denied if the applicant misses the interview, and the advisor should continue to determine eligibility.

TWH, F-200, Household Composition

Revision 15-4; Effective October 1, 2015

F—210 General Policy

Revision 15-4; Effective October 1, 2015

The Modified Adjusted Gross Income (MAGI) household composition and certified Eligibility Determination Group (EDG) for Former Foster Care in Higher Education (FFCHE) consists of the applicant only. The applicant is the only certified member on the FFCHE EDG.

Example: An individual, age 22, is married and lives with her husband and their child. The individual applies for and is eligible for the FFCHE program. The MAGI household composition and certified EDG consists of only the individual. Her husband and child are not included.

F—220 Verification Requirements

Revision 15-4; Effective October 1, 2015

There are no verification requirements for household composition. Accept the individual's statement as verification.

TWH, F-300, Citizenship

Revision 15-4; Effective October 1, 2015

F—310 General Policy

Revision 15-4; Effective October 1, 2015

The Former Foster Care in Higher Education (FFCHE) program follows the Medical Programs policy for citizenship and alien status eligibility in A-300, Citizenship.

Exception: Applicants do not receive the period of reasonable opportunity explained in A-351.1, Reasonable Opportunity.

Applicants who are U.S. citizens and certain legally admitted alien residents are eligible for FFCHE if they meet all other eligibility criteria.

Reminder: The State Online Query (SOLQ) and the Wire Third-Party Query (WTPY) inquiry systems cannot be used to verify citizenship for this program. See F-2140, Pending Information on Applications.

TWH, F-400, Social Security Number (SSN)

Section 400, Social Security Number (SSN)

Revision 10-2; Effective April 1, 2010

F—410 General Policy

Revision 10-2; Effective April 1, 2010

Applicants must provide an SSN or apply for one through the Social Security Administration before certification. Use policy in A-411, Determining Advisor Action at Application, listed under the All Programs heading when an applicant does not have an SSN.

TWH, F-500, Age

Section 500, Age

Revision 15-4; Effective October 1, 2015

F—510 General Policy

Revision 15-4; Effective October 1, 2015

Applicants are eligible to receive Former Foster Care in Higher Education (FFCHE) program benefits beginning the month after their 21st birthday through the end of the month of their 23rd birthday. Applicants who wish to have coverage during the month of their 21st birthday must apply for benefits under an appropriate Medicaid program.

Note: These individuals may be eligible for Medicaid for Transitioning Foster Care Youth (MTFCY) during the month of their 21st birthday. See Part M, Medicaid for Transitioning Foster Care Youth (MTFCY).

F—520 Verification Requirements

Revision 10-2; Effective April 1, 2010

Accept self-declaration as verification of age.

F—530 Documentation Requirements

Revision 10-2; Effective April 1, 2010

Document the individual's self-declaration establishing the age.

TWH, F-600, Relationship

Section 600, Relationship

Revision 15-4; Effective October 1, 2015

Relationship requirements do not apply to the Former Foster Care in Higher Education (FFCHE) program.

TWH, F-700, Identity

Revision 10-2; Effective April 1, 2010

F—710 General Policy

Revision 10-2; Effective April 1, 2010

To establish identity, follow the Medical Programs policy in A-600, Identity.

TWH, F-800, Residence

Section 800, Residence

Revision 15-4; Effective October 1, 2015

F—810 General Policy

Revision 15-4; Effective October 1, 2015

To determine residence eligibility, follow TP 33, TP 34, TP 35, TP 43, TP 44, TP 45 and TP 48 policy in A-700, Residence.

TWH, F-900, Adequate Health Coverage (Third-Party Resource)

Revision 17-2; Effective April 1, 2017

F—910 General Policy

Revision 17-2; Effective April 1, 2017

An applicant/recipient is not eligible to receive Former Foster Care in Higher Education (FFCHE) benefits if the individual currently has adequate health coverage. Adequate health coverage is also known as a third-party resource (TPR). Adequate health coverage is defined as receiving coverage under:

- group health insurance;
- health insurance coverage;
- Medicare (Part A or Part B);
- Medicaid (with the exception of the Healthy Texas Women, Medicaid with Spend Down, and Community Attendant);
- armed forces insurance; or
- a state health risk pool.

Deny an application for an individual who has adequate health coverage.

Do not consider a plan with a limited scope of coverage such as dental, vision, long-term care, etc., or for only a specific illness/disease, such as drug/substance abuse, as adequate health coverage.

Consider an applicant/recipient as having adequate health coverage even if it has limits on benefits or high deductibles.

If staff receive a task with information that the individual has TPR and the “NHIC” box is greyed out, advisors deny rather than pend the EDG. This information has already been verified by the Office of Inspector General – Third Party Liability area.

When an FFCHE applicant is denied due to adequate health care coverage, Form TF0001, Notice of Case Action, will read:

“We found that you already have private health insurance. To learn more about the insurance you already get, call toll-free 1-800-846-7307 (after you pick a language, press 2).”

In some instances, the parents of FFCHE recipients have TPR coverage for them without the individual knowing. If the individual states they are not aware of the TPR, staff should advise them to call the claims administrator’s Third Party Liability Customer Service Line at 1-800-846-7307 and select option 2. This will allow the individual to obtain information regarding their TPR.

If the TPR information in the Texas Integrated Eligibility Redesign System (TIERS) has been verified by the claims administrator but needs to be updated, staff should fax the completed Form H1039, Medical Insurance Input, to the claims administrator at 512-514-4215.

F—920 Verification Requirements

Revision 10-2; Effective April 1, 2010

Accept self-declaration of adequate health coverage.

Exception: If an applicant is denied due to receiving adequate health coverage and the applicant calls to notify HHSC that the medical insurance is not adequate health coverage, staff would need to verify if the coverage is considered adequate health coverage.

F—930 Documentation Requirements

Revision 10-2; Effective April 1, 2010

Staff must document in case comments the existence of adequate health coverage.

TWH, F-1000, Eligibility Begin Dates

Section 1000, Eligibility Begin Dates

Revision 15-4; Effective October 1, 2015

F—1010 General Policy

Revision 15-4; Effective October 1, 2015

The applicant is eligible for 12 months beginning the first day of the application month if all eligibility criteria are met. The applicants are eligible to receive benefits beginning the month after their 21st birthday through the end of the month of their 23rd birthday.

The medical effective date cannot precede the:

- effective date of the program (October 1, 2009), or
- the month after the individual's 21st birthday.

If an applicant applies in the month of the applicant’s 21st birthday, the individual cannot be eligible for the Former Foster Care in Higher Education (FFCHE) program until the following month.

Applicants who wish to have coverage during the month of their 21st birthday must apply for benefits under an appropriate Medicaid program.

Note: These individuals may be eligible for Medicaid for Transitioning Foster Care Youth (MTFCY) during the month of their 21st birthday. See Part M, Medicaid for Transitioning Foster Care Youth (MTFCY).

Examples:

- An individual turns age 21 on May 5. She filed an FFCHE application on May 1. The individual is ineligible to receive FFCHE during May, the month of application, since she turns 21 during May. Her eligibility begin date will be June 1. If the applicant wishes to receive benefits for the application month, she must file an application for an appropriate Medicaid program.
- The individual turns age 23 on May 5. She is no longer eligible to receive FFCHE benefits effective June 1.

Three months prior coverage is not available in the FFCHE program. An applicant may apply for three months prior coverage under a Medicaid program and receive assistance if eligible.

In the event an FFCHE recipient becomes pregnant and does not apply for or is not eligible for Medicaid, the newborn is not eligible for TP 45 – Medicaid for Newborn Children. If the mother wants coverage for the baby, she must apply for Medicaid; if eligible, the child will be certified for TP 43 – Medical Assistance for Children Under Age 1.

F—1011 Types of Coverage

Revision 15-4; Effective October 1, 2015

FFCHE recipients will have two types of coverage. The type of coverage determines how recipients access their health care services.

Fee-for-Service – Initial coverage for FFCHE recipients. Although FFCHE individuals are not Medicaid recipients, they will have access to any Medicaid provider and will be allowed to self-refer to specialists. The provider submits claims directly to the claims administrator for reimbursement of the FFCHE-covered services (the coverage mirrors services available to Medicaid recipients). The Texas Health and Human Services Commission (HHSC) will use state funds to pay these claims.

Managed Care – A service delivery program that provides medical care in a managed care setting. The state pays a monthly premium to the health maintenance organization (HMO) for each recipient enrolled in the plan. The plan processes all provider claims.

Enrollment into managed care is mandatory for FFCHE recipients; however, when a recipient is determined eligible for the FFCHE program, fee-for-service coverage is provided until the recipient is enrolled into managed care. Managed care coverage is determined using prospective enrollment following current cutoff rules. Managed care health benefits are provided through the STAR Program.

Example: An application is received on January 1 and processed on January 25 (after cutoff); the managed care effective date is March 1. The initial months (January and February) will be covered as fee-for-service.

TWH, F-1100, Domicile

Revision 10-2; Effective April 1, 2010

Domicile requirements do not apply to the Former Foster Care in Higher Education program.

TWH, F-1200, Deprivation

Revision 10-2; Effective April 1, 2010

Deprivation requirements do not apply to the Former Foster Care in Higher Education program.

TWH, F-1300, Child Support

Revision 10-2; Effective April 1, 2010

Child and medical support requirements do not apply to the Former Foster Care in Higher Education program.

TWH, F-1400, Resources

Revision 15-4; Effective October 1, 2015

Resources are not considered in determining eligibility for Former Foster Care in Higher Education (FFCHE).

TWH, F-1500, Income

Revision 15-4; Effective October 1, 2015

Income is not considered as a factor in determining eligibility for Former Foster Care in Higher Education (FFCHE).

TWH, F-1600, Deductions

Revision 15-4; Effective October 1, 2015

Since there is no income test, deductions are not considered as a factor in determining eligibility for Former Foster Care in Higher Education (FFCHE).

TWH, F-1700, School Enrollment

Revision 15-4; Effective October 1, 2015

F—1710 General Policy

Revision 15-4; Effective October 1, 2015

An applicant or recipient must be enrolled in an institution of higher education located in Texas to receive Former Foster Care in Higher Education (FFCHE) health care benefits. The applicant/recipient may be attending school half-time or full-time. There is no requirement regarding the number of hours the student must be taking. The following are considered institutions of higher education:

- college (public or private),
- community college,
- junior college,
- technical institute, and
- university.

Note: Trade schools such as beauty schools or mechanic schools do not meet the definition of an institution of higher education.

F—1720 Verification Requirements

Revision 15-4; Effective October 1, 2015

School enrollment must be verified at application and renewal. The following are valid sources of verification for school enrollment:

- financial aid statement;
- enrollment certification;
- official fee receipt; and
- Form H1870, School Enrollment Verification Form.

Note: Online courses are only acceptable if the university/college has a branch located in Texas.

F—1730 Documentation Requirements

Revision 10-2; Effective April 1, 2010

Document the type of institution the applicant/recipient is attending and the source of school enrollment verification.

TWH, F-1800, Management

Revision 15-4; Effective October 1, 2015

Management requirements are not applicable for the Former Foster Care in Higher Education (FFCHE) program.

TWH, F-1900, Reminders

Revision 15-4; Effective October 1, 2015

F—1910 General Policy

Revision 15-4; Effective October 1, 2015

Before certifying applicants and recertifying recipients, complete the following:

- Ensure the applicant completes each question and signs and dates the application.
- Give the applicant Form H1019-F, Reporting Changes to Your Case. Explain that changes must be reported within 10 days after knowing about the change. Indicate the appropriate reporting requirement on Page 1.
- Refer the applicant to other programs for which the individual might be eligible such as the Supplemental Nutrition Assistance Program (SNAP); Temporary Assistance for Needy Families (TANF); Medicaid; Supplemental Security Income (SSI); or Retirement, Survivors and Disability Insurance (RSDI). Refer individuals with a disability who are ineligible for Medical Programs for families

and children to the Texas Health and Human Services Commission (HHSC) Medicaid for the Elderly and People with Disabilities (MEPD) programs.
- Inform applicants of the right to request a review of their case for any HHSC action that affects their eligibility.
- Inform the applicant that the information provided is subject to verification by third parties.

There is no requirement to inform individuals to report accidents.

F—1920 Documentation Requirements

Revision 15-4; Effective October 1, 2015

Document that Form H0025, HHSC Application for Voter Registration, was given to the applicant, authorized representative or representative payee in the Agency Use Only section of the application.

Related Policy
Registering to Vote, A-1521

TWH, F-2000, Case Disposition

Revision 15-4; Effective October 1, 2015

F—2010 Notice to Applicants

Revision 15-4; Effective October 1, 2015

When processing an application, redetermination or change, advisors are required to inform the individual if their request is pended, certified, sustained, or denied. Eligibility Determination Group (EDG) disposition is the end result of processing the request for assistance and will generate Form TF0001, Notice of Case Action. However, if the EDG cannot be disposed because it is pending for additional information/verification, the advisor must provide the individual with Form H1020, Request for Information or Action.

Form H1020, Request for Information or Action

Form H1020 informs the individual of the:

- reason the case is pending;
- action the individual or advisor must take;
- date by which the individual or advisor must take action; and
- date the advisor must deny the application or case if the individual does not take action, if applicable.

Note: For Spanish-speaking only individuals, ensure that all comments provided are in Spanish.

Form TF0001F, Notice of Case Action

TF0001F informs the individual:

- the date benefits begin; or
- the date of denial; and
- about his/her right to request a review of the case action.

Note: For Spanish-speaking only individuals, ensure that all comments provided are in Spanish.

F—2020 Length of Certification

Revision 15-4; Effective October 1, 2015

The Texas Integrated Eligibility Redesign System (TIERS) calculates the eligibility end date from the date the advisor disposes the EDG as follows:

- Applications – initial certification month plus 11 months.
- Renewals – 12 months from the last certification month.

Individuals are eligible for Former Foster Care in Higher Education (FFCHE) health care benefits for 12 months or through the month of their 23rd birthday, whichever is earlier.

Exception: A individual is not eligible to receive 12 months of coverage if the individual:

- reaches age 23,
- dies,
- voluntarily withdraws,
- moves out-of-state,
- reports receipt of adequate health coverage, or
- is not attending an institution of higher education.

F—2030 Setting Special Reviews

Revision 15-4; Effective October 1, 2015

Use Medical Programs policy in A-2330, Setting Special Reviews, to set special reviews.

F—2040 Adverse Action

Revision 15-4; Effective October 1, 2015

After certification, give households advance notice of adverse actions to deny benefits except for reasons listed in A-2344.1, Form TF0001 Required (Adequate Notice), and A-2344.2, No Form TF0001 Required.

Former FFCHE recipients receiving a notice of adverse action do not have the right to request a fair hearing. FFCHE recipients can request a review of their case action. See F-2300, Request for Review.

TWH, F-2100, Processing Time Frames

Revision 15-4; Effective October 1, 2015

F—2110 Applications

Revision 15-4; Effective October 1, 2015

Advisors must make an eligibility determination by the 45th day from the file date.

Reopen an application denied for failing to furnish information/verification if the missing information is provided by the 60th day from the file date. Use the date the missing information/verification was provided as the new file date.

Use the original application or renewal form until it is 60 days old. If the information on the form has changed or is more than 45 days old, the individual and advisor must update the form.

F—2120 Deadlines

Revision 10-2; Effective April 1, 2010

Provide Form TF0001-F, Notice of Case Action, the same day eligibility is determined for an application but no later than 45 days from the file date.

F—2130 Missed Interviews

Revision 10-2; Effective April 1, 2010

No interview is required to process an application or renewal unless requested by the applicant or recipient. If requested, provide the individual with a telephone interview. If the individual fails to keep the interview, do not deny the application or renewal but continue to process the request for assistance.

F—2140 Pending Information on Applications

Revision 10-2; Effective April 1, 2010

Advisors must request documents that are readily available to the household and consider it sufficient verification. Use the verification sources listed in the various eligibility elements of Part A, Determining Eligibility, as potential and acceptable sources of verification. C-900, Verification and Documentation, gives information on verification procedures.

In determining eligibility, staff must consider any information the individual reports between the application date and the decision date. Include any information the individual reports during the application decision process.

F—2150 Notice of Renewal/Expiration

Revision 15-4; Effective October 1, 2015

The Texas Integrated Eligibility Redesign System (TIERS) sends a renewal packet containing Form H1869, Renewal for Health Care Services; Form H1870, School Enrollment Verification Form; and a business reply envelope in the 11th month of the 12-month certification period.

F—2160 Processing Renewals

Revision 10-2; Effective April 1, 2010

F—2161 How to Process a Renewal

Revision 15-4; Effective October 1, 2015

Former Foster Care in Higher Education (FFCHE) recipients receive a passive renewal. Individuals are only required to return a renewal packet if information they provided during the application process has changed. If the individual does not return a renewal packet by the first calendar day of the last month of the certification period, TIERS automatically re-certifies the FFCHE Eligibility Determination Group (EDG) for another 12-month period, or through the month of the individual's 23rd birthday, whichever is earlier. This will not require the Centralized Benefit Services (CBS) advisor to run eligibility or dispose the case.

Exception: School enrollment must be verified at application or renewal for FFCHE. If an FFCHE individual does not return the renewal packet, TIERS will process the passive renewal and will pend the EDG for school enrollment verification. If verification is not provided, the advisor will be required to run eligibility and dispose the case to sustain or deny benefits.

There is no interview requirement for an FFCHE renewal. The file date is the day any local Texas Health and Human Services Commission (HHSC) eligibility determination office receives the FFCHE application.

Verification from an associated EDG can be used if provided within 90 days of the FFCHE file date.

Follow the policy below when Form H1869/Form H1869-S, Renewal for Health Care Benefits, is returned for a renewal.

If the individual provides Form H1869/Form H1869-S indicating no change and has an associated EDG, review the associated EDG to determine if there is any conflicting data and if there is any documentation to clear the conflicting information. If not, request new verification via Form H1020, Request for Information or Action.

If the individual returns Form H1869/Form H1869-S reporting changes, provides verification and there are no associated EDGs, process the renewal using the new verification.

If the individual returns Form H1869/Form H1869-S reporting changes, provides verification and there are associated EDGs, review the associated EDGs and use the most recent information provided.

If the associated EDGs have other information the family did not report for the FFCHE EDG that would impact FFCHE eligibility, contact the individual (by telephone or Form H1020 with due date) to determine if the information in the associated EDGs is correct before denying or taking adverse action on the EDG.

If the individual returns Form H1869/Form H1869-S reporting changes without verification and has associated EDGs, request new verification via Form H1020.

If the individual returns Form H1869/Form H1869-S indicating changes, does not provide verification and does not have associated EDGs, request information needed to determine eligibility. If the individual does not provide the information, do not renew eligibility.

F—2170 Renewal Time Frames

Revision 10-2; Effective April 1, 2010

If the individual returns a renewal packet, advisors must make an eligibility determination by the 30th day from the file date.

Note: A renewal application is considered a renewal if it is received by the last day of the 12-month certification period.

Reopen a renewal application denied for failing to furnish information or verification if the missing information/verification is provided by the 60th day from the file date. Use the date the missing information/verification was provided as the new file date.

Use the original Form H1869/Form H1869-S, Renewal for Health Care Benefits, until it is 60 days old. If the information on Form H1869/Form H1869-S has changed or is more than 45 days old, the individual and advisor must update the form.

Reminder: Consider a renewal application received after the last day of the 12-month certification period as an application using application processing time frames.

F—2180 Pending Information

Revision 15-4; Effective October 1, 2015

Allow the household at least 10 days to provide missing information/verification. The due date must be a workday. Advisors must request documents that are readily available to the household if the documents are anticipated to be sufficient verification. If the applicant has any active or inactive EDGs, check to see if any verification previously provided for another EDG can be used to determine eligibility for FFCHE.

Use verifications accepted for Temporary Assistance for Needy Families (TANF), Medical Programs or the Supplemental Nutrition Assistance Program (SNAP).

For example, if you accept wage verification for a SNAP case, that same verification is acceptable for TANF, Medical Programs or FFCHE.

Exception: Verification of U.S. citizenship for applicants must be from a Medicaid-acceptable source. Staff cannot access the State Online Query/Wire Third-Party Query (SOLQ/WTPY) inquiry to verify citizenship or Retirement, Survivors and Disability Insurance (RSDI) for FFCHE processing. Advisors must request other types of verification, such as copies of birth certificates for citizenship and award letters for RSDI benefits.

Note: Do not use verification that is over 90 days old from the FFCHE file date.

F—2181 Summary of Due Dates for Form H1020, Request for Information or Action

Revision 15-4; Effective October 1, 2015

Case Action	Due Date	Final Due Date
Application	10 days	• 30th day, or • 10th day if the household's Form H1020 due date extends beyond the 30th day
Renewal	10 days	30th day, or by the 10th day if the household's Form H1020 due date extends beyond the last day of the last benefit month
Incomplete review	10 days	10th day

Note: Staff have until the 45th day from the file date to determine eligibility for applications.

TWH, F-2200,Changes

Revision 15-4; Effective October 1, 2015

F—2210 How to Report a Change

Revision 15-4; Effective October 1, 2015

Centralized Benefit Services (CBS) staff process all changes for Former Foster Care in Higher Education (FFCHE) recipients. FFCHE recipients can report changes:

- online through YourTexasBenefits.com;
- by visiting a local eligibility determination office (which will forward the change to CBS);
- by calling 2-1-1; or
- in writing, by mail or fax, or by completing Form H1019-F, Reporting Changes to Your Case. The individual may mail or fax the change to:
  - Document Processing Center:
    HHSC
    P.O. Box 149024
    Austin, TX 78714-9024
    Toll-free fax: 1-877-447-2839
  - A local eligibility determination office (which must send the change to CBS).

Note: When an FFCHE recipient reports a change by telephone, staff must verify that the person speaking is the individual or the authorized representative.

An FFCHE recipient must report the following changes:

- Address changes
- Receipt of health insurance
- Pregnancy
- If the individual moves out of state
- School enrollment status – no longer attending school

Exception: Individuals receiving FFCHE as of December 2013 and not eligible for Former Foster Care Children (FFCC) must also report income changes.

F—2220 Action on Changes

Revision 10-2; Effective April 1, 2010

Follow policy listed in B-600, Changes, for Medical Programs to determine how to process changes for FFCHE recipients.

TWH, F-2300, Request for Review

Revision 18-1; Effective January 1, 2018

F—2310 Request for Review Procedures

Revision 18-1; Effective January 1, 2018

Former Foster Care in Higher Education (FFCHE) recipients receiving notice of adverse action are not entitled to continued benefits when the Texas Health and Human Services Commission (HHSC) denies benefits for any reason if granting continued benefits would extend the 12-month eligibility period or extend the benefits past the person's 23rd birthday.

FFCHE recipients do not have the right to request a fair hearing. FFCHE recipients can request a review of the case action. A request for review is any expression of dissatisfaction with an adverse action. Advisors must tell FFCHE recipients that they must submit requests for review in writing.

FFCHE recipients have 30 business days from the date of the notification letter to submit a request for review concerning the decision that resulted in an adverse action. They must submit the request for review in writing to:

- Health and Human Services Commission
  Attention: Complaint Department
  P. O. Box 149027
  Austin, TX 78714-9027; or
- by toll-free fax to 877-542-5951.

Upon receipt of the request for review, HHSC (Centralized Benefit Services staff) reviews the adverse action and responds in writing within 10 business days from the date of receipt of the request. The response letter (Form TF0001F, Notice of Case Action) has information about the agency's answer to the request for review. HHSC staff document the final decision in the Texas Integrated Eligibility Redesign System (TIERS) Case Comments.

When HHSC receives a request for review after 30 business days or finds the request for review is not for an adverse action, HHSC denies the request and generates Form TF0001F, which informs the household of the denial reason.

TWH, F-2400, Automated Support

Revision 15-4; Effective October 1, 2015

F—2410 Data Broker

Revision 15-4; Effective October 1, 2015

Advisors must follow the policy explained in C-817, Electronic Data Sources (ELDS), and C-820, Data Broker.

TWH, Part M, Medicaid for Transitioning Foster Care Youth (MTFCY)

TWH, M-100, Application Processing

Revision 17-1; Effective January 1, 2017

M—110 Medicaid for Transitioning Foster Care Youth (MTFCY)

Revision 15-4; Effective October 1, 2015

The Chafee Foster Care Independence Act of 1999 gave states the option to extend Medicaid coverage to the population of youth who are between ages 18 and 21 and have aged out of foster care. Senate Bill 51, 77th Texas Legislature, Regular Session, 2001, was passed and signed into law effective September 1, 2001. This law allows the state to provide Medicaid coverage to youths who are aging out of foster care until they reach their 21st birthday.

The process to cover these individuals is coordinated between the Texas Department of Family and Protective Services (DFPS), which administers the foster care program, and the Texas Health and Human Services Commission (HHSC). When a child who is not eligible for Former Foster Care Children (FFCC) ages out of foster care in Texas, Medicaid eligibility is transferred from Foster Care Medicaid to Medicaid for Transitioning Foster Care Youth (MTFCY). DFPS certifies initial MTFCY eligibility for youths aging out of foster care and HHSC is then responsible for determining their future Medicaid eligibility.

Note: There may be situations in which HHSC processes the initial certification.

M—111 Type of Assistance (TP) 70 – Medical Assistance – MTFCY

Revision 15-4; Effective October 1, 2015

In order to be eligible for MTFCY, individuals must:

- be ineligible for FFCC (see Part E, Former Foster Care Children [FFCC]);
- be ages 18 up to 21;
- have been in foster care or voluntary agency (VolAg) conservatorship in Texas on their 18th birthday, or have had an Interstate Compact on the Placement of Children (ICPC) agreement*;
- meet Medical Programs citizenship and Social Security number requirements;
- be a Texas resident;
- not have adequate health coverage as defined by HHSC; and
- have countable income equal to or less than the applicable income limit for TP 70, defined in C-131.1, Federal Poverty Income Limits (FPIL). **Exception:** Individuals who have had an ICPC agreement do not need to meet the income requirement.

* Centralized Benefit Services (CBS) staff must contact DFPS to determine whether the individual had an ICPC agreement. DFPS has three business days to respond.

Exception: Individuals without an ICPC agreement enrolled on MTFCY on or before December 31, 2013, who were not eligible for FFCC because they aged out of foster care in a state other than Texas or they did not receive fully funded Medicaid when they aged out of foster care will remain on MTFCY until they reach the age limit.

CBS advisors are responsible for processing requests for MTFCY and for case maintenance of the MTFCY caseload (applications, renewals, changes, etc.). This type of assistance is identified in TIERS as TP 70.

Note: Federal regulations require states to provide Unaccompanied Refugee Minors (URMs) with the same range of medical benefits and services as those available to children who were in foster care. CBS is responsible for ensuring URMs continue to receive medical services through the end of their 21st birthday.

M—112 Application Processing

Revision 17-1; Effective January 1, 2017

Centralized Benefit Services (CBS) receives:

- a new MTFCY case/Eligibility Determination Group (EDG) via an interface with the Texas Department of Family and Protective Services (DFPS); or
- an application completed by an individual who aged out of foster care.

Note: DFPS provides a notice of eligibility to each individual.

CBS staff are notified by DFPS or HHSC Quality Assurance when a referral/interface is not completed. In cases where a DFPS referral/interface is not completed or processed, CBS staff must contact DFPS to determine the reason why the individual was not sent to HHSC via the interface and confirm whether eligibility criteria is met for MTFCY. If the individual meets the eligibility criteria in M-111, Type of Assistance (TP) 70 - Medical Assistance - MTFCY, CBS staff certify the individual for MTFCY without requiring an application.

There are instances when an individual is denied ongoing MTFCY coverage and must submit a new application for benefits. An individual may be denied ongoing MTFCY coverage if the individual:

- voluntarily withdraws;
- moves out of state; or
- fails to return verification during a renewal.

Individuals denied ongoing MTFCY benefits may experience a gap in coverage. When there is a gap in coverage, individuals must apply using any of the Medical Programs application channels explained in A-113, Application Requests and Submissions.

One of the following questions must be marked **Yes** on the application for eligibility to be considered for MTFCY.

- Were you in foster care at age 18 or older?
- Were you in an approved Unaccompanied Refugee Minor's Resettlement Program at age 18 or older?

If ineligible for MTFCY, the individual will be considered for eligibility under other Medical Programs.

M—113 Requesting an Application

Revision 15-4; Effective October 1, 2015

Applicants may request to apply for MTFCY as explained in A-113, Application Requests and Submissions.

If an applicant requests help completing an application, a volunteer or staff member must provide assistance. Anyone assisting the applicant in completing a paper application must initial the part completed, or sign the form indicating assistance was provided.

Related Policy
Registering to Vote, A-1521

M—114 Authorized Representatives (AR)

Revision 15-4; Effective October 1, 2015

An individual may designate an individual or organization as an AR, following the policy explained in A-170, Authorized Representatives (AR).

M—120 Office Procedures

Revision 10-2; Effective April 1, 2010

M—121 Filing an Application

Revision 17-1; Effective January 1, 2017

Individuals who wish to apply for MTFCY can:

- submit an application as explained in A-113, Application Requests and Submissions; and
- sign an application as explained in A-122, Application Signature.

M—122 File Date

Revision 17-1; Effective January 1, 2017

The file date is the day an application is received in one of the following ways:

- by an HHSC eligibility determination office;
- online through YourTexasBenefits.com;
- by telephone through 2-1-1; or
- through an account transfer from the Marketplace.

The file date is the day any HHSC eligibility determination office or call center vendor accepts an application containing the applicant's name, address, and appropriate signature. This is day zero in the application process.

Document why a certain file date was used to determine eligibility when:

- the file date used differs from the received date on the application; or
- the application has two received dates (stamp dates).

Note: For applications received outside of normal business hours, the file date is the next business day.

Related Policy
Application Signature, A-122.1

M—130 Interviews

Revision 10-2; Effective April 1, 2010

M—131 General Policy

Revision 10-2; Effective April 1, 2010

An interview is not required when applying for or renewing an application for the MTFCY program. Schedule a phone interview only if the individual requests an interview. The State Portal Scheduler does not support scheduling of the MTFCY program. Any requests for an

interview must be scheduled manually.

Note: Do not deny the application if the applicant misses the interview; continue determining eligibility.

TWH, M-200, Household Composition

Revision 15-4; Effective October 1, 2015

M—210 General Policy

Revision 15-4; Effective October 1, 2015

To determine the Modified Adjusted Gross Income (MAGI) household composition for Medicaid for Transitioning Foster Care Youth (MTFCY), the advisor follows the policy explained in A-240, Medical Programs.

Exception: An individual received via the Texas Department of Family and Protective Services (DFPS) interface will continue to have a MAGI household size of one. MAGI household size may change at the time of redetermination if additional information is received indicating that additional people should be included in the MAGI household composition.

M—220 Verification Requirements

Revision 15-4; Effective October 1, 2015

There are no verification requirements for household composition. Accept the individual's statement as verification.

TWH, M-300, Citizenship

Revision 15-4; Effective October 1, 2015

M—310 General Policy

Revision 15-4; Effective October 1, 2015

For most Medicaid for Transitioning Foster Care Youth (MTFCY) applications received via the Texas Department of Family and Protective Services (DFPS) interface, citizenship and alien status has been verified. For MTFCY applications not received via the DFPS interface, a period of reasonable opportunity may be granted if necessary, following the Medical Programs policy for citizenship and alien status eligibility in A-300, Citizenship.

Applicants who are U.S. citizens and certain legally admitted alien residents are eligible for MTFCY if they meet all other eligibility criteria.

TWH, M-400, Social Security Number (SSN)

Revision 10-2; Effective April 1, 2010

M—410 General Policy

Revision 10-2; Effective April 1, 2010

Applicants must provide an SSN or apply for one through the Social Security Administration (SSA) before certification. Use policy in A-411, Determining Advisor Action at Application, listed under the All Programs heading when an applicant does not have an SSN.

TWH, M-500, Age

Revision 10-2; Effective April 1, 2010

M—510 General Policy

Revision 10-2; Effective April 1, 2010

To receive Medicaid for Transitioning Foster Care Youth benefits, individuals must be at least age 18 and younger than age 21. Applicants are eligible to receive benefits from age 18 through the month of their 21st birthday.

M—520 Verification Requirements

Revision 10-2; Effective April 1, 2010

Accept self-declaration as verification of age.

M—530 Documentation Requirements

Revision 10-2; Effective April 1, 2010

Document the individual's self-declaration establishing the age.

TWH, M-600, Relationship

Revision 10-2; Effective April 1, 2010

Relationship requirements are not applicable in the Medicaid for Transitioning Foster Care Youth program.

TWH, M-700, Identity

Revision 10-2; Effective April 1, 2010

M—710 General Policy

Revision 10-2; Effective April 1, 2010

To establish identity, follow Medical Programs policy in A-600, Identity.

TWH, M-800, Residence

Revision 15-4; Effective October 1, 2015

M—810 General Policy

Revision 15-4; Effective October 1, 2015

To determine residence eligibility, follow TP 33, TP 34, TP 35, TP 43, TP 44 and TP 48 policy in A-700, Residence.

TWH, M-900, Adequate Health Coverage (Third-Party Resource)

Revision 15-4; Effective October 1, 2015

M—910 General Policy

Revision 15-4; Effective October 1, 2015

An applicant or recipient is not eligible to receive Medicaid for Transitioning Foster Care Youth (MTFCY) benefits if the individual currently has adequate health coverage. Adequate health coverage is also known as a third-party resource (TPR). Adequate health coverage is defined as receiving coverage under:

- group health insurance,
- health insurance coverage,
- Medicare (Part A or Part B),
- Medicaid (with the exception of the Texas Women's Health Program, Medicaid with Spend Down, and Community Attendant),
- Armed Forces insurance, or
- a state health risk pool.

Deny an application for an individual who has adequate health coverage.

Do not consider a plan with a limited scope of coverage such as dental, vision, long-term care, etc., or for only a specific illness/disease such as drug/substance abuse as adequate health coverage.

Consider an applicant/recipient as having adequate health coverage even if it has limits on benefits or high deductibles.

If staff receive a task with information that the individual has TPR and the "NHIC" box is greyed out, advisors deny rather than pend the EDG. This information has already been verified by the Office of Inspector General – Third Party Liability area.

When an MTFCY applicant is denied due to adequate health care coverage, Form TF0001, Notice of Case Action, will read:

"We found that you already have private health insurance. To learn more about the insurance you already get, call toll-free 1-800-846-7307 (after you pick a language, press 2)."

In some instances, the parents of MTFCY recipients have TPR coverage for them without the individual knowing. If the individual states they are not aware of the TPR, staff should advise them to call the claims administrator's Third Party Liability Customer Service Line at 1-800-846-7307 and select option 2. This will allow the individual to obtain information regarding their TPR.

If the TPR information in the Texas Integrated Eligibility Redesign System (TIERS) has been verified by the claims administrator but needs to be updated, staff should fax the completed Form H1039, Medical Insurance Input, to the claims administrator at 512-514-4215.

M—920 Verification Requirements

Revision 10-2; Effective April 1, 2010

Accept self-declaration of adequate health coverage.

Exception: If an applicant is denied due to receiving adequate health coverage and the applicant calls to notify HHSC that the medical insurance is not adequate health coverage, staff would need to verify if the coverage is considered adequate health coverage.

M—930 Documentation Requirements

Revision 10-2; Effective April 1, 2010

Staff must document in case comments the existence of adequate health coverage.

TWH, M-1000, Medicaid Eligibility

Revision 15-4; Effective October 1, 2015

M—1010 General Policy

Revision 10-2; Effective April 1, 2010,

The applicant is continuously eligible for 12 months beginning the first day of the application month if all eligibility criteria are met. Applicants are eligible to receive benefits beginning the month of their 18th birthday through the end of the month of their 21st birthday.

The medical effective date cannot precede the month of the applicant’s 18th birthday.

M—1011 Three Months Prior Coverage

Revision 10-2; Effective April 1, 2010

Follow policy in A-830, Medicaid Coverage for the Months Prior to the Month of Application, to provide Medicaid coverage if the individual meets eligibility criteria.

M—1012 Types of Coverage

Revision 15-4; Effective October 1, 2015

The type of coverage determines how recipients access Medicaid services. There are two types of coverage. They are fee-for-service and managed care.

Fee-for-Service — Also known as traditional Medicaid, allows access to any Medicaid provider and self-referral to specialists. The provider submits claims directly to the claims administrator for reimbursement of Medicaid-covered services.

Managed Care — A service delivery program that provides medical care in a managed care setting. The state pays a monthly premium to the health maintenance organization (HMO) for each recipient enrolled in the plan. The plan processes all provider claims.

Medicaid for Transitioning Foster Care Youth recipients have the option to enroll in either type of coverage. See A-821.2, Managed Care.

Related Policy
Types of Coverage, A-821

TWH, M-1100, Domicile

Revision 10-2; Effective April 1, 2010

Domicile requirements do not apply to the Medicaid for Transitioning Foster Care Youth program.

TWH, M-1200, Deprivation

Revision 10-2; Effective April 1, 2010

Deprivation requirements do not apply to the Medicaid for Transitioning Foster Care Youth program.

TWH, M-1300, Child Support

Revision 10-2; Effective April 1, 2010

Child and medical support requirements do not apply to the Medicaid for Transitioning Foster Care Youth program.

TWH, M-1400, Resources

Revision 15-4; Effective October 1, 2015

Resources are not considered in determining eligibility for Medicaid for Transitioning Foster Care Youth (MTFCY).

TWH, M-1500, Income

Revision 15-4; Effective October 1, 2015

M—1510 General Policy

Revision 15-4; Effective October 1, 2015

Medicaid for Transitioning Foster Care Youth (MTFCY) individuals must have income less than or equal to the applicable income limit for TP 70, defined in C-131.1, Federal Poverty Income Limits (FPIL).

Advisors must use Modified Adjusted Gross Income (MAGI) rules to determine financial eligibility for MTFCY following the Medical Programs policy, explained in A-1300, Income.

Exception: Individuals who have had an Interstate Compact on the Placement of Children (ICPC) agreement do not need to meet the income requirement.

TWH, M-1600, Deductions

Revision 10-2; Effective April 1, 2010

M—1610 General Policy

Revision 10-2; Effective April 1, 2010

Use Medical Programs policy in A-1400, Deductions, to determine which deductions a household is eligible to receive.

TWH, M-1700, School Enrollment

Revision 10-2; Effective April 1, 2010

School attendance requirements are not applicable for the Medicaid for Transitioning Foster Care Youth program.

TWH, M-1800, Management

Revision 10-2; Effective April 1, 2010

Management requirements are not applicable for the Medicaid for Transitioning Foster Care Youth program.

TWH, M-1900, Reminders

Revision 15-4; Effective October 1, 2015

M—1910 General Policy

Revision 15-4; Effective October 1, 2015

Before certifying applicants and recertifying recipients, advisors must:

- Ensure the applicant completes each question and signs and dates the application.
- Give the applicant Form H1019, Report of Change. Explain that changes must be reported within 10 days after knowing about the change. Indicate the appropriate reporting requirement on Page 1.
- Refer the applicant to other programs for which the individual might be eligible such as the Supplemental Nutrition Assistance Program (SNAP); Temporary Assistance for Needy Families (TANF); Medicaid; Supplemental Security Income (SSI); or Retirement, Survivors and Disability Insurance (RSDI). Refer individuals with a disability who are ineligible for Medical Programs for families and children to the Texas Health and Human Services Commission (HHSC) Medicaid for the Elderly and People with Disabilities (MEPD) programs.
- Inform the applicant of the right to appeal any HHSC action that affects the individual's eligibility.
- Inform the applicant that the information the applicant provides is subject to verification by third parties.

There is no requirement to inform individuals to report accidents.

M—1920 Documentation Requirements

Revision 15-4; Effective October 1, 2015

Document that Form H0025, HHSC Application for Voter Registration, was given to the applicant, authorized representative or representative payee in the Agency Use Only section of the application.

Related Policy
Registering to Vote, A-1521

TWH, M-2000, Case Disposition

Revision 15-4; Effective October 1, 2015

M—2010 Notice to Applicants

Revision 15-4; Effective October 1, 2015

When processing an application, redetermination or change, advisors are required to inform the individual if their request is pended, certified, sustained, or denied. Eligibility Determination Group (EDG) disposition is the end result of processing the request for assistance and will generate Form TF0001, Notice of Case Action. However, if the EDG cannot be disposed because it is pending for additional information/verification, the advisor must provide the individual with Form H1020, Request for Information or Action.

Form H1020, Request for Information or Action

Form H1020 informs the individual the:

- reason the case is pending,
- action the individual or advisor must take,
- date by which the individual or advisor must take action, and
- date the advisor must deny the application/case if the individual does not take action, if applicable.

Note: For Spanish-speaking only individuals, ensure that all comments provided are in Spanish.

Form TF0001, Notice of Case Action

TF0001 informs the individual:

- the date benefits begin,
- the date of denial,
- about his/her right to appeal, and
- address and telephone number of free legal services available in the area.

Note: For Spanish-speaking only individuals, ensure that all comments provided are in Spanish.

M—2020 Length of Certification

Revision 15-4; Effective October 1, 2015

The Texas Integrated Eligibility Redesign System (TIERS) calculates the eligibility end date from the date the advisor disposes the EDG as follows:

- Applications – initial certification month plus 11 months.
- Renewals – 12 months from the last certification month.

Individuals are continuously eligible for Medicaid for Transitioning Foster Care Youth benefits for 12 months or through the month of their 21st birthday, whichever is earlier.

Exception: An individual is not eligible to receive 12 months of continuous eligibility if the individual:

- starts receiving adequate health coverage,
- reaches age 21,
- dies,
- voluntarily withdraws, or
- moves out-of-state.

M—2030 Setting Special Reviews

Revision 10-2; Effective April 1, 2010

Use Medical Programs policy in A-2330, Setting Special Reviews, to set special reviews.

M—2040 Adverse Action

Revision 10-2; Effective April 1, 2010

Any household receiving a notice of adverse action has the right to request a fair hearing. In some situations, households may continue receiving benefits pending an appeal. After certification, give households advance notice of adverse actions to deny benefits except for reasons listed in A-2344.1, Form TF0001 Required (Adequate Notice), and A-2344.2, No Form TF0001 Required.

For adverse action, use current policy in A-2340, Adverse Action.

TWH, M-2100, Processing Time Frames

Revision 15-4; Effective October 1, 2015

M—2110 Applications

Revision 15-4; Effective October 1, 2015

Advisors must make an eligibility determination by the 45th day from the file date.

Advisors reopen an application denied for failing to furnish information/verification if the missing information is provided by the 60th day from the file date. Use the date the missing information/verification was provided as the new file date.

Advisors use the original application until it is 60 days old.

If the information on the form has changed or is more than 45 days old, the individual and advisor must update the form.

M—2120 Deadlines

Revision 10-2; Effective April 1, 2010

Provide Form TF-0001, Notice of Case Action, the same day eligibility is determined for an application but no later than 45 days from the file date.

M—2130 Missed Interviews

Revision 10-2; Effective April 1, 2010

No interview is required to process an application or renewal unless requested by the applicant/individual. If requested, provide the applicant/individual a telephone interview. If the individual fails to keep the interview, do not deny the application or renewal but continue to process the request for assistance.

M—2140 Pending Information on Applications

Revision 15-4; Effective October 1, 2015

Advisors may not request additional information or documentation from clients unless such information is not available electronically or the information obtained electronically is not consistent with the information provided by the client.

If additional information is needed, advisors must request documents that are readily available to the household and are considered to be sufficient verification. Each handbook section lists potential verification sources. C-900, Verification and Documentation, gives information on verification procedures.

In determining eligibility, advisors must consider any information the individual reports between the application date and the decision date. Include any information the individual reports during the application decision process.

M—2150 Notice of Renewal/Expiration

Revision 15-4; Effective October 1, 2015

The system generates and sends renewal correspondence to individuals enrolled in Medicaid for Transitioning Foster Care Youth (MTFCY) following the process explained in B-121, Notice of Redetermination/Certification Expiration, for TP 08 and Children's Medicaid (TP 43, TP 44 and TP 48).

Note: The system will generate Form H1206, Health Care Benefits Renewal – MTFCY, rather than Form H1206, Health Care Benefits Renewal – MA, for individuals renewing MTFCY.

M—2160 Processing Renewals

Revision 10-2; Effective April 1, 2010

M—2161 How to Process a Renewal

Revision 15-4; Effective October 1, 2015

MTFCY recipients complete the administrative renewal process explained in B-122.4, Medical Program Administrative Renewals.

Note: If an individual is required to return a renewal form and returns a paper Form H1206, Health Care Benefits Renewal – MTFCY, the form is routed to Centralized Benefit Services (CBS) for processing.

M—2170 Renewal Time Frames

Revision 15-4; Effective October 1, 2015

For individuals required to return a renewal packet, advisors must process the manual renewal as explained in B-122.4.2, Processing a Manual Renewal.

M—2180 Pending Information

Revision 15-4; Effective October 1, 2015

Allow the household at least 10 days to provide missing information/verification. The due date must be a workday. Advisors must request documents that are readily available to the household if the documents are anticipated to be sufficient verification. If the applicant has any

active or inactive Eligibility Determination Groups (EDGs), check to see if any verification previously provided for the other EDGs can be used to determine eligibility for MTFCY.

Use verifications accepted for the Temporary Assistance for Needy Families (TANF) program, Medical Programs or the Supplemental Nutrition Assistance Program (SNAP).

For example, if you accept wage verification for a SNAP case, that same verification is acceptable for TANF, Medical Programs or MTFCY.

Exception: Only Medical Programs sources of verification of U.S. citizenship for applicants can be used.

Note: Do not use verification that is over 90 days old from the MTFCY file date.

M—2181 Summary of Due Dates for Form H1020, Request for Information or Action

Revision 15-4; Effective October 1, 2015

Case Action	Due Date	Final Due Date
Application	10 days	• 30th day, or • 10th day if the household's Form H1020 due date extends beyond the 30th day
Renewal	10 days	• 30th day or by cutoff in the last benefit month of certification, whichever is later; or • 10th day if the household's Form H1020 due date extends beyond the last day of the last benefit month
Incomplete review	10 days	10th day

Note: Staff have until the 45th day from the file date to determine eligibility for applications.

TWH, M-2200, Changes

Revision 16-4; Effective October 1, 2016

M—2210 How to Report a Change

Revision 15-4; Effective October 1, 2015

Centralized Benefit Services (CBS) staff process all changes for Medicaid for Transitioning Foster Care Youth (MTFCY) recipients. MTFCY recipients can report changes:

- online through YourTexasBenefits.com;
- by visiting a local eligibility determination office (which will forward the change to CBS);
- by calling 2-1-1; or
- in writing, by mail or fax, or by completing Form H1019, Report of Change. The individual may mail or fax the change to:
    - Document Processing Center:

HHSC
P.O. Box 149024
Austin, TX 78714-9024
Toll-free fax: 1-877-447-2839

- A local eligibility determination office (which will send the change to CBS).

Note: When a change is reported by telephone, staff must verify that the person speaking is the individual or an authorized representative.

An individual is continuously eligible for MTFCY for 12 months or through the month of his 21st birthday, whichever is earlier.

An individual must report the following changes:

- an address change;
- income, including sources of income, regular hours worked, and pay rate;
- Modified Adjusted Gross Income (MAGI) expenses;
- voluntary withdrawal of the individual;
- receipt of health insurance; or
- if the individual moves out of state.

Process all other changes, including agency-generated changes, at the next renewal.

Exception: If the individual failed to report required information at the time of the application that causes the individual to be ineligible for MTFCY, advisors must deny the benefits and send a fraud referral to the Office of the Inspector General.

M—2220 Action on Changes

Revision 15-4; Effective October 1, 2015

If an individual reports a change or the advisor receives an agency-generated change during the 12-month continuous eligibility period and has:

- no associated Eligibility Determination Group (EDG) – document the change and handle at renewal, unless it is a change of address, the certified individual dies, a voluntary withdrawal, receipt of health insurance or the individual moves out of Texas.
- an associated EDG – document the change and handle at renewal, unless it is a change of address, the certified individual dies, a voluntary withdrawal, receipt of health insurance or the individual moves out of Texas.
- a change of address – mail the individual Form H0025, HHSC Application for Voter Registration, to register to vote based on the new address. If the individual contacts CBS or 2-1-1 to decline the opportunity to register to vote after receipt of Form H0025, mail Form H1350, Opportunity to Register to Vote, to the individual for a signature. File Form H1350 in the case record when the individual returns the form and retain the form for at least 22 months.

Follow Medical Programs policy in B-600, Changes, for verification and documentation requirements.

Related Policy
Registering to Vote, A-1521

M—2221 Returned Mail

Revision 16-4; Effective October 1, 2016

When returned mail is received, the vendor creates and assigns a Returned Mail (RTML) task to Centralized Benefit Services (CBS) staff for processing.

Upon receipt of the RTML task, CBS staff must take the following actions:

1. Review the address on the returned mail, the case record, and the State Portal to determine whether the household has reported a new address. If a new address has been reported, process the address change and, if there is a Supplemental Nutrition Assistance Program (SNAP) Eligibility Determination Group (EDG), any related changes in shelter expenses.
2. If a new address has not been reported and a forwarding address was not provided, attempt to contact the household via telephone to obtain an updated address and document the attempt. If the household provides a new address, process the address change and, if there is a SNAP EDG, any related changes in shelter expenses. Otherwise go to Step 3.
3. If there is an individual(s) in the household who receives Retirement, Survivor's and Disability Insurance (RSDI) or Supplemental Security Income (SSI), use the State Online Query (SOLQ) to verify the household's address. Use the address in SOLQ to update the address if the address in SOLQ differs from the address on file and, if there is a SNAP EDG, explore shelter expenses.

If the address in SOLQ matches the address in the TIERS record, document in TIERS Case Comments that the SOLQ inquiry address matches the TIERS address and take no further action.

If unable to contact the individual by phone and there is not an individual(s) in the household who receives RSDI or SSI for the:

- MTFCY EDG, go to Step 4; and
- SNAP EDG, follow Step 5 under the process for a case that includes a SNAP EDG in B-638, Returned Mail.

4. If unable to update the address, simultaneously send emails using the following CBS email box to:

- Health Plan Operations (HPO) using the following email box:
  - cbs_ffche-mtfcy@hhsc.state.tx.us and
- Preparation for Adult Living (PAL) using the following email box:
  - OES_FFCC@hhsc.state.tx.us

HPO Process

- Send an email to the Medicaid CHIP Division (MCD) Health Plan Operations (HPO) at HPO_Star_Plus@hhsc.state.tx.us .
- Include in the subject line **Returned Mail – [last four digits of the client's case number]**.
- Include the following information in the email:
  - case name;
  - case number;
  - individual's date of birth (DOB), Social Security Number (SSN), and Medicaid individual Identification Number; and
  - date the response is needed.
- Leave the RTML task pending.

PAL Process

- Use the link below to identify the Lead Regional PAL staff covering the region of the client's last known address.
  - http://www.dfps.state.tx.us/Child_Protection/Youth_and_Young_Adults/Preparation_For_Adult_Living/PAL_coordinators.asp
- Send an email to the identified Lead Regional PAL staff.
- Include in the subject line **Returned Mail -- [last four digits of the client's case number].**
- Include the following information in the email:
  - case name;
  - case number;
  - individual's DOB, SSN, and Medicaid Individual Identification Number; and
  - date the response is needed.
- Leave the RTML task Pending.

Note:

For an individual who aged out of the Unaccompanied Refugee Minor (URM) Resettlement program, contact the following agencies and individuals to determine if the agency or individual has an updated address for the former URM:

- The URM's former Voluntary Agency (VolAg); and
- The two agencies in Texas that have URM programs:
  - Catholic Charities Diocese of Fort Worth
    - Jennifer Frazier, URM Director, at jfrazier@ccdofw.org
- Catholic Charities Diocese of Galveston-Houston
  - Debbie Sandberg, URM Coordinator, at 713-874-6505 or dsandberg@catholiccharities.org
  - Raj Kendrick, URM Director, at 281-874-6530 or rkendrick@catholiccharities.org

5. The MCD HPO and DFPS PAL staff have ten calendar days to respond. It is important that staff make the request as soon as possible. The response will include either:

- the known address on file for the individual; or
- no known address on file for the individual.

MCD HPO responds to the CBS email mailbox (cbs_ffche-mtfcy@hhsc.state.tx.us) and copies the original requestor with information from the plan by the tenth calendar day from when the email is sent, either confirming or denying that they have an address on file for the client. If they confirm, the response will include the address on file.

The **DFPS PAL** program responds to the email box (OES_FFCC@hhsc.state.tx.us) and copies the original requestor with information from the Lead Regional PAL staff by the tenth calendar day from when the email is sent, either confirming or denying that they have an address on file for the client. If they confirm, the response will include the address on file.

Note: If the MCD HPO and DFPS PAL both respond and provide different addresses, use the address received from the MCD HPO (unless the individual has already provided an address).

6. For cases with a SNAP EDG, if by the Form H1020 due date, the household:

- provides the requested information, process the address change for all active EDGs, including the MTFCY EDG, and address any related changes in shelter expenses for the SNAP EDG; or
- fails to provide the requested information, deny the SNAP EDG for failure to provide information. Send Form TF0001, Notice of Case Action, using the denial reason, "Failed to Provide Information".

For the MTFCY EDG, if by the tenth calendar day due date the HPO/PAL information:

- is provided, use the information to update the address in the TIERS record; or
- is not provided, use the following steps to deny the EDG(s) using the denial reason "Unable to Locate" as stated in A-2344.1, Form TF0001 Required (Adequate Notice).
    - In Change Action Mode, go to "Household Information" and select "Yes" for the question "is the worker unable to locate the household?"
    - Run eligibility.

Note: The HPO/PAL information cannot be used to verify residence for SNAP EDGs.

7. If MCD HPO or DFPS PAL provide an updated address within 30 days of the EDG's denial due to "Unable to Locate," reopen the EDG.

For the SNAP EDG, if the household is denied for failure to provide information and provides a correct address within the advance notice adverse action period, reopen the EDG using the original certification period and process any related changes in shelter expenses. Please refer to the TIERS Advance Notice of Adverse Action Reference Guide in the ASK iT Knowledge Base for instructions.

Notes:

- If an address provided by MCD HPO or the DFPS PAL program differs from an address provided by the household, contact the household to resolve the discrepancy.
- For SNAP EDGs, if the household provides verification of residence, but does not provide information regarding shelter expenses, re-budget eligibility without the shelter expense and notify the household, according to policy in A-631, Actions on Changes.

Related Policy

Actions on Changes, B-631
Returned Mail, B-638

TWH, M-2300, Fair Hearings

Revision 10-2; Effective April 1, 2010

M—2310 Appeals Procedures

Revision 10-2; Effective April 1, 2010

Medicaid for Transitioning Foster Care Youth applicants or recipients receiving a notice of adverse action are not entitled to continued benefits when benefits are denied for any reason if doing so would extend the 12-month continuous eligibility period or benefits past their 21st birthday.

See B-1000, Fair Hearings, for specific appeals policy and procedures.

TWH, M-2400, Automated Support

Revision 15-4; Effective October 1, 2015

M—2410 Data Broker

Revision 15-4; Effective October 1, 2015

Advisors must follow the policy explained in C-817, Electronic Data Sources (ELDS), and C-820, Data Broker.

Exception: The consent policy explained in C-817 does not apply to individuals that are transferred to the Texas Health and Human Services Commission (HHSC) via the Texas Department of Family and Protective Services (DFPS) interface.

TWH, Part R, Refugee Medical Assistance (RMA)

Revision 17-2; Effective April 1, 2017

Effective February 1, 2017, HHSC no longer determines eligibility for Refugee Medical Assistance (RMA) and benefits provided to Unaccompanied Refugee Minors (URM's) under Former Foster Care Children (FFCC) or Medicaid for Transitioning Foster Care Youth (MTFCY).

TWH, Part W, Healthy Texas Women (HTW)

TWH, W-100, Application Processing

Revision 17-2; Effective April 1, 2017

W—110 Healthy Texas Women (HTW)

Revision 17-2; Effective April 1, 2017

HTW provides for a continuous 12-month certification period with the following limited health care benefits:

- Annual family planning exams
- Family planning counseling and education
- Treatment of certain sexually transmitted infections
- Birth control (except emergency birth control), including methods to permanently prevent pregnancy (tubal ligations or Essure)
- Follow-up family planning visits related to the method of birth control

Note: For individuals ages 15-17, a parent or legal guardian's signature is required.

W—111 Type of Assistance (TA) 41 – Health Care – HTW

Revision 17-2; Effective April 1, 2017

To qualify for HTW, applicants must:

- be female, ages 15 through 44 (for applicants ages 15-17, a parent or legal guardian **must** apply on their behalf);
- have countable income of less than or equal to the 200% federal poverty income limit;
- be a U.S. citizen or legally admitted alien who meets all eligibility requirements for Medicaid;
- be a Texas resident;
- not be pregnant;

- not have creditable health insurance; and
- not currently receive Medicaid, Medicare (Part A or B) or Children's Health Insurance Program benefits.

HTW applications and renewals are processed and disposed by specialized Texas Works advisors located at the San Antonio customer care center.

Notes:

- A legal guardian is a person who has been appointed by a judge to take care of a child younger than age 18.
- Applications received for individual ages 15-17 without a parent or legal guardian signature must be denied using the denial reason, “Denied 15-17 without parent or legal guardian’s signature."
- Married minors ages 15-17 are not eligible for HTW. The HTW application must be denied using the denial reason, “Denied 15-17 married minors”.

Related Policy
General Policy, W-510

W—112 Application Procedures

Revision 17-2; Effective April 1, 2017

Applicants must complete Form H1867/H1867-S, Healthy Texas Women Application Form, or Form H1867-R/H1867-RS, Healthy Texas Women Renewal.

Note: No other application can be used to apply for HTW.

W—113 Requesting an Application

Revision 17-2; Effective April 1, 2017

Form H1867/H1867-S, Healthy Texas Women Application, may be downloaded from the HHSC Texas Works Handbook and is also available:

- online at www.YourTexasBenefits.com;
- online at www.healthytexaswomen.org;
- by calling 2-1-1;
- by calling toll-free 1-866-993-9972;
- at the local Texas Health and Human Services Commission (HHSC) benefits office;
- from participating family planning or participating providers; and
- at participating Supplemental Nutritional Assistance for Women, Infants and Children (WIC) offices and community-based organizations.

On the same day the request is received, provide the applicant an application packet that includes the following:

- Form H1867 or Form H1867-S
- Form H0025, HHSC Application for Voter Registration
- A postage-paid envelope addressed to:

  Texas Health and Human Services Commission
  P.O. Box 149021
  Austin, TX 78714-9021

Note: Form H0050, Parent Profile Questionnaire, is not required.

If an applicant requests help completing Form H1867/H1867-S or Form H0025, a volunteer or staff member must give help and initial the parts completed or sign Form H1867/H1867-S to show the applicant received help.

Related Policy
Registering to Vote, A-1521

W—120 Office Procedures

Revision 17-2; Effective April 1, 2017

W—121 Filing an Application

Revision 17-2; Effective April 1, 2017

Applicants submit Form H1867/H1867-S, Healthy Texas Women Application:

- online at www.YourTexasBenefits.com;
- online at www.healthytexaswomen.org;
- by calling 2-1-1;
- by mail to:

Texas Health and Human Services Commission
P.O. Box 149021
Austin, TX 78714-9021

- by fax toll-free to 1-866-993-9971 (HTW designated fax line);
- at a local HHSC benefits office; or
- at participating family planning provider offices.

If a local HHSC benefits office receives any Form H1867/H1867-S; Form H1867-R/H1867-RS, Healthy Texas Women Application; Form H1867-R/H1867-RS, Healthy Texas Women Renewal; or Form H1831, Adjunctive Eligibility Letter, staff must date stamp and fax it to the designated fax line no later than the next business day. When an HHSC office receives Form H1867-R/H1867-RS or Form H1831, staff must date stamp and fax it to the Document Processing Center using current procedures.

Accept all submitted forms if they have the applicant's name, address and signature. HHSC does not need an original signature for faxed applications.

W—122 Telephonic Signatures

Revision 17-2; Effective April 1, 2017

The HTW program allows individuals who apply via 2-1-1 to submit applications using a telephonic signature. HHSC will send the following correspondence based on the actions taken by the individual.

Action	Correspondence
Individual telephonically signs the application.	Form H1031, Telephonic Signatures Cover Letter, notifies the HTW applicant or parent/legal guardian of a minor HTW applicant they submitted a telephonically signed application or renewal.
Individual declines to telephonically sign the application.	Form M5021A, Signature Form, notifies the individual a signature is needed to complete the application process, and Form H1867, Healthy Texas Women Application, populated with the information provided over the phone.

W—123 File Date

Revision 17-2; Effective April 1, 2017

The file date is the day any HHSC benefits office accepts Form H1867/H1867-S, Healthy Texas Women Application; Form H1867-R/H1867-RS, Healthy Texas Women Renewal; or Form H1831, Adjunctive Eligibility Letter, containing the applicant's name, address and appropriate signature. This is day zero in the application process.

Document why a certain file date was used to determine eligibility when:

- a file date differs from the received date on the application; or
- the application has two received dates (stamp dates).

Note: Because family planning providers may have extended weekend hours and will fax a majority of the applications, the file date is the day it is faxed to the HTW fax line.

Related Policy
General Policy, W-910

W—124 Faxed Applications

Revision 17-2; Effective April 1, 2017

When an individual or provider states that an application was faxed to the HTW designated fax line, but it is determined that the fax was not received, verbally inform the individual or provider to fax the confirmation page and original application to determine the correct file date.

If HTW staff receives the fax confirmation page and the original application:

- Within 30 days of the submission of the original application, the file date is the submission date as shown on the fax confirmation page. Use the date printed by the fax machine to verify the original submission date.
- More than 30 days after the original submission date, the file date is the date the application is resubmitted.

W—130 Interviews

Revision 07-0; Effective July 1, 2007

W—131 General Policy

Revision 17-2; Effective April 1, 2017

An interview is not required when applying for or renewing an application for HTW. Schedule a telephone interview only if the individual requests an interview. Process an application or renewal by mail or telephone.

Note: Do not deny the application if the applicant misses the interview; continue determining eligibility.

TWH, W-200, Household Composition

Revision 17-2; Effective April 1, 2017

W—210 General Policy

Revision 17-2; Effective April 1, 2017

Household composition is self-declared. Married minors are not eligible for the Healthy Texas Women (HTW) program.

W—211 Budget Group

Revision 17-2; Effective April 1, 2017

The budget group for a minor applicant consists of the:

- minor applicant;
- minor's parent(s);
- minor’s siblings; and
- minor’s children.

The budget group for an adult applicant consists of the:

- applicant;
- applicant's spouse; and
- mutual and non-mutual children under age 19 of the applicant and/or spouse.

A woman may not exclude a mandatory child from her budget group.

Do not include the following individuals in the HTW budget group:

- individuals who do not meet age and relationship requirements;
- Supplemental Security Income (SSI) recipients;
- children receiving foster care or adoption assistance;
- individuals who are incarcerated;
- residents of state supported living centers or institutions. If the child's living arrangement is questionable, refer to A-241.3.1, Children's Living Arrangements; or
- HTW minor's legal guardian. A legal guardian is a person who has been appointed by a judge to take care of a child younger than age 18.

W—212 Certified Group

Revision 17-2; Effective April 1, 2017

Treat women age 18 as adults. The certified group consists only of the woman (adult or minor) applying, and there can only be one certified woman on an HTW EDG. Do not certify an incarcerated woman or married minors.

W—220 Verification Requirements

Revision 07-0; Effective July 1, 2007

There are no verification requirements for household determination.

TWH, W-300, Citizenship

Revision 17-2; Effective April 1, 2017

W—310 General Policy

Revision 17-2; Effective April 1, 2017

The Healthy Texas Women (HTW) program follows the Medical Programs citizenship policy in A-300, Citizenship.

Exception: Applicants do not receive the period of reasonable opportunity explained in A-351.1, Reasonable Opportunity.

Applicants who are U.S. citizens and certain legally admitted alien residents are eligible for HTW if they meet all other eligibility criteria.

TWH, W-400, Social Security Number (SSN)

Revision 13-1; Effective January 1, 2013

W—410 General Policy

Revision 13-1; Effective January 1, 2013

All applicants must provide an SSN or apply for one through the Social Security Administration (SSA) before certification. Follow policy in A-411, Determining Advisor Action at Application, under the All Programs heading when an applicant does not have an SSN.

TWH, W-500, Age

Revision 17-2; Effective April 1, 2017

W—510 General Policy

Revision 17-2; Effective April 1, 2017

To receive Healthy Texas Women (HTW) benefits, an individual must be age 15 through 44. An applicant is considered age 15 the month of her 15th birthday and age 44 through the month of her 45th birthday. For individuals ages 15 through 17, a parent or legal guardian must apply on the individual's behalf.

Ten days prior to a women turning 18 years old, she will receive Form H1871, HTW Client Turning 18 Years Old, to inform her she is now responsible for managing her own HTW EDG. The form also provides information about how to report a confidential address.

Married minors are not eligible for HTW; the TF0001-W will inform the minor of other services they may be eligible to receive.

Examples:

- A woman turns age 15 on February 9. A parent filed an HTW application January 17. The woman is ineligible to receive HTW as she is not turning age 15 in the application month. A parent or legal guardian must reapply in the month of February to meet the age requirements.
- A woman turns age 18 on July 27. A parent filed an HTW application June 5. The woman is eligible for HTW. Ten days prior to her 18th birthday (July 17), the Form H1871 is generated to inform her once she turns 18 she is responsible for managing her own HTW EDG.
- A woman turns age 45 on May 5. She will no longer be eligible to receive HTW benefits effective June 1.

Age is self-declared. If questionable, verify the applicant's age using the Bureau of Vital Statistics (BVS). If unable to verify using BVS, attempt to contact the applicant to clear the discrepancy. Use information provided by the applicant on a previous Eligibility Determination

Group, if possible.

If an HTW application is received in a month the applicant:

- is age 14 and the application is processed in a month she becomes age 15, deny the application because of age;
- is age 44, and the application is processed in a month she becomes age 45, if otherwise eligible, certify for the month of application and the month of her 45th birthday; or
- becomes age 45, and the application is processed the month after her 45th birthday, if otherwise eligible, certify for the month of application only.

Use the following denial reason:

- **English** — You do not meet the age requirement for the Healthy Texas Women. To receive benefits under this program, you must be 15 through 44 years of age.
- **Spanish** — Usted no llena los requisitos de edad del programa Healthy Texas Women. Para recibir beneficios bajo este programa, tiene que tener entre 15 y 44 años de edad.

Married minors ages 15 through 17 are not eligible for HTW. Advisors must use the denial reason, “Denied 15-17 married minors”. The TF0001, Notice of Case Action will include the following language:

English:

Notice Language –You are not able to get Healthy Texas Women services because you are an emancipated minor. You might be able to get services through other programs:

Medicaid or CHIP. Apply by: (1) going to YourTexasBenefits.com or (2) calling 2-1-1 or 1-877-541-7905 for an application (after you pick a language, press 2).

Family Planning Program services. Apply by: (1) going to HealthyTexasWomen.org or (2) calling 2-1-1 or 1-877-541-7905 (after you pick a language, press 2).

Spanish:

Notice Language – Usted no puede recibir servicios de Healthy Texas Women porque es una menor de edad emancipada. Es posible que usted pueda recibir servicios a través de otros programas:

Medicaid o CHIP. Para hacer la solicitud: (1) vaya a YourTexasBenefits.com o (2) llame al 2-1-1 o al 1-877-541-7905 para pedir una solicitud (después de seleccionar un idioma, oprima el 2).

Servicios del Programa de Planificación Familiar. Para hacer la solicitud: (1) vaya a HealthyTexasWomen.org o (2) llame al 2-1-1 o al 1-877-541-7905 (después de seleccionar un idioma, oprima el 2).

When a parent or legal guardian does not apply for a minor between the ages of 15 through 17 Advisors must use the denial reason of, “Denied 15 -17 without parent or legal guardian’s signature” The TF0001, Notice of Case Action will include the following language:

Notice Language–You are not able to get Healthy Texas Women services. A parent or legal guardian must apply for young women ages 15 to 17 -- that was not done in this case. You might be able to get services through other programs:

Medicaid or CHIP. Apply by: (1) going to YourTexasBenefits.com or (2) calling 2-1-1 or 1-877-541-7905 for an application (after you pick a language, press 2).

Family Planning Program services. Apply by: (1) going to HealthyTexasWomen.org or (2) calling 2-1-1 or 1-877-541-7905 (after you pick a language, press 2).

Spanish:

Notice Language – Usted no puede recibir servicios de Healthy Texas Women. Uno de los padres o un tutor deben llenar la solicitud para jovencitas de 15 a 17 años, lo cual no se hizo en este caso. Es posible que usted pueda recibir servicios a través de otros programas:

Medicaid o CHIP. Para hacer la solicitud: (1) vaya a YourTexasBenefits.com o (2) llame al 2-1-1 o al 1-877-541-7905 para pedir una solicitud (después de seleccionar un idioma, oprima el 2).

Servicios del Programa de Planificación Familiar. Para hacer la solicitud: (1) vaya a HealthyTexasWomen.org o (2) llame al 2-1-1 o al 1-877-541-7905 (después de seleccionar un idioma, oprima el 2).

W—520 Verification Requirements

Revision 07-0; Effective July 1, 2007

Accept self-declaration as verification of age.

W—530 Documentation Requirements

Revision 07-0; Effective July 1, 2007

Document the individual's self-declaration establishing her age.

TWH, W-600, Relationship

Revision 17-2; Effective April 1, 2017

W—610 General Policy

Revision 17-2; Effective April 1, 2017

To be part of the budget group, a legal parent-child relationship must exist between a child and:

- an adoptive parent by proof of adoption; or
- the mother by proof of having given birth to the child.

Related Policy
Budget Group, W-211

W—620 Verification Requirements

Revision 07-0; Effective July 1, 2007

Accept self-declaration as verification for establishing relationship.

W—630 Documentation Requirements

Revision 07-0; Effective July 1, 2007

Advisors must document the individual's self-declaration for establishing relationship.

TWH, W-700, Identity

Revision 13-1; Effective January 1, 2013

W—710 General Policy

Revision 13-1; Effective January 1, 2013

To establish identity, follow policy for Medical Programs in A-600, Identity.

TWH, W-800, Residence

Revision 17-2; Effective April1, 2017

W—810 General Policy

Revision 17-2; Effective April1, 2017

The Healthy Texas Women (HTW) program follows Children's Medicaid policy in A-700, Residence, to determine acceptable residence eligibility.

TWH, W-900, Health Care Eligibility

Revision 17-2; Effective April 1, 2017

W—910 General Policy

Revision 17-2; Effective April 1, 2017

A woman is continuously eligible for 12 months beginning the first day of the month all eligibility criteria are met. There is no three months prior eligibility for the Healthy Texas Women (HTW) program.

Note: This does not include three months prior only Medicaid or Medical Assistance - Medically Needy with Spend Down programs. An applicant can apply for and receive three months prior benefits under a Medicaid program.

The medical effective date (MED) cannot precede the month of the women's 15th birthday.

This is a fee-for-service program. Fee-for-service allows access to any health care provider and self-referral to specialists. The provider submits claims directly to the claims administrator for reimbursement of covered services.

If a household failed to report required information at the time of the application that causes the woman to be ineligible for HTW, advisors must deny the case.

Eligibility Determination Groups (EDGs) with end dates do not require an action to close when the individual does not return Form H1867-R/H1867-RS, Healthy Texas Women Renewal, or Form H1831, Adjunctive Eligibility Letter. These EDGs will close the last day in the 12th month of the certification period.

Note: Women are eligible to receive HTW during their Pay for Performance forfeit month(s).

Related Policy
Pay for Performance, A-2150
Eligibility Begin Dates, W-1920

W—911 Current Medicaid, Medicare (Part A or B) and Children's Health Insurance Program (CHIP) Recipients

Revision 17-2; Effective April 1, 2017

A woman is not eligible to receive Healthy Texas Women (HTW) benefits if currently receiving Medicaid, Medicare (Part A or B) or CHIP. If an application is received for a woman who is actively receiving Medicaid, Medicare (Part A or B) or CHIP, deny the application using the following disposition denial reason:

- **English** — You are ineligible to receive Healthy Texas Women services as you are currently receiving assistance under Medicare, Medicaid or CHIP.
- **Spanish** — Usted no llena los requisitos para recibir los servicios del Healthy Texas Women ya que actualmente recibe ayuda de Medicare, Medicaid o CHIP.

Staff must verify via State Online Query (SOLQ) that an applicant is not currently enrolled in Medicare (Part A or B). The Texas Integrated Eligibility Redesign System (TIERS) verifies if the applicant is receiving Medicaid or CHIP benefits at application, renewal and during the HTW 12-month continuous eligibility period.

If applications are received for …	and the …	the advisors must …	TIERS will …	Note:
both HTW and Medicaid before either are processed,	HTW application is certified first,	continue working on the Medicaid application. If the Medicaid EDG is certified,	automatically deny the HTW EDG. If the individual is eligible, the MED for the Medicaid application will follow current MED policy.	If the applicant is not certified for Medicaid, she will continue to receive ongoing HTW benefits.
both HTW and Medicaid before either are processed,	Medicaid application is certified first,	deny the HTW application. Use the appropriate denial code and provide the individual with Form TF001W, Notice of Case Action.	issue an error if the worker attempts to certify a HTW EDG and the individual is actively receiving Medicaid benefits.	

Note: This does not include three months prior only Medicaid or Medical Assistance - Medically Needy with Spend Down programs. An applicant can apply for and receive three months prior benefits under Medicaid. The three months prior check boxes will be disabled when Health Care-HTW is selected.

Related Policy
Eligibility Begin Dates, W-1920

W—912 Pregnant Women

Revision 17-2; Effective April 1, 2017

Women who are pregnant are ineligible to receive HTW benefits. If the question, "Are you pregnant?" is marked **Yes** on Form H1867/H1867-S, Healthy Texas Women Application; Form H1867-R/H1867-RS, Healthy Texas Women Renewal; or Form H1831, Adjunctive Eligibility Letter, deny the application/renewal using the following denial reason code and add the statement below to the comment section of Form TF001W, Notice of Case Action.

- **English** — On your application, you told us you are pregnant. Women who are pregnant cannot receive Healthy Texas Women benefits. To find out if you can receive Medicaid for pregnant women, please complete, sign and return the attached application.
- **Spanish** — En la solicitud, usted nos dijo que está embarazada. Las mujeres embarazadas no pueden recibir beneficios del programa Healthy Texas Women. Para saber si puede recibir Medicaid para mujeres embarazadas, por favor, llene, firme y envíe la solicitud adjunta.

Include Form H1010, Texas Works Application for Assistance — Your Texas Benefits, along with Form TF001W, Notice of Case Action, and a self-addressed stamped envelope addressed to the Document Processing Center when denying an application due to pregnancy.

If the question is not answered, pend the EDG. Allow the applicant normal processing time frames to provide an answer. Advisors must manually pend for verification. Verification is self-declared. Deny the application for failure to provide verification if the applicant/recipient does not provide verification.

Do not deny the recipient if a report of pregnancy is received during the 12-month continuous coverage period. Record the change and take action on the information at the next renewal.

Note: For HTW recipients who apply for Medicaid for Pregnant Women (TP 40), TIERS will deny the HTW EDG once the recipient is certified to receive benefits for her pregnancy.

W—913 Third-Party Resource (TPR)

Revision 17-2; Effective April 1, 2017

A woman is ineligible to receive HTW benefits if she has creditable health coverage (TPR). The applicant/recipient has creditable health coverage if her private health insurance covers family planning services.

An applicant/recipient's private health insurance is considered to cover family planning services if it provides **both:**

- family planning-related physician office visits and procedures, **and**
- contraceptive drugs and devices.

In making this determination, only consider whether the private health insurance provides coverage and do not give consideration to other issues such as high deductibles or dollar limits on drug coverage.

Form H1867/H1867-S, Healthy Texas Women Application, and Form H1867-R/H1867-RS, Healthy Texas Women Renewal, ask the applicant the following questions:

1. Do you have health insurance that covers family planning services? **Yes No**
2. If yes, will filing a claim on your health insurance cause physical, emotional or other harm to you from your spouse, parents or other person? **Yes No**
3. If yes, you must provide an explanation below of your situation.

A HTW applicant with creditable health coverage is eligible to receive benefits **only** if identifying and providing information to assist in pursuing third parties is against her best interest.

Staff must pend the applicant if she does not answer questions 1 and/or 2. Allow the applicant normal processing time frames to provide an answer. Verification is self-declared by the applicant. If the applicant does not self-declare the answer to question 1 and/or 2 by the deadline, deny the application for failure to provide.

If the applicant states **Yes** to question 1 and question 2 but leaves question 3 blank, do not pend the applicant for an answer; continue determining eligibility.

If the applicant states **Yes** to question 1 and **No** to question 2, deny the application using the following denial reason code and add the statement below to the comment section of Form TF001W, Notice of Case Action.

- **English** — On your application you told us you are covered by other health insurance. Women who are covered by other health insurance cannot receive Healthy Texas Women benefits.
- **Spanish** — En la solicitud, usted nos dijo que tiene cobertura de otro seguro médico. Las mujeres con cobertura de otro seguro médico no pueden recibir beneficios del programa Healthy Texas Women.

If during the recipient's 12-month continuous coverage period she reports having creditable health insurance, record the change and take action on the TPR information at the next renewal.

W—914 Auto Enrollment into HTW

Revision17-2; Effective April 1, 2017

Individuals receiving Medicaid for Pregnant Women (TP40) will be auto-enrolled in HTW at the end of their TP40 certification (with or without a birth outcome), if the woman is not eligible for Medicaid or CHIP.

The individual must meet the following eligibility requirements to be auto-enrolled to HTW:

- must be age 18 through 44; and
- must not have open/active TPR.

TIERS triggers Alert 824, Pregnancy Ending Test MAGI, on first day of the TP40 last benefit month to create a Task List Manager. Advisors will run the full modified adjusted gross income (MAGI) cascade. If the worker process results in a denial of Medicaid and CHIP because the individual:

- does not meet eligibility requirements, the TP40 individual is referred to the Marketplace and auto-enrolled into HTW; or
- failed to provide the verification needed to make a Medicaid/CHIP eligibility determination, the individual is not referred to the Marketplace; however, is auto-enrolled into HTW.

No other financial or non-financial rules will be applied for individuals who are auto-enrolled to HTW.

The effective date of the HTW EDG will be the first day of the month following the TP40 end of certification month.

When a woman is auto enrolled into HTW, TIERS will generate:

- a TF0001W– Notice of Case Action; and
- Form H1872, HTW Opting Out and Reporting Confidential Address.

The Form H1872 will provide the HTW individual with an opportunity to voluntarily withdrawal (opt out) and/or report a confidential address. The Form TF0001-W and H1872 will be mailed to the individual's current case address, since a confidential address for the HTW individual may not be available at the time of auto-enrollment.

Related Policy
Confidentiality, W-2400

W—920 Verification Requirements

Revision 17-2; Effective April 1, 2017

Accept self-declaration of pregnancy and TPR.

W—930 Documentation Requirements

Revision 07-0; Effective July 1, 2007

For TPR, staff must document in case comments:

- the availability of TPR for family planning services;
- if filing a claim would cause physical, emotional or other harm to the individual; and
- why, if provided.

TWH, W-1000, Domicile

Revision 17-2; Effective April 1, 2017

W—1010 General Policy

Revision 17-2; Effective April 1, 2017

Domicile verification is used to determine who is included in the budget group. A child must live in the home with a Healthy Texas Women (HTW) applicant/individual to be included in the budget group. A home is the family setting maintained or being established, as evidenced by continuation of responsibility for day-to-day care of the child by the relative with whom the child is living.

A child living in the home is not a requirement to receive HTW benefits. Domicile verification is not required when the HTW applicant has no children.

W—1020 Verification Requirements

Revision 07-0; Effective July 1, 2007

Accept self-declaration as verification of domicile.

TWH, W-1100, Deprivation

Revision 17-2; Effective April 1, 2017

Deprivation does not apply to Healthy Texas Women (HTW).

TWH, W-1200, Child Support

Revision 17-2; Effective April 1, 2017

Child and medical support requirements do not apply to Healthy Texas Women (HTW).

TWH, W-1300, Resources

Revision 17-2; Effective April 1, 2017

W—1310 General Policy

Revision 17-2; Effective April 1, 2017

Resources are exempt for Healthy Texas Women (HTW). However, staff must remember to verify income, such as royalties, dividends or interest generated by a resource.

TWH, W-1400, Income

Revision 18-1; Effective January 1, 2018

W—1410 General Policy

Revision 17-2; Effective April 1, 2017

Income is any type of payment that is of gain or benefit to a household. Income is either counted or exempted from the budgeting process. Earned income is related to employment and entitles a household to deductions not allowed for unearned income. Unearned income is income received without performing work-related activities. It includes benefits from other programs. To determine the date income can reasonably be anticipated, use factors specific to the source of income and the distance it has to travel through the mail, weekends and holidays.

Consider the income of any person who is included in the certified or budget group/Eligibility Determination Group (EDG).

Retirement, Survivors, and Disability Insurance (RSDI); Supplemental Security Income (SSI); Veterans Affairs (VA) benefits; or other such funds legally obligated to a beneficiary are not counted if a payee who is not a member of the household:

- receives the funds; and
- does not make the money available to the beneficiary.

In the beneficiary's EDG, the total amount of the legally obligated funds the payee makes available to the beneficiary in cash, by way of vendor payment or through items purchased for the beneficiary using the beneficiary's money (includes payments made by the payee to a third party on behalf of the beneficiary) is counted as unearned income. Any portion of the funds the payee keeps for the payee's own use is counted as unearned income in the payee's EDG.

The income of the following individuals must be considered:

- any person who is included in the certified or budget group/EDG member, including disqualified members;
- any person living in the home who is not included in the certified or budget group but who is legally responsible for a member of the certified group; and
- an alien's sponsor.

Exception: the income of a legal guardian for an HTW minor is not considered when determining the HTW eligibility.

If a woman is determined to be eligible, the EDG should not be denied if the budget group income increases above the income limit. The budget should be adjusted to reflect the new income.

Do not set a special review if the individual indicates that a change in income from any source will occur before the next renewal.

Since the Healthy Texas Women (HTW) provides limited benefits, a woman is not required to pursue and accept all income to which she is legally entitled per A-1311, Requirement to Pursue Income.

Note: As a prudent worker judgment, staff should inform the applicant of any income for which she may be eligible to receive.

W—1411 Types of Income

Revision 15-4; Effective October 1, 2015

W—1411.1 Disability Benefits

Revision 15-4; Effective October 1, 2015

W—1411.1.1 Agent Orange Settlement Payments

Revision 15-4; Effective October 1, 2015

Agent Orange Settlement Payments disbursed by AETNA Insurance Company and paid to the following individuals are exempt:

- veterans with disabilities exposed to Agent Orange while in Vietnam who suffer from total disabilities caused by any disease, and
- survivors of these deceased veterans.

These veterans receive yearly payments. Survivors of these deceased veterans receive a lump-sum settlement payment.

Note: Veteran's Administration payments are counted as unearned income, including benefits paid to veterans with service-connected disabilities resulting from exposure to Agent Orange. See W-1411.4.20, Veterans Benefits.

W—1411.1.2 Disability Insurance Benefits

Revision 15-4; Effective October 1, 2015

Count as unearned income.

W—1411.1.3 Radiation Exposure Compensation Act Payments

Revision 15-4; Effective October 1, 2015

Payments from the Radiation Exposure Compensation Act (the "Act"), Public Law 101-426, are exempt.

The Act established a program to pay damages to individuals for injuries or deaths caused by exposure to radiation from nuclear testing and uranium mining. When the affected individual is deceased, the surviving spouse, children, parents, grandchildren, or grandparents receive the payments.

W—1411.1.4 Worker's Compensation

Revision 15-4; Effective October 1, 2015

The gross benefit is counted as unearned income, less amounts:

- recouped for a prior worker's compensation overpayment, or
- paid for attorney's fees. **Note:** The Texas Workers' Compensation Commission (TWCC) or a court sets the amount of the attorney's fee to be paid.

A deduction from the gross benefit for court-ordered child support payments is not allowed.

Exception: Worker's compensation benefits paid to the individual for out-of-pocket medical expenses are considered as reimbursements.

W—1411.2 Education and Training

Revision 15-4; Effective October 1, 2015

W—1411.2.1 Educational Assistance

Revision 15-4; Effective October 1, 2015

Educational assistance, including educational loans, are exempt, regardless of the source. Loans for education, including loans from relatives or other people, are considered as educational assistance only if payment is deferred.

Educational assistance is:

- any financial aid for vocational or educational courses from:
  - an organization (such as fraternal, alumni, etc.); or

    - a government program or agency (such as the U.S. Office of Education, Department of Veterans Affairs, or Texas Department of Assistive and Rehabilitative Services).
- provided to students who are enrolled in a:
    - program that provides for completion of a secondary high school diploma or the equivalent (such as a general equivalency diploma [GED]);
    - school for people with intellectual or physical disabilities; or
    - post-secondary institution.

Note: "Post-secondary" includes institutions of higher education and others not requiring a high school diploma (such as community colleges and vocational educational programs) authorized by the state to provide educational or training programs beyond secondary education.

The U.S. Office of Education under Title IV of the Higher Education Act administers most educational assistance programs. A few examples of the most common Title IV educational assistance grants include:

- Pell Grants,
- Stafford Loan Program,
- Parent Loans for Students (PLUS Loans),
- Supplemental Educational Opportunity Grants,
- College Work Study, and
- Carl D. Perkins Loans (Title IV, Part E) (formerly National Direct Student Loans).

The National Community Services Act (NCSA) program also provides educational assistance. Individuals are awarded from $1,000 to $4,000 per year of completed services to apply toward past or future educational expenses. The educational award is not counted, as it is always made payable directly to the financial institution or institution of higher learning.

The Department of Veterans Affairs administers education programs designed for veterans, reservists, members of the National Guard, and their widows and orphans. These include:

- Montgomery GI Bill (MGIB) Active Duty Educational Assistance Program,
- Vocational Rehabilitation,
- Post-Vietnam Era Veterans' Educational Assistance Program (VEAP),
- Survivor's and Dependent's Educational Assistance (DEA), and
- MGIB - Selected Reserve Educational Assistance Program.

W—1411.2.2 Job Training

Revision 15-4; Effective October 1, 2015

W—1411.2.2.1 Workforce Innovation and Opportunity Act (WIOA)

Revision 15-4; Effective October 1, 2015

All WIOA payments are exempt.

W—1411.2.2.2 Other Job Training and Training Allowances

Revision 15-4; Effective October 1, 2015

Portions of payments earmarked as reimbursements for training-related expenses are exempt, and any excess is counted as earned income.

W—1411.3 Employment and Self-Employment Income

Revision 15-4; Effective October 1, 2015

W—1411.3.1 Children's Earned Income

Revision 17-2; Effective April 1, 2017

Exempt the earnings of a child under age 18 who is:

- a full-time student, including a home-schooled student**;** or
- a part-time student employed less than 30 hours a week.

Exempt the earnings of an 18-year-old in the budget group if the 18-year-old is:

- a full-time student, including a home-schooled child, or a part-time student employed less than 30 hours a week; **and**
- considered a child. A child is defined as a household member under 19 years of age unless the child is married or legally emancipated.

W—1411.3.2 Contractual Earnings

Revision 15-4; Effective October 1, 2015

Contractual earnings are wages and salaries only. Self-employment income, unearned income, or income received on an hourly or piecework basis are not included. The two basic types of contractual earnings are:

- **Seasonal employment** — available only during certain months of the year and recurs each year. **Examples:** School-related employment, certain types of farm work, and summer or winter employment. Divide seasonal employment that is a household's annual means of support over 12 months. If the income supports the household for only a portion of the year and the household has income from other sources the rest of the year, average the earnings over the time they are intended to cover.
- **Contractual employment** — nonseasonal employment that is contracted for a specific time and does not recur. Divide earnings over the time covered by the contract.

W—1411.3.2.1 Monthly Budgeting of Contractual Earnings

Revision 15-4; Effective October 1, 2015

Contractual earnings may be budgeted monthly by:

- dividing the total gross amount earned under the contract by the number of months the contract covers or by 12 months, whichever is applicable; and
- adding this amount to any other income, and then budgeting according to usual procedures. **Note:** These steps should not be followed if the income is not received as stipulated in the contract or if labor disputes interrupt income.

If the individual's employment situation changes and the income is not received as stipulated in the contract or if labor disputes interrupt income, advisors should:

- recompute the income or adjust the benefits accordingly; and
- document all the facts that caused the recomputation or adjustment.

W—1411.3.3 Military Pay and Allowances

Revision 15-4; Effective October 1, 2015

Military pay and allowances for housing, food, base pay, and flight pay is counted as earned income, less pay withheld to fund education under the GI Bill.

W—1411.3.3.1 Family Subsistence Supplemental Allowance (FSSA)

Revision 15-4; Effective October 1, 2015

FSSA is a monthly payment made to certain low-income service members and their families so they will not have to depend on the Supplemental Nutrition Assistance Program (SNAP) to meet their needs. The service members' pay statements usually include the FSSA and are counted as earned income.

W—1411.3.3.2 Combat (Hazardous Duty) Payments

Revision 15-4; Effective October 1, 2015

All of the combat payments, also known as hazardous duty payments, received by a legal parent who is a member of the U.S. military, absent solely because the individual has been deployed to a combat zone, are counted as earned income.

W—1411.3.4 Self-Employment

Revision 15-4; Effective October 1, 2015

Self-employment income is usually income from one's own business, trade, or profession rather than from an employer. However, some individuals may have an employer and receive a regular salary. If an employer **does not** withhold income taxes or Federal Insurance Contributions Act (FICA) taxes, even if required to do so by law, the person is considered self-employed.

Advisors must inform households in writing to keep self-employment records and receipts for verification purposes for future recertifications. Form TF0001, Notice of Case Action, contains the self-employment information.

W—1411.3.4.1 Types of Self-Employment Income

Revision 15-4; Effective October 1, 2015

Types of self-employment include:

- odd jobs, such as mowing lawns, babysitting, and cleaning houses;
- owning a private business, such as a beauty salon or auto mechanic shop;
- farm income; and
- income from property.

For details about determining the amount of self-employment income for TWHP, see the following sections:

- A-1323.4.4, Determining the Amount of Self-Employment Income;
- A-1323.4.5, Allowable Costs of Producing Income;
- A-1323.4.6, Computation Methods;
- A-1323.4.7, Determining Net Self-Employment Income;
- A-1323.4.8, Changes in Annual or Seasonal Self-Employment Income; and
- A-1323.4.9, Rebudgeting Income and Expenses.

W—1411.3.4.2 Property Income

Revision 15-4; Effective October 1, 2015

Income from renting, leasing, or selling property on an installment plan is self-employment income. Property includes equipment, vehicles, and real property.

Income from property is counted as:

- earned if the:
  - person spends an average of at least 20 hours a week in management or maintenance activities; or
  - income is from noncommercial boarding situations.
- unearned if the person spends an average of less than 20 hours a week in management or maintenance activities.

Work-related expenses are allowed for earned income. For unearned income, only the expenses associated with producing the income should be deducted.

If the individual sells property on an installment plan, the payments are counted as income. The balance of the note is exempted as an inaccessible resource.

W—1411.3.4.3 Noncommercial Roomer/Boarder Payments

Revision 15-4; Effective October 1, 2015

The noncommercial roomer/boarder policy is used if a noncertified household member makes payments to a certified member under a formal or informal landlord/tenant relationship. Payments made by boarders for room, meals, and other shelter expenses are counted. Payments made by roomers for room and other shelter expenses are counted.

See A-1323.4.5, Allowable Costs of Producing Income, to determine the countable amount of noncommercial roomer/boarder payments. If there is not a formal or informal landlord/tenant relationship, A-1326.1, Cash Gifts and Contributions, policy applies.

Roomer/boarder status should not be given to:

- anyone whose income can be applied to the certified group; or
- a dependent child who is an ineligible alien.

W—1411.3.5 Wages, Salaries, Commissions and Tips

Revision 15-4; Effective October 1, 2015

The actual gross amount of all wages, salaries, commissions, bonuses and tips count as earned income before deductions such as flexible fringe benefits, cafeteria plans and employee retirement contributions are withheld from the amount.

Wages held by the employer at the request of the employee or garnished wages are counted as income in the month the household would otherwise have been paid. If, however, an employer holds the employee's wages as a general practice, this money counts as income in the month it is paid.

An advance counts in the month it is received. When an advance is repaid, the payback amount is deducted from the gross pay and the remainder is budgeted as the countable gross amount.

W—1411.3.5.1 Federal Tax Refunds and Earned Income Tax Credits (EIC)

Revision 15-4; Effective October 1, 2015

Households with tax dependents and earnings below levels established by the Internal Revenue Service (IRS) are potentially eligible to receive EIC payments from the IRS.

EIC money is included in an individual's:

- paycheck (advance EIC payments) before the individual files an income tax return, or
- IRS refund after the individual files an annual income tax return.

Federal tax refunds and EIC payments are exempt.

W—1411.3.5.2 Flexible Fringe Benefits

Revision 15-4; Effective October 1, 2015

Fringe benefit plans allow the employee to choose from benefit components such as insurance, extra vacation time, and payments to third parties for medical bills or child care. These are also called "cafeteria plans."

Under some plans, employers may:

- withhold wages to pay for benefits selected by the employee; or
- offer benefit credits in addition to wages, which the employee can use to purchase benefits.

Some plans may pay the remaining unused credit as part of the employee's wages.

If the employer …	the advisor must count …
withholds the employee's wages to purchase benefits,	the held wages as earnings in the pay period the employee would have normally received them.
provides credit in addition to wages,	as earnings only the portion that is paid directly to the employee. If the employer pays the unused credit in cash, the advisor must follow the steps below to determine the countable excess income: 1. Determine the total amount of gross wages/salary. 2. Add the benefit credit amount to the wages/salary from Step 1. 3. Subtract the cost of fringe benefits up to the amount of the benefit credit from the amount in Step 2. 4. The remaining income from Step 3 is the countable gross earned income for the EDG.

W—1411.3.5.3 Income from Tips

Revision 15-4; Effective October 1, 2015

Household members who are employed in service-related occupations (beauticians, waiters, delivery staff, etc.) are likely to earn tips in addition to wages. Tips are counted as earned income.

Tip income is added to wages before applying conversion factors.

Note: Tips are not considered as self-employment income unless related to a self-employment enterprise.

W—1411.3.5.4 Vacation Pay

Revision 15-4; Effective October 1, 2015

If an individual receives vacation pay …	the payment is considered …

If an individual receives vacation pay …	the payment is considered …
during or before termination of employment,	earned income.
after termination of employment in one lump sum,	a liquid resource in the month received.
after termination of employment in multiple checks,	unearned income.

W—1411.3.6 Temporary Census Income

Revision 15-4; Effective October 1, 2015

Exempt wages.

W—1411.4 Government Payments

Revision 15-4; Effective October 1, 2015

Government payments are counted unless exempted in this section or by other policy in W-1400, Income.

W—1411.4.1 Adoption Assistance

Revision 15-4; Effective October 1, 2015

Adoption assistance payments are exempt.

W—1411.4.2 Crime Victim's Compensation Payments

Revision 15-4; Effective October 1, 2015

Crime victim's compensation payments are provided from the funds authorized by state legislation to assist a person who:

- was a victim of a violent crime;
- was the spouse, parent, sibling, or adult child of a victim who died as a result of a violent crime; or
- is the guardian of a victim of a violent crime.

The Office of the Attorney General (OAG) distributes the payments monthly or in a lump sum. These payments are exempt.

W—1411.4.3 Government Disaster Payments

Revision 15-4; Effective October 1, 2015

Federal disaster payments and comparable disaster assistance provided by states, local governments, and disaster assistance organizations are exempt if the household is subject to legal penalties when the funds are not used as intended (including temporary employment of six months or less for disaster-related work, paid under the Workforce Innovation and Opportunity Act and funded by the National Emergency Grant).

Examples:

- Payments by the Individual and Family Grant Program or Small Business Administration to rebuild a home or replace personal possessions damaged in a disaster.
- Payments from the Federal Emergency Management Agency (FEMA) to assist with rent.

W—1411.4.4 Government Housing Assistance

Revision 15-4; Effective October 1, 2015

The value of government housing or rental subsidies, whether cash, two-party check, in-kind, or vendor-paid, are exempt.

W—1411.4.5 Transitional Living Allowance

Revision 15-4; Effective October 1, 2015

Transitional living allowances (TLA) are exempt. The Texas Department of Family and Protective Services (DFPS) distributes TLA to a foster child who:

- is under age 21;
- has completed the preparation for adult living (PAL) classes; and
- has left foster care or is transitioning out of foster care.

Payments:

- are received for a maximum of 12 months;
- cannot exceed $500 a month;
- cannot total more than $1,000; and
- are intended for expenses other than ongoing room and board.

W—1411.4.6 In-Home and Family Support Program (IH/FSP) Payments

Revision 15-4; Effective October 1, 2015

IH/FSP payments are from funds authorized by state legislation to assist persons with disabilities so they can live in the community. These payments are distributed by the Texas Department of Aging and Disability Services (DADS) to eligible individuals with:

- physical disabilities, who may receive grants of up to $1,200 annually with a maximum lifetime amount of $3,600; or
- intellectual disabilities, or eligible children newborn through age 3 with a developmental delay, who may receive grants of up to $2,500 annually.

These grants are available to purchase services, equipment, home modifications, or other items related to the individual's disability. State law requires that, to the extent possible, these funds be disbursed in a manner that does not interfere with the applicant's eligibility for Temporary Assistance for Needy Families (TANF), SNAP or Medicaid.

If a household member receives one IH/FSP payment during the year, the policy in W-1412.2, Reimbursements, applies.

If a household member receives more than one payment:

- any portion of the payment that is a reimbursement for expenses not included in the standard of need or for medical needs that are not paid by Medicaid is deducted; and
- prorate the income over the period covered.

W—1411.4.7 National and Community Services Act (NCSA)

Revision 15-4; Effective October 1, 2015

The NCSA established a corporation to administer paid volunteer service programs. The corporation provides funds, training, and technical assistance to states and communities to develop and expand human, education, environmental, and public safety services.
The corporation oversees programs created under the Domestic Volunteer Service Act (DVSA) of 1973 such as:

- Volunteers in Service to America (VISTA),
- Retired and Senior Volunteer Program (RSVP),
- Foster Grandparents, and
- Senior Companion Program.

The corporation also administers programs established in 1993 that include:

- AmeriCorps,
- Learn and Serve, and
- National Senior Service Corps (Senior Corps).

For programs established in 1973:

Payments, living allowances, and stipends are exempt.

For programs established in 1993:

Payments except on-the-job-training (OJT) payments are exempt.

OJT payments for adults are counted as earned income. A child's OJT payment is exempt if the child is under:

- age 19; and
- under parental control of another household member.

Exception: OJT payments received by AmeriCorps volunteers are exempt.

W—1411.4.8 Native and Indian Claims

Revision 15-4; Effective October 1, 2015

Exempted payments made to Native Americans under various public laws include, but are not limited to, the following:

- Distributions from Native Corporations made under the Alaska Native Claims Settlement Act (ANCSA) (Public Law [PL] 92-203 and Section 15 of PL 100-241).
- Funds distributed per capita or held in trust by the Indian Claims Commission for members of Indian tribes, as follows:
  - Grand River Band of Ottawa Indians (PL 94-540);
  - Income to certain tribal members from land held in trust by the United States government (PL 94-114, Section 6);
  - Income resulting from provisions of PL 92-254; and
  - Red Lake Band of Chippewa (PL 98-123, Section 3) or Assiniboine Tribe of the Fort Belknap Indian Community, and the Assiniboine Tribe of the Fort Peck Indian Reservation (PL 98-124, Section 5).
- Funds distributed by the Secretary of Interior to tribal members from:
  - tribal trust funds on a per capita basis (PL 98-64); or
  - judgment funds from claims against the United States and held in trust or distributed on a per capita basis (PL 93-134, as amended by 97-458).
- Payments by the Indian Claims Commission to the:
  - Passamaquoddy Tribe, the Penobscot Nation, and the Houlton Band of Maliseet Indians or any of their members [Maine Indian Claims Settlement Act of 1980, PL 96-420, Section 9(c)].
  - Confederated Tribes and Bands of Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation (PL 95-433).
  - Seneca Nation or its members (Seneca Nation Settlement Act of 1990, PL 101-503).
  - Blackfeet, Gros Ventre, and Assiniboine tribes of Montana (PL 97-408).
  - Saginaw Chippewa of Mississippi [PL 99-123, Section 6(b)(2)].
- Payments to the Turtle Mountain Band of Chippewa, Arizona (PL 97-403).
- Payments to heirs of deceased Indians made under the Old Age Assistance Claims Settlement Act (PL 98-500).

Exception: Money given to Native Americans from gaming revenues (such as from casino profits, race tracks, lotteries, etc.) is not exempt under these laws. Gaming revenues are counted as unearned income.

W—1411.4.9 Nutrition Programs

Revision 15-4; Effective October 1, 2015

The following amounts are exempt:

- the value of food assistance under the Child Nutrition Act of 1966 and under the National School Lunch Act; and
- benefits received under Title VII, Nutrition Program for the Elderly, of the Older American Act of 1965.

W—1411.4.10 One-Time Grandparent Payments

Revision 15-4; Effective October 1, 2015

One-Time Grandparent payments are exempt as income.

W—1411.4.11 One-Time Temporary Assistance for Needy Families (OTTANF)

Revision 15-4; Effective October 1, 2015

OTTANF is exempt as income.

W—1411.4.12 Payments to Vietnam Veterans' Children

Revision 15-4; Effective October 1, 2015

W—1411.4.12.1 Payments to Vietnam Veterans' Children Born with Spina Bifida (Public Law 104-204)

Revision 15-4; Effective October 1, 2015

These VA payments made to Vietnam veterans' children who are born with spina bifida are exempt.

W—1411.4.12.2 Payments to Children of Women Vietnam Veterans Born with Certain Birth Defects (Public Law 106-419)

Revision 15-4; Effective October 1, 2015

VA payments made to the children of women Vietnam veterans who are born with a birth defect are exempt.

W—1411.4.13 Payments to Victims of Nazi Persecution

Revision 15-4; Effective October 1, 2015

Payments made to individuals because of their status as victims of Nazi persecution are exempt.

W—1411.4.14 Payments to World War II Filipino Veterans and Spouses

Revision 15-4; Effective October 1, 2015

Under the American Recovery and Reinvestment Act of 2009 (Division A, Title X, Section 1002), some World War II Filipino veterans who served in the military forces of the Government of Commonwealth of the Philippines, and their spouses, are authorized to receive one-time lump-sum payments of up to $15,000.

These payments are exempt.

W—1411.4.15 Relocation Assistance

Revision 15-4; Effective October 1, 2015

The following payments are exempt if provided under:

- Title II of the Uniform Relocation Assistance and Real Property Acquisitions Act of 1970;
- Title I of Public Law 100-383 (these payments are made to Aleuts or individuals of Japanese ancestry [or their heirs] who were relocated during World War II); or
- Public Law 93-531 to members of the Navajo or Hopi Tribes.

W—1411.4.16 Retirement, Survivors, and Disability Insurance (RSDI)

Revision 15-4; Effective October 1, 2015

The benefit amount, including the deduction for the Medicare premium, less any amount that is being recouped for a prior RSDI overpayment, is counted as unearned income.

Note: The Social Security Administration (SSA) may deposit RSDI benefits into a Direct Express card debit account. See www.ssa.gov/pubs/10073.html.

W—1411.4.17 Supplemental Security Income (SSI)

Revision 15-4; Effective October 1, 2015

The income of an SSI recipient is exempt.

W—1411.4.18 Temporary Assistance for Needy Families (TANF)

Revision 15-4; Effective October 1, 2015

The TANF benefit amount (after recoupment) counts as unearned income.

Retroactive or restored TANF or refugee cash assistance payments are exempt as income.

W—1411.4.18.1 TANF Annual School Subsidy Payment

Revision 15-4; Effective October 1, 2015

TANF annual school subsidy payments are exempt.

W—1411.4.19 Unemployment Compensation

Revision 15-4; Effective October 1, 2015

The gross unemployment insurance benefit (UIB), less any amount being recouped for a UIB overpayment, counts as unearned income.

Exception: The gross amount counts if the household agreed to repay a SNAP overpayment through voluntary garnishment.

W—1411.4.20 Veterans Benefits

Revision 15-4; Effective October 1, 2015

The VA provides payments to veterans with disabilities and/or their spouses/dependents and to spouses/dependents of deceased veterans. VA benefits are not subject to federal or state income tax or child support garnishment.

Three basic VA benefit programs are described in this section:

- Pension,
- Disability Compensation, and
- Dependency and Indemnity Compensation (DIC).

VA Pension

VA pension payments are made to certain veterans with disabilities based on financial needs. Low-income veterans who either have a disability or are age 65 and older may be eligible for a VA pension if they have 90 days or more of active military service with at least one day during a period of war. Payments are made to bring the veteran's total income, including other retirement or Social Security income, to a level set by Congress. Recipients must re-qualify each year to continue to receive payments. There is a similar pension benefit available for surviving spouses and dependent minor children of such deceased veterans.

VA Disability Compensation

VA disability compensation is a payment made to a veteran with a service-related disability. Eligibility is not based on financial need. The amount of the payment varies with the percentage of the veteran's disability and the number of the veteran's dependents living in or out of the home. The payment can also be made to a spouse, child or parent of a veteran because of the service-related death of the veteran.

Dependency and Indemnity Compensation

DIC is a monthly benefit paid to eligible survivors of active duty service members and survivors of those veterans whose deaths are determined by VA to be service-related. This payment is a flat monthly payment, regardless of other income. The payment is payable for the life of the spouse, provided the spouse does not remarry before age 57; however, should a remarriage end, DIC benefits can be reinstated. This payment is adjusted annually for cost-of-living increases and is non-taxable. VA adds a monthly transitional payment to the surviving

spouse with minor children for the first two years of DIC entitlement or until the last child turns age 18, whichever occurs first. See http://benefits.va.gov/Compensation/current_rates_dic.asp for current payment amounts.

Veterans with certain disabilities may be eligible for additional special monthly compensation such as:

- Aid and Attendance and Housebound payments, which are an allowance to veterans and dependents who are in need of regular aid and attendance by another person, or a veteran who is permanently housebound; and
- reimbursement for unusual medical expenses.

The gross benefit less any amount recouped or suspended for VA overpayment is counted as unearned income, except as described below for reimbursement for medical and attendant care expenses. These special compensation payments that are intended to cover medical and attendant care expenses are exempt. These payments are exempt as reimbursement as explained in A-1332, Reimbursements.

Apportioned VA payments are a direct payment of the dependent's portion of the VA benefit to a dependent spouse or child not living with the veteran. Apportioned VA payments are unearned income to the dependent spouse or child not living with the veteran.

Other Types of Veterans Benefits

- Military retirement payment — A payment made to an individual who retired from active duty military service after at least 20 years of service. Military retirement is not a VA program, but is paid by the Defense Finance and Accounting Service in Cleveland (DFAS-CL). The gross payment is counted as unearned income.
- Survivor Benefit Plan (SBP) — Active duty members are automatically enrolled in this program. Surviving spouses and/or children of service members who die while on active duty may be entitled to SBP payments made by DFAS-CL. SBP payments are equal to 55 percent of what a member's retirement pay would have been had the member been retired at 100 percent disability. An SBP payment is reduced by the amount of payments provided under the VA DIC program.

At retirement, retirees may choose to purchase the SBP. In this case, the SBP pays retired military members' eligible survivors an inflation-adjusted monthly income. Basic SBP for a spouse pays a benefit equal to 55 percent of the retired individual's pay. Eligible children may also be SBP beneficiaries while they are dependents of the retired individual, either alone or added to spouse coverage. Any VA DIC paid to a spouse is subtracted from SBP payments, although VA DIC payments to or for children do not affect SBP payments. SBP premiums are refunded to the survivor if the monthly VA DIC amount is greater than the SBP monthly annuity.

The gross amount of any SBP payment is counted as unearned income.

VA educational assistance programs — Different programs provide education assistance, including vocational rehabilitation. The policy in A-1322.1, Educational Assistance, applies.

W—1411.4.21 DFPS Relative Caregiver Reimbursement Program Payments

Revision 15-4; Effective October 1, 2015

One-time integration payments are exempt from income.

Flexible support payments are exempt from income.

W—1411.4.22 Healthy Marriage Development Program Payments

Revision 15-4; Effective October 1, 2015

A payment received for completing the Healthy Marriage Development Program is exempt. The advisor must document as required by policy in A-1380, Documentation Requirements.

W—1411.5 Income from Property

Revision 15-4; Effective October 1, 2015

W—1411.5.1 Dividends and Royalties

Revision 15-4; Effective October 1, 2015

Dividends count as unearned income. **Exception:** Dividends from insurance policies are exempt as income.

Royalties count as unearned income, less any amount deducted for production expenses and severance taxes.

W—1411.5.2 Payments for Mineral Rights

Revision 15-4; Effective October 1, 2015

Payments for mineral rights count as unearned income.

W—1411.6 Other

Revision 15-4; Effective October 1, 2015

W—1411.6.1 Cash Gifts and Contributions

Revision 18-1; Effective January 1, 2018

Cash gifts and contributions count as unearned income unless they:

- are made by a private, nonprofit organization on the basis of need; and
- total $300 or less per household in a federal fiscal quarter. The federal fiscal quarters are January to March, April to June, July to September, and October to December.

If these contributions exceed $300 in a quarter, the excess amount counts as income in the month received.

Exception: Contributions from noncertified household members are budgeted according to policy explained in W-1411.6.1.1, Contributions from Noncertified Household Members.

Related Policy
MyGoalsPayments, A-1326.1

W—1411.6.1.1 Contributions from Noncertified Household Members

Revision 15-4; Effective October 1, 2015

If a noncertified person(s) lives in the home with a member of the budget group and shares household expenses (no landlord/tenant relationship), any payments the noncertified person makes to the unit for common household expenses (including food, shelter, utilities, and items for home maintenance) are exempt. If a noncertified household member makes additional payments for use by a certified member, it is a contribution.

If a noncertified household member makes payments to a certified member under a formal or informal landlord/tenant relationship, countable income is determined according to the roomer/boarder policy in W-1411.3.4.3, Noncommercial Roomer/Boarder Payments.

W—1411.6.1.2 Gifts from Tax-Exempt Organizations

Revision 15-4; Effective October 1, 2015

Gifts from tax-exempt organizations are exempt if the gift is for a child with a life-threatening condition and the amount of the gift is:

- less than $2,000 annually, and
- not converted to cash.

If the gift is converted into cash or exceeds $2,000 a year, the conversion or the excess counts as unearned income in the month of receipt and is exempt as a resource in the months that follow.

W—1411.6.2 Child Support

Revision 15-4; Effective October 1, 2015

Payments obtained on behalf of a child count as unearned income. Payments are considered as child support if:

- a court ordered the support, or
- the child's caretaker or the person making the payment states the purpose of the payment is to support the child.

Advisors must consider the following in determining child support:

- Gifts or donations as contributions are not considered child support. Gifts are items or money that only benefit the child for a specific purpose, such as a birthday present. These gifts or donations include (but are not limited to) clothes, toys, or personal items, or money to purchase clothes, toys, or personal items.
- Ongoing child support income is considered as income to the children, even if someone else living in the home receives it.
- Child support arrears is considered as unearned income to the caretaker.

If an absent parent is making child support payments but moves back into the home of the caretaker and child, the child support is not counted. The earnings and/or other income count as a regular household member.

If a caretaker receives current child support for a nonmember (or a member who is no longer in the home) but uses the money for personal or household needs, the amount counts as unearned income. The amount actually used for or provided to the nonmember for whom it is intended to cover is not counted.

If a single payment covers two or more children (including at least one who is not an applicant/recipient) and the support order does not specify a portion for each child, the payment is prorated among all of the children. When two or more children receive child support from the same father and one child receives Supplemental Security Income, the payment is always prorated.

W—1411.6.2.1 Counting Child Support

Revision 15-4; Effective October 1, 2015

For child support paryments issued via …	funds are …
warrants,	mailed from Austin, Texas, the day after the disbursement date listed on the Texas Child Support Enforcement System (TXCSES) inquiry system. When determining availability, consider the distance the payment has to travel through the mail.
direct deposit/electronic transfers,	available two business days after the disbursement date listed on the TXCSES Web inquiry system.
Texas debit cards,	available two business days after the disbursement date listed on the TXCSES Web inquiry system.

Full child support payments are counted, less the $75 disregard deduction.

W—1411.6.2.2 Lump-Sum Child Support Payments

Revision 15-4; Effective October 1, 2015

Lump-sum child support payments received or anticipated to be received more often than once a year count as unearned income in the month received. Lump-sum child support payments received once a year or less frequently are not counted as income. See W-1412.1, Lump-Sum Payments.

Lump-sum payments on child support arrears are received from the following sources:

- **IRS intercept program** — This occurs when the IRS intercepts the absent parent's tax refund to pay child support arrears.
- **Excess payment** — When the OAG sends a second excess payment to the individual, the advisor receives Form H1719, Notice of Excess Payment, with the date and the amount. See the glossary for more information.
- **OAG adjustments** — The advisor receives a PBS-OAGF1 Report, Clients Receiving a Lump Sum Adjustment from OAG-Possible Ineligibility. The Texas Health and Human Services Commission (HHSC) produces this report when the OAG makes adjustments to an EDG that result in a lump-sum amount being distributed to the individual. Adjustments may occur when federal distribution changes are implemented, court orders are modified, or EDG errors are corrected.

Lump-sum payments on current child support are received from the following sources:

- **Advance pay** — Advance pay occurs when the absent parent is current on obligated amounts and voluntarily pays an amount in advance of the obligated monthly amount. **Example:** The absent parent is obligated to pay $200 a month and is current on that amount. The absent parent loses his job and receives a severance payment of $2,000 and decides to pay $1,000 in advance to cover child support for the next five months. The payment to the individual is not counted as income.
- **Future pay** — Future pay occurs when the absent parent is current on obligated amounts and voluntarily and routinely pays an extra amount over the obligated amount. **Example:** The absent parent is obligated to pay $200 a month and is current on that amount. The absent parent pays $25 extra each month (or some months). The OAG releases the money as received. This payment counts as unearned income if the advisor can anticipate that it will be received more often than once a year.

W—1411.6.2.3 Medical Support Payments

Revision 15-4; Effective October 1, 2015

When a court order is entered, it designates the amount of child support and/or medical support a parent receives on behalf of the children. Medical support is in the form of:

- health insurance, ordered in addition to child support; or
- a cash amount for the purpose of offsetting medical expenses.

If the individual does not receive Medicaid and is responsible for paying medical expenses, the payments are considered a reimbursement and the policy for reimbursement in W-1412.2, Reimbursements, applies.

If the individual has an open child support EDG with the OAG for children receiving Medicaid, the OAG processes medical support payments through an interface with HHSC/Third Party Recovery, and the individual does not receive a direct payment. If an individual is not referred to the OAG for services and is receiving or begins receiving cash medical support payments, the individual is required to remit the payments to the Third Party Recovery unit. Cash medical support payments that the individual receives and remits to Third Party Recovery are not counted. Any of the cash medical support payment from the absent parent that the individual continues to keep counts as income.

W—1411.6.3 Energy Assistance

Revision 15-4; Effective October 1, 2015

Exempt energy assistance.

Exception: Count cash payments received from private nonprofit organizations as unearned income.

W—1411.6.4 Foster Care and Permanency Care Assistance (PCA) Payments

Revision 15-4; Effective October 1, 2015

Foster care or permanency care payments are exempt.

Note: Do not include a person receiving foster care or permanency care payments in a budget or certified group.

W—1411.6.5 In-Kind Income

Revision 15-4; Effective October 1, 2015

In-kind income is exempt.

W—1411.6.6 Interest

Revision 15-4; Effective October 1, 2015

Interest counts as unearned income.

W—1411.6.7 Loans (Noneducational)

Revision 15-4; Effective October 1, 2015

Financial assistance is considered a loan if:

- there is an understanding that the individual will repay the money; and
- the individual can reasonably explain how the loan will be repaid.

These loans are exempt from income. Contributions that are not considered loans are counted as unearned income.

W—1411.6.8 Pensions

Revision 15-4; Effective October 1, 2015

A pension is any benefit derived from former employment (such as retirement benefits or a disability pension). A pension counts as unearned income.

W—1411.6.9 Trust Funds

Revision 15-4; Effective October 1, 2015

Withdrawals or dividends that the household can receive from a trust fund that is exempt from resources count as unearned income.

W—1411.6.10 Resettlement-Reception and Placement (R&P)

Revision 15-4; Effective October 1, 2015

R&P counts as income in the month received.

W—1411.6.11 Refugee Cash Assistance (RCA)

Revision 15-4; Effective October 1, 2015

RCA counts as income in the month received.

W—1411.6.12 Match Grant

Revision 15-4; Effective October 1, 2015

Count match grant as income in the month received.

W—1411.6.13 Spousal Diversion and Dependent Allowance

Revision 15-4; Effective October 1, 2015

The portion of income from a spouse or parent in a nursing facility that is diverted to the family members living in the community counts as unearned income.

The spousal diversion and dependent allowance are determined by the Medicaid for the Elderly and People with Disabilities worker processing the application for nursing facility coverage. When nursing facility coverage is approved and disposed, the Texas Integrated Eligibility Redesign System (TIERS) will add this income in the community family member's approved Texas Works (TW) EDGs upon running Eligibility. Advisors do not make Data Collection entries for this income.

W—1411.6.14 Welfare-to-work Income

Revision 15-4; Effective October 1, 2015

Welfare-to-work income is exempt.

W—1411.6.15 Alimony Received

Revision 15-4; Effective October 1, 2015

Alimony received is counted as unearned income for the individual who received the payment.

W—1411.6.16 Annuity

Revision 15-4; Effective October 1, 2015

An annuity is a series of payments paid under a contract and made at regular intervals over a period of more than one full year. Payments can be either fixed (under which one receives a definite amount) or variable (not fixed). An individual can buy the contract alone or with the help of an employer.

Annuity payments are counted as unearned income.

W—1411.6.17 Capital Gains

Revision 15-4; Effective October 1, 2015

Capital gains are profit from the sale of property or of an investment when the sale price is higher than the initial purchase price (for example, profits from the sale of stocks, bonds, or from the sale of real estate).

Capital gains are exempt.

W—1411.6.18 Housing Allowance

Revision 15-4; Effective October 1, 2015

Housing allowances are exempt.

W—1411.6.19 Life Estate

Revision 15-4; Effective October 1, 2015

Life estate income is income an individual receives from ownership of property that an individual only possesses ownership of for the duration of one’s life (for example, rental income).

Life estate income is counted as unearned income.

W—1411.6.20 Jury Duty Pay

Revision 15-4; Effective October 1, 2015

Jury duty pay is taxable income received from jury duty as compensation.

Jury duty pay is exempt.

W—1411.6.21 Court Awards

Revision 15-4; Effective October 1, 2015

Court awards are taxable money that an individual receives as the result of a lawsuit (for example, compensation for lost wages or punitive damages awards).

Follow policy in W-1412.1, Lump-Sum Payments.

W—1411.6.22 Canceled Debt

Revision 15-4; Effective October 1, 2015

Canceled debts are debts that have been canceled, forgiven, or discharged, and the canceled amount is included as countable income on federal income tax returns (for example, loan foreclosures or canceled credit card debt).

Canceled debt income is exempt.

W—1412 Types of Payments

Revision 15-4; Effective October 1, 2015

W—1412.1 Lump-Sum Payments

Revision 15-4; Effective October 1, 2015

Lump sums received once a year or less are exempt, unless specifically listed as income. **Note:** Retroactive or restored payments are considered to be lump-sum payments and are exempt. Any portion that is ongoing income is separated from a lump-sum amount and counted as income.

Example: A person receives a lump-sum payment in the amount of $4,950 from the SSA in the month of March. Effective that same month, the person receives his first monthly RSDI payment of $950, which is included in the $4,950 lump-sum payment. Staff must budget the $950 RSDI payment beginning with the month of March as an ongoing payment and consider the $4,000 as a lump-sum payment.

A lump-sum payment counts as income in the month received if the individual gets it or expects to get it more often than once a year.

Exceptions: Contributions, gifts, and prizes count as unearned income in the month received, regardless of frequency of pay.

If a lump sum reimburses a household for burial, legal, medical bills or damaged/lost possessions, the countable amount of the lump sum is reduced by the amount earmarked for these items.

Federal tax refunds and EICs are exempt as income.

W—1412.2 Reimbursements

Revision 15-4; Effective October 1, 2015

A reimbursement (not to exceed the individual's expense) is exempt if it is provided specifically for a past or future expense:

- that is not included in HHSC's standard of need, or
- for medical needs that are not paid by Medicaid.

If the reimbursement exceeds the individual's expenses, any excess counts as unearned income. A reimbursement to exceed the individual's expenses is not considered unless the individual or provider indicates the amount is excessive.

Note: A reimbursement for future expenses is exempt only if the individual plans to use it as intended.

W—1412.3 Third-Party Beneficiary

Revision 15-4; Effective October 1, 2015

Money an individual receives that is intended and used for maintenance of a nonmember is exempt.

If an individual receives a single payment for more than one beneficiary, the amount actually used for the nonmember is excluded up to the nonmember's identifiable portion or prorated portion, if the portion is not identifiable.

W—1412.4 Vendor Payments

Revision 15-4; Effective October 1, 2015

Payments that a person or organization outside the household makes directly to the individual's creditor or person providing the service are exempt.

Exception: Money legally obligated to the household, but which the payer makes to a third party for a household expense is counted as income.

Example: The absent parent is court-ordered to pay $400 a month. Instead, the absent parent pays $150 cash support and also pays $300 of the custodial parent's rent directly to the landlord for a total of $450. The $150 cash and $250 of the vendor-paid rent counts as child support, since that portion is legally obligated to the individual. The $50 amount over the legally obligated child support of $400 is considered an exempt vendor payment.

W—1413 Income Limits

Revision 17-2; Effective April 1, 2017

See the income limit for HTW (TA 41) in C-131.1, Federal Poverty Income Limits (FPIL).

W—1414 Calculating Household Income

Revision 17-2; Effective April 1, 2017

Use the policy in A-1350, Calculating Household Income, for TP 40, MA – Pregnant Women.

Exceptions:

- Reasonable compatibility does not apply to HTW.
- Budget expenses following the TANF and SNAP policy in Section A-1358, How to Budget Expenses.

W—1415 Determining Countable Income in Special Household Situations

Revision 15-4; Effective October 1, 2015

Use the policy in A-1360, Determining Countable Income in Special Household Situations, for TP 40, MA – Pregnant Women.

W—1420 Adjunctive Eligibility

Revision 17-2; Effective April 1, 2017

Do not verify income or expenses if it is determined the applicant or recipient is adjunctively eligible. A woman is adjunctively eligible if in the application month or in the ninth month of the 12-month certification period she is included in an active:

- SNAP EDG;
- TANF EDG;
- TP 08, MA - Parents and Caretaker Relatives EDG; or
- Children's Medicaid EDG (TP 43, TP 44 and TP 48), including being an EDG name on a TP 45, MA – Newborn Children EDG.

Exception: A woman is not adjunctively eligible if the only services received in the month adjunctive eligibility is being determined are expedited SNAP benefits with postponed verification.

Adjunctive eligibility is determined at application and renewal. TIERS determines adjunctive eligibility and omits the income and expense pages if the applicant/individual is determined adjunctively eligible.

A woman can also be adjunctively eligible if it is verified that she or someone in her budget group received Women, Infants and Children (WIC) benefits in the HTW application month.

Note: At renewal, consider a woman adjunctively eligible for HTW if the household received WIC benefits in any of the last three months of the 12-month certification period.

W—1430 Reserved

Revision 13-1; Effective January 1, 2013

W—1431 Women, Infants and Children (WIC) Verification

Revision 17-2; Effective April 1, 2017

Use the following documents to verify WIC eligibility:

- active WIC voucher;
- verification of certification letter; or
- active Electronic Benefit Transfer (EBT) shopping list.

WIC verification must be current. Verify that the applicant received WIC benefits in the HTW application month.

W—1432 Income Verification

Revision 17-2; Effective April 1, 2017

For proof/verification of income, accept a copy of any one or more of the following:

- a paycheck stub issued in the last 60 days from the file date;
- a copy of the most recent tax return;
- the most recent Social Security statement or check;
- the most recent child support check;
- proof of self-employment;
- a letter from an employer verifying current income and frequency of payment; or
- the most recent proof of other income received.

Use the Children's Medicaid verification policy in A-1371, Verification Sources, and the additional sources listed below to verify the household income.

Additional income verification sources for HTW include:

- the most recent child support check; and
- C-820, Data Broker; C-825.14.1, OAG Child Support Data; C-832, Office of the Attorney General (OAG) Inquiry; and C-833, TXCSES Web Child Support Portal Inquiry.

When two or more consecutive pay stubs are submitted and the income amounts on the stubs are not identical, the eligibility determination is based on an average of the income reflected in the multiple pay stubs. Exclude pay stubs that appear to be non-representative when averaging.

When two or more non-consecutive pay stubs are submitted, if representative, the most recent pay stub is used to determine the income. If non-representative, use the next most recent representative pay stub.

Note: If possible, use the year-to-date method to determine the missing pay stub.

W—1440 Documentation Requirements

Revision 07-0; Effective July 1, 2007

Follow the current Medical Programs policy for documenting income in A-1380, Documentation Requirements.

TWH, W-1500, Deductions

Revision 17-2; Effective April 1, 2017

W—1510 General Policy

Revision 15-4; Effective October 1, 2015

Households are allowed the following deductions:

- work-related expense deduction — up to $120;
- dependent care;
- payments to dependents living outside the home;
- alimony;
- child support payments — deduct child support payments made by a member of the budget group; and
- $75 disregard — deduct up to $75 of child support received by members of the budget group.

W—1511 Rules That Apply to Deductions

Revision 17-2; Effective April 1, 2017

Actual amounts (amounts that have already been billed) are used for the interview month, and amounts that have not been billed may be projected.

- The following expenses are not deducted:
  - expenses paid to another member of the same Eligibility Determination Group (EDG);
  - expenses paid by a reimbursement, an exempt vendor payment or in-kind benefit; or
  - past-due balances, late charges or finance charges.
- The most recent month's bills are used to project expenses. Unexpected changes should be considered during the certification period.
- Only household expenses expected during the certification period should be considered.
- The income conversion factors are used to determine monthly expenses if expenses are billed weekly, biweekly or semi-monthly.

Deductions must not be allowed if:

- verification of the expense is required;
- the household fails to provide required verification; and
- the advisor is not able to verify the expense directly using other automated systems that are acceptable verification sources and accessible to the advisor or through another method.

Note: The EDG must not be denied for failure to provide the verification.

W—1512 Types of Deductions

Revision 15-4; Effective October 1, 2015

W—1512.1 Earned Income Deduction

Revision 15-4; Effective October 1, 2015

The earned income deduction is the work-related expense.

W—1512.1.1 Work-Related Expense

Revision 15-4; Effective October 1, 2015

A work-related expense deduction of up to $120 a month (not to exceed the person's monthly earnings) is allowed from the earned income of each employed household member whose needs are included in the budget or certified group.

W—1512.2 Dependent Care Deduction

Revision 15-4; Effective October 1, 2015

The maximum dependent care deduction is up to and including:

- $200 a month for each child under age 2;
- $175 a month for each child age 2 or older; and
- $175 a month for each adult with disabilities.

An earned income deduction is allowed for the actual cost of unreimbursed payments up to and including the maximum amount when the individual incurs an expense for:

- the care of a child or adult with disabilities (even when the child or adult with disabilities is not included in the budget group); and/or
- transportation of a child to and/or from day care or school.

The expense must be both necessary for employment and incurred by an employed person who is included in the budget group.

W—1512.3 Diversions, Alimony and Payments to Dependents Outside the Home

Revision 15-4; Effective October 1, 2015

The following deductions are allowed:

- alimony; and
- payments to dependents living outside the home.

W—1512.4 Child Support Deductions

Revision 15-4; Effective October 1, 2015

Child support payments made by a member of the budget group are deducted.

Exceptions:

- Child support payments paid directly or through the Office of the Attorney General to a child living in the home are not deducted.
- If a payment is intended for more than one child and only one child lives in the home, only the portion of the payment that is for the child that does not live in the home is deducted.

W—1512.4.1 Allowable Child Support Deductions

Revision 15-4; Effective October 1, 2015

Allowable child support payments may be in the form of:

- cash support;
- medical support; or
- payments to third parties.

A levy or garnish fee charged by an employer is not deductible.

A legal obligation is not required to allow the deduction.

W—1512.4.2 Budgeting Child Support Deductions

Revision 15-4; Effective October 1, 2015

Child support collected through a tax intercept is not an allowable child support deduction.

A child support payment may be owed by one household member but be paid by another member. The child support expense for the household member paying the expense is allowed.

If the household member with the legal obligation or the household member paying the legal obligation leaves the home, the household's eligibility for the deduction must be redetermined.

W—1512.5 $75 Disregard Deduction

Revision 15-4; Effective October 1, 2015

Up to $75 of child support received by members of the budget group may be deducted.

W—1520 Verification Requirements

Revision 15-4; Effective October 1, 2015

Verify the following at application, complete review (if the deduction is new) or if the amount changes:

- dependent care;
- actual amount of child support and alimony paid to persons outside the home; and
- actual amount of payment to persons outside the home whom a person can claim as tax dependents or is legally obligated to support.

Note: Do not reverify deductions at renewal unless the individual reports a change in the amount.

Use the Temporary Assistance for Needy Families (TANF) verification sources listed in A-1441, Verification Sources.

If an individual fails to provide proof/verification of deductions, do not deny the case. Disallow the deduction. If the individual subsequently provides proof/verification, use the proof/verification at the next renewal if the proof/verification is dated within 90 days of the renewal file date.

If by omitting the deduction the application is denied, and the individual subsequently provides the proof/verification by the 60th day of the file date, reopen the application using the date the proof/verification was provided as the new file date.

W—1530 Documentation Requirements

Revision 17-2; Effective April 1, 2017

Use the TANF and Supplemental Nutrition Assistance Program (SNAP) documentation policy found in A-1450, Documentation Requirements.

Note: Do not delay disposition if an applicant does not provide verification by the due date on Form H1020, Request for Information or Action, and all other pended information has been provided if the applicant is income-eligible to receive Healthy Texas Women (HTW) benefits without the deductions.

TWH, W-1600, School Attendance

Revision 17-2; Effective April 1, 2017

School attendance requirements are not applicable for Healthy Texas Women (HTW).

TWH, W-1700, Management

Revision 17-2; Effective April 1, 2017

Management requirements are not applicable for Healthy Texas Women (HTW).

TWH, W-1800, Reminders

Revision 17-2; Effective April 1, 2017

W—1810 General Policy

Revision 17-2; Effective April 1, 2017

Before certifying applicants and recertifying individuals, complete the following:

- Ensure the applicant completes each question and signs and dates:
  - Form H1867/H1867-S, Healthy Texas Women Application Form;
  - Form H1867-R/H1867-RS, Healthy Texas Women Renewal; or
  - Form H1831, Adjunctive Eligibility Letter.

Note: HTW applications and renewals may have a telephonic signature when the applicant/client calls 2-1-1 and applies for or renews eligibility for HTW.

- During processing or during an interview, note if the applicant indicates changes on Form H1867/H1867-S, H1867-R/H1867-RS, or H1831. Document the nature of the change and when the individual expects the change to occur.
- Give the applicant Form H1019-W, HTW Report of Change. Explain that she must report address changes within 10 days after knowing about the change. Indicate the appropriate reporting requirement on page one.
- Refer the applicant to other programs she might be eligible for such as the Supplemental Nutrition Assistance Program (SNAP); Temporary Assistance for Needy Families (TANF); Medicaid; Family Planning; Supplemental Security Income (SSI); Women, Infants and Children (WIC); and Social Security. Refer people with disabilities or age 65 and older who are ineligible for Medical Programs for families and children to the Texas Health and Human Services Commission (HHSC) Medicaid for the Elderly and People with Disabilities (MEPD) program.
- Inform the applicant of her right to appeal any HHSC action that affects her eligibility.
- Inform the applicant that the information she provides is subject to verification by third parties.

There is no requirement to inform individuals to report accidents.

Related Policy
Telephonic Signatures, A-122

W—1820 Documentation Requirements

Revision 17-2; Effective April 1, 2017

Document that Form H0025, HHSC Application for Voter Registration, was given to the applicant in the Agency Use Only section of Form H1867/H1867-S, Healthy Texas Women Application Form.

Related Policy
Registering to Vote, A-1521

TWH, W-1900, Case Disposition

Revision 17-2; Effective April 1, 2017

W—1910 Notice to Applicants

Revision 17-2; Effective April 1, 2017

Case disposition is the individual's notice of eligibility status. At the end of the interview or during the processing of Form H1867/H1867-S, Healthy Texas Women Application; Form H1867-R/H1867-RS, Healthy Texas Women Renewal; or Form H1831, Adjunctive Eligibility Letter, give the individual one or more of the following notices if the case is pended, certified, sustained or denied:

Form H1020, Request for Information or Action, which informs the individual of the:

- reason the case is pending;
- action the individual or advisor must take;
- date by which the individual or advisor must take action; and
- date the advisor must deny the application/case if the individual does not take action, if applicable.

Form TF001W, Notice of Case Action, which informs the individual of the:

- date benefits begin;
- date of denial;
- right to appeal; and
- address and telephone number of free legal services available in the area.

HTW individuals who are auto-enrolled receive Form H1872, HTW Opting Out and Reporting Confidential Address, along with Form TF0001-W. The Form H1872 informs the individual of the:

- options to voluntary withdrawn from HTW; and
- process to report a confidential address.

HTW individuals turning 18 years old will receive Form H1871, HTW Client Turning 18 Years Old, ten days prior to their 18th birthday, which informs the individual:

- of the process to report a confidential address; and
- they are now responsible for managing their HTW benefits.

Note: For individuals who only speak Spanish, ensure that all comments provided are in Spanish.

W—1920 Eligibility Begin Dates

Revision 17-2; Effective April 1, 2017

The applicant is eligible the first day of the file date month or, if ineligible the month of application for certain reasons, the month following the month of application.

Women who are auto-enrolled into Healthy Texas Women (HTW) have an effective date of the first of the month following the Medicaid for Pregnant Women (TP 40) end date. **Example:** If the TP 40 end date is September 30, then the HTW effective date is October 1.

A woman is ineligible to receive HTW benefits if she applies the month after her 45th birthday.

Related Policy
Current Medicaid, Medicare (Part A or B) and Children's Health Insurance Program (CHIP) Recipients, W-911

W—1930 Length of Certification

Revision 17-2; Effective April 1, 2017

The Texas Integrated Eligibility Redesign System (TIERS) calculates an end date from the date the advisor certifies the application/renewal as follows:

- Applications — initial certification month plus 11 months.
- Renewals — 12 months from the last certification month.

Women are continuously eligible for Healthy Texas Women benefits for 12 months or through the month of the woman's 45th birthday, whichever is earlier.

Exception: A woman does not receive her 12 months of continuous eligibility if she:

- is found eligible for Medicaid, Medicare (Part A or B) or the Children's Health Insurance Program;
- dies;
- voluntarily withdraws; or
- moves out of Texas.

W—1940 Setting Special Reviews

Revision 07-0; Effective July 1, 2007

Do not set a special review even if a known change is to occur during the woman's 12-month continuous eligibility period. Document the known change and use the information at the next renewal. Follow current procedures and report the known change if the applicant has other active Eligibility Determination Group cases.

W—1950 Adverse Action

Revision 15-4; Effective October 1, 2015

Any household receiving a notice of adverse action has the right to request a fair hearing. In some situations, households may continue benefits pending an appeal. After certification, give households advance notice of adverse actions to deny benefits except for reasons listed in A-2344.1, Form TF0001 Required (Adequate Notice), and A-2344.2, No Form TF0001 Required.

For adverse action, use current policy in A-2340, Adverse Action.

TWH, W-2000, Processing Time Frames

Revision 17-2; Effective April 1, 2017

W—2010 Applications

Revision 17-2; Effective April 1, 2017

Advisors must make an eligibility determination by the 45th day from the file date.

Reopen an application denied for failing to furnish information/verification if the missing information is provided by the 60th day from the file date. Use the date the missing information was provided as the new file date.

Use the original Form H1867/H1867-S, Healthy Texas Women Application, or an untimely Form H1867-R/H1867-RS, Healthy Texas Women Renewal, until it is 60 days old. If the information on the form has changed or is more than 45 days old, the individual and advisor must update the form.

W—2020 Deadlines

Revision 13-1; Effective January 1, 2013

Provide Form TF001W, Notice of Case Action, the same day eligibility is determined for an application but no later than 45 days from the file date.

W—2030 Missed Appointments

Revision 07-0; Effective July 1, 2007

No appointment is required to process an application or renewal unless requested by the applicant/individual. If requested, provide the applicant/individual a telephone interview. If she fails to keep the appointment, do not deny the application/renewal but continue to process.

W—2040 Pending Information on Applications

Revision 15-4; Effective October 1, 2015

Advisors must request documents that are readily available to the household to be sufficient verification. Each handbook section lists potential verification sources. C-900,Verification and Documentation, gives information on verification procedures.

In determining eligibility, advisors must consider any information the individual reports between the application date and the decision date. Include any information the individual reports during the application decision process.

W—2050 Notice of Renewal/Expiration

Revision 17-2; Effective April 1, 2017

The Texas Integrated Eligibility Redesign System (TIERS) sends a renewal packet during the 10th month of the 12-month continuous eligibility period if it is determined that the recipient is not adjunctively eligible. If she is determined adjunctively eligible, TIERS sends Form H1831, Adjunctive Eligibility Letter, in lieu of the renewal application.

Staff must determine if a woman is eligible to continue to receive Healthy Texas Women (HTW) benefits using the same eligibility requirements for an application. If Form H1831 states **Yes** to the pregnancy question, deny the renewal using the denial reason language in W-913, Pregnant Women.

If the woman states on Form H1831 that she has creditable health insurance that covers family planning services and that filing a claim will not cause her physical, emotional or other harm, deny the renewal using the denial reason language in W-914, Third-Party Resource (TPR).

W—2060 Processing Renewals

Revision 07-0; Effective July 1, 2007

W—2061 How to Process a Renewal

Revision 17-2; Effective April 1, 2017

Renewals are processed by mail or telephone. There is no interview requirement for a HTW renewal. The file date is the date any local Texas Health and Human Services Commission (HHSC) Eligibility Office receives the HTW renewal. If the renewal is received via fax outside of HHSC business hours, the file date is the next HHSC business day.

Verification from an associated Eligibility Determination Group (EDG) can be used if provided within 90 days of the HTW file date.

Follow the policy below when Form H1867-R/H1867-RS, Healthy Texas Women Renewal, or Form H1831, Adjunctive Eligibility Letter, is returned for a renewal:

- If the woman previously reported a change that did not have to be acted on before the renewal, but does not send verification with Form H1867-R/H1867-RS or Form H1831, request verification via Form H1020, Request for Information or Action.
- If she provides Form H1867-R/H1867-RS or Form H1831 indicating no change and has an associated EDG, review the associated EDG to determine if there is documentation to clear any conflicting information. If not, request new verification via Form H1020.

- If she returns Form H1867-R/H1867-RS or Form H1831 reporting changes, provides verification, and there is no associated EDG, process the renewal using the new verification.
- If she returns Form H1867-R/H1867-RS or Form H1831 reporting changes, provides verification, and there is an associated EDG, review the associated EDG and use the information provided for the HTW EDG as it is the most recent. The information may vary from the other EDG information since less documentation is required.
- If the associated EDG has other information that the family did not report for the HTW EDG, that would impact HTW eligibility, contact the woman (by telephone or Form H1020 with the due date) to determine if the information in the associated EDG is correct before denying or taking adverse action on the EDG.
- If the family reports new information that must be considered for the associated EDG such as a new job, follow current procedures to report the change on the other associated EDG.
- If she returns Form H1867-R/H1867-RS or Form H1831, reporting changes without verification, and has an associated EDG, request new verification via Form H1020. Do not renew eligibility if the information reported on Form H1867-R/H1867-RS or Form H1831 must be verified and verification/proof is not provided. Do not allow a deduction expense if the individual does not provide verification.
- If she returns Form H1867-R/H1867-RS or Form H1831 indicating changes, does not provide verification, and does not have an associated EDG, request information needed to determine eligibility. If she does not provide the information, do not renew eligibility.

Exception: Do not verify an income or expense change at renewal that was reported during the 12-month eligibility period if the individual is only required to provide Form H1831 at renewal since she was determined adjunctively eligible.

Process a denial action to close the EDG and record workload activity if the woman is not eligible for another 12-month continuous eligibility period.

Process the action before cutoff in the 12th month to ensure the denial code reflects the specific reason for denial.

Note: If the woman does not return the renewal form or adjunctive eligibility letter, take no action. The EDG automatically closes at the end of the 12-month eligibility period.

W—2062 Summary of Due Dates for Form H1020, Request for Information or Action

Revision 07-0; Effective July 1, 2007

Case Action	Due Date	Final Due Date
Application	10 days	• 30 days, or • 10th day if 10 days end after 30th day
Untimely renewal	10 days	• 30 days, or • 10th day if 10 days end after 30th day
Timely renewal	10 days	• last workday of last benefit month, or • 10th day if 10 days end after last benefit month
Incomplete review	10 days	• 10 days

Note: Staff have until the 45th day of the file date to determine eligibility.

W—2070 Renewal Time Frames

Revision 17-2; Effective April 1, 2017

HHSC must receive an individual's renewal application on or before the first day of the last month of certification. Consider a renewal untimely if received after the first day of the last month of certification. Process an untimely renewal using application processing time frames.

Staff must determine renewal eligibility on a timely submitted renewal no later than the last workday of the last month of certification to be considered processed timely.

If an individual is determined adjunctively eligible, TIERS mails the individual Form H1831, Adjunctive Eligibility Letter, in the 10th month of the 12-month certification period. Form H1831 informs the individual that the certification is ending and that she is financially eligible for a new 12-month certification. The individual must also meet non-financial requirements for HTW. Form H1831 asks the individual if she is pregnant or has creditable health insurance. Staff must determine, based on the answers provided by the individual, if she is eligible to continue receiving HTW benefits.

Individuals must sign and return the form, complete the renewal process via YourTexasBenefits.com, or call 2-1-1 to complete a telephone renewal and meet all non-financial requirements in order to receive continued benefits.

HHSC must receive Form H1831 no later than the last workday of the last certification month for the individual to receive a new 12-month continuous eligibility period. If HHSC does not receive the form by the last workday of the last certification month, the individual must reapply using Form H1867/H1867-S, Healthy Texas Women Application Form.

For adjunctively eligible individuals, staff must complete renewals by the last workday of the last certification month, or within five workdays from receiving Form H1831 if received on the last workday of the last certification month.

W—2080 Pending Information

Revision 17-2; Effective April 1, 2017

If the applicant cannot furnish all required proof/verification during the interview or with the application, allow the household at least 10 days to provide it. The due date must be a workday. Determine what sources of proof/verification are readily available to the household and request those first if you expect them to be sufficient proof/verification. If the applicant has an active or inactive EDG, check to see if any proof/verification previously provided on another EDG can be used to determine eligibility for HTW.

Note: Do not use proof/verification more than 90 days old from the HTW file date.

Use verification accepted for Temporary Assistance for Needy Families (TANF), Medical Programs or the Supplemental Nutrition Assistance Program (SNAP) for all programs.

For example, if you accept wage verification for a SNAP case, that same verification is acceptable for TANF or Medical Programs.

Exception: Verification of U.S. citizenship for applicants must be from a Medicaid acceptable source.

Form H1867/H1867-S, Healthy Texas Women Application Form, and Form H1867-R/H1867-RS, Healthy Texas Women Renewal, provide the applicant/individual the opportunity to provide a different mailing address and contact telephone number due to confidentiality issues. Since HTW provides family planning services, it is imperative for advisors to respect the privacy of an applicant/individual.

TWH, W-2100, Changes

Revision 17-2; Effective April 1, 2017

W—2110 How to Report a Change

Revision 17-2; Effective April 1, 2017

Healthy Texas Women (HTW) individuals can report changes:

- via YourTexasBenefits.com;
- via Your Texas Benefits Mobile App;
- by calling or visiting a local Texas Health and Human Services Commission (HHSC) Benefits Office;
- in writing, by mail or fax;
- by completing Form H1019, Report of Change, or Form H1019-W, HTW Report of Change, and mailing or faxing the form to a local HHSC Benefits Office; or
- by calling 2-1-1.

Note: When a change is reported by calling 2-1-1, staff must verify that the person speaking has the authority to report a change.

A woman is continuously eligible for HTW for 12 months or through the month of her 45th birthday, whichever is earlier.

Report the following changes:

- an individual's change of address;
- death of the individual;
- voluntary withdrawal of the individual;
- an individual's receipt of creditable health coverage; or
- if the individual moves out of Texas.

Process all other changes, including the report of creditable health coverage and agency-generated changes, at the next renewal.

Exception: If the applicant/individual failed to report required information at the time of the application that causes the applicant/individual to be ineligible for HTW, advisors must deny the case.

W—2111 Changes Received via Telephone

Revision 17-2; Effective April 1, 2017

When an individual reports a change by telephone that includes a HTW Eligibility Determination Group (EDG) in the case, staff must verify that the person reporting the change is the HTW applicant/recipient, or for HTW minor recipients, the parent or legal guardian, before discussing any information regarding the HTW EDG.

If the individual is the HTW applicant/recipient or parent/legal guardian, ask the individual which EDGs the change pertains to – all EDGs including HTW, all EDGs excluding HTW or only HTW, and take the appropriate action.

If the individual is not the HTW applicant/recipient or parent/legal guardian, **do not** discuss the HTW EDG information with this person; only discuss the information regarding the other EDGs.

If the change is a mailing address change for **only** the HTW EDG, enter the mailing/confidential address into the Issuance Address page for the HTW EDG. **Do not** enter the new mailing address in the Address page, as this will change the Case Level Address for all of the other EDGs.

W—2112 Changes Received via Mail

Revision 17-2; Effective April 1, 2017

When an individual reports a change by mail and there is an HTW EDG in the case, staff must determine if the change pertains to all EDGs, including HTW, all EDGs excluding HTW or only HTW.

If the written change:

- does not specifically state that the mailing address change is for only the HTW EDG, only take action on the appropriate EDGs, excluding the HTW EDG;
- specifically states the change is for only the HTW EDG, only make changes to the HTW EDG and no other EDGs; or
- specifically states the change is for all EDGs including the HTW, take action on all EDGs as stated by the HTW recipient.

Note: The written report of change must specifically state the name of the person reporting the change to process an HTW change. Compare the name provided to the HTW recipient, or parent/legal guardian for HTW minors. If this person is not the HTW recipient or parent/legal guardian, do not change the mailing/confidential address for the HTW EDG.

W—2113 Changes Received at a Local HHSC Benefits Office

Revision 17-2; Effective April 1, 2017

If an individual visits a local eligibility office, staff must determine the person is the HTW applicant/recipient or parent/legal guardian of an HTW minor.

If the individual is the HTW applicant/recipient or parent/legal guardian, ask the individual which EDGs the change pertains to – all EDGs including HTW, all EDGs excluding HTW or only HTW, and take the appropriate action.

If the individual is not the HTW applicant/recipient or parent/legal guardian, **do not** discuss the HTW EDG information with this person; only discuss the information regarding the other EDGs.

W—2120 Action on Changes

Revision 15-4; Effective October 1, 2015

If an individual reports a change or the advisor receives an agency-generated change during the 12-month continuous eligibility period and has:

- **No associated EDG**, document the change and handle at renewal, unless it is a change of address, the certified woman dies, a voluntary withdrawal, or the individual moves out of Texas.
- **An associated EDG**, document the change and handle at renewal unless it is a change of address, the certified woman dies, a voluntary withdrawal, or the individual moves out of Texas. Process the change for an associated EDG using current process.
- **A change of address**, mail the individual Form H0025, HHSC Application for Voter Registration, to register to vote based on the new address. If the individual contacts the local eligibility office or 2-1-1 to decline the opportunity to register to vote after receipt of Form H0025, mail Form H1350, Opportunity to Register to Vote, to the individual for a signature. File Form H1350 in the case record when the individual returns the form and retain the form for at least 22 months.

Related Policy
Registering to Vote, A-1521

W—2130 Determining Whether New Income Information Is a Reported Change

Revision 17-2; Effective April 1, 2017

When an advisor processes a HTW application/renewal during a Temporary Assistance for Needy Families (TANF)/Medicaid/Supplemental Nutrition Assistance Program (SNAP) certification period and a household member's source of income currently budgeted on another active EDG has not changed, the advisor must determine whether the member is reporting a change in income. To do this, the advisor determines if the income verification the applicant provided with the HTW application/renewal is:

- a more recent payment than previously verified; and
- within the range of payments previously verified that are currently used in the budget for the associated active case(s), whether the individual provides only one or more than one payment.

If a change is reported during the HTW application/renewal, the advisor processing the HTW EDG must take action on the associated TANF/Medicaid/SNAP EDG. The file date is considered the report date for purposes of determining the effective date of the change. The date the advisor works the HTW EDG and becomes aware of the change is day zero for purposes of taking action on the change for the associated EDG. The individual must provide any requested verification by the due date on Form H1020, Request for Information or Action, to be considered timely verification.

For more information, see policy in B-623.1, Determining Whether New Income Information Is a Reported Change.

TWH, W-2200, Fair Hearings

Revision 17-2; Effective April 1, 2017

W—2210 Appeals Procedures

Revision 17-2; Effective April 1, 2017

Healthy Texas Women (HTW) applicants/individuals receiving a notice of adverse action are not entitled to continued benefits when benefits are denied for any reason if doing so would extend the 12-month continuous eligibility period.

Refer to B-1000, Fair Hearings, for specific appeals policy and procedures.

TWH, W-2300, Automated Support

Revision 15-4; Effective October 1, 2015

W—2310 Data Broker

Revision 15-4; Effective October 1, 2015

Advisors must follow the policy explained in C-817, Electronic Data Sources (ELDS), and C-820, Data Broker.

TWH, W-2400, Confidentiality

Revision 17-2; Effective April 1, 2017

The Texas Health and Human Services Commission (HHSC) must accommodate reasonable requests to receive communications by alternative means or at alternate locations.

The individual must specify in writing the alternate mailing address or means of contact and include a statement that using the home mailing address or normal means of contact could endanger the individual. The following forms allow individuals to provide a confidential mailing address and/or telephone number:

- Form H1867/H1867-S, Healthy Texas Women Application Form;
- Form H1867-R/H1867-RS, Healthy Texas Women Renewal;
- Form H1871, HTW Client Turing 18 Years Old; and
- Form H1872, HTW Opting Out and Reporting Confidential Address.

Staff must not provide any information regarding Healthy Texas Women (HTW) to anyone other than the certified household member or the parent/legal guardian of an HTW minor.

W—2410 Applications

Revision 17-2; Effective April 1, 2017

When a woman submits an HTW application and provides a mailing/confidential address, staff must determine if the current **mailing address**, if any, on the Texas Integrated Eligibility Redesign System (TIERS) is the same as the mailing/confidential address on the HTW application.

If the current **mailing address** is:

- Different from the address provided on the HTW application or no case information exists in TIERS, enter the mailing/confidential address provided on the HTW application in the Issuance Address page for the HTW Eligibility Determination Group (EDG).
- The same as the address provided on the HTW application, no action is required.

If the **physical address** is different on the HTW application than what is verified in TIERS, report the new address using current change processes for the other EDGs.

Related Policy
How to Report a Change, W-2110
Changes, B-600

W—2420 Renewals

Revision 17-2; Effective April 1, 2017

TIERS mails out Form H1867-R/H1867-RS, Healthy Texas Women Renewal, or Form H1831, Adjunctive Eligibility Letter, in the 10th month of the 12-month certification period. TIERS uses the Form TF0001, Notice of Case Action, address hierarchy when mailing these correspondences.

When staff receive Form H1867-R/H1867-RS or Form H1831, staff must determine if the individual has provided a new mailing/confidential address for the HTW EDG. Staff perform an inquiry in the Issuance Address page to determine if the mailing/confidential address has changed or was not entered.

Staff must also determine if the individual has a different mailing address for the HTW renewal than the other EDGs.

If the mailing/confidential address:

- is different from the other EDGs, then enter the mailing/confidential address into the Issuance Address page for the HTW EDG;
- is different from the Issuance Address page, enter the new mailing/confidential address into the Issuance Address page for the HTW EDG;
- was never provided, enter the mailing/confidential address into the Issuance Address page; and
- is the same as the current mailing address for the other EDGs, no action is required.

If the **physical address** is different on the HTW renewal packet or the adjunctive eligibility letter than what is verified in TIERS, report the new address using current change processes for the other EDGs.

Related Policy
How to Report a Change, W-2110
Changes, B-600

W—2430 Telephone Numbers

Revision 17-2; Effective April 1, 2017

Staff must determine if the telephone number provided by the HTW applicant is different than what was provided for the other EDGs.

If the telephone number is different, document the following in the case comments:

Use (insert telephone number) when contacting the individual regarding HTW EDG information.

W—2440 Creating Separate Cases

Revision 17-2; Effective April 1, 2017

Follow the steps listed below to determine if a new case is needed when a woman applies for HTW. Perform an inquiry for every woman applying for HTW to determine if she is included in an existing EDG.

If the applicant …	and …	then …
does not have an existing HTW EDG,	she or her spouse (or non-spouse with mutual children in the budget group) is the case name on an existing case,	associate her HTW application with that case.

If the applicant …	and …	then …
does not have an existing HTW EDG,	she is included in an EDG in someone else's case such as her mother, father, non-spouse with no mutual children, etc.,	create a new case for her and associate the HTW application with the new case.

Because of the confidentiality issues with HTW, staff must correctly determine and create a separate case. Failure to correctly create a separate HTW case will cause TIERS to send Form TF001W, Notice of Case Action, to an incorrect address and include the HTW information on the notice.

TWH, Part X, Medicaid for Breast and Cervical Cancer (MBCC)

TWH, X-100, Application Processing

Revision 17-3; Effective July 1, 2017

X—110 Medicaid for Breast and Cervical Cancer (MBCC)

Revision 15-4; Effective October 1, 2015

The Breast and Cervical Cancer Control Program and Treatment Act of 2000 gives states the authority to provide Medicaid to low-income women previously not eligible under the Medicaid program. The Centers for Medicare and Medicaid Services approved a state plan amendment to allow Texas to provide full Medicaid benefits to uninsured women under age 65 who are identified through the Texas Department of State Health Services (DSHS) Breast and Cervical Cancer Services (BCCS) programs and who are in need of treatment for breast or cervical cancer, including pre-cancerous conditions. The program was implemented September 1, 2002.

The 80th Texas Legislature, Regular Session, 2007, provided funding to expand the pool of providers who provide screening and diagnostic services to women. As of September 1, 2007, any provider can diagnose a woman for breast or cervical cancer so that she may be eligible for Medicaid through MBCC.

MBCC is displayed in the Texas Integrated Eligibility and Redesign System (TIERS) as TA 67, MA-MBCC.

X—111 MBCC-Presumptive

Revision 12-3; Effective July 1, 2012

Presumptive eligibility is a Medicaid option that allows states to enroll women in Medicaid for a limited period of time based on a determination by a Medicaid provider of likely Medicaid eligibility. Texas chose the presumptive eligibility option offered in the Breast and Cervical Cancer Control Program and Treatment Act of 2000. The option facilitates prompt Medicaid enrollment and immediate access to services for women who are in need of treatment for breast or cervical cancer.

BCCS contractors determine a woman's presumptive eligibility for MBCC and indicates this on Form H1034, Medicaid for Breast and Cervical Cancer. Specialized staff at Centralized Benefit Services (CBS) certify the woman for MBCC-Presumptive if additional information or verification is needed to determine eligibility for another type of Medicaid or ongoing MBCC.

MBCC-Presumptive is displayed in TIERS as TA 66, MA – MBCC-Presumptive.

X—120 General Overview

Revision 17-1; Effective January 1, 2017

To qualify for MBCC, an applicant must:

- be a woman under age 65;
- have been screened for breast or cervical cancer and found to need treatment for either breast or cervical cancer;
- not be insured, that is, she must not otherwise have creditable coverage (creditable coverage refers to a health plan that covers treatment for breast and cervical cancer as well as current enrollment in Medicaid, Medicare or the Children's Health Insurance Program [CHIP]);
- meet Medical Programs citizenship and identity requirements;
- not be eligible for another type of medical assistance; and
- be a resident of Texas.

Only specified staff at CBS determines eligibility for MBCC-Presumptive and MBCC.

If a woman returns the requested information or verification and meets Medicaid eligibility requirements for another type of Medicaid or MBCC, her MBCC-Presumptive Eligibility Determination Group (EDG) is denied prospectively and she is certified for the other type of Medicaid or MBCC. If the woman fails to return the requested information or if based on the information provided, she does not meet Medicaid eligibility requirements, her MBCC-Presumptive EDG is denied effective the date she is found ineligible for ongoing Medicaid.

Once determined eligible for MBCC, a woman remains eligible for Medicaid through the duration of her cancer treatment or until she no longer meets the eligibility criteria, whichever is earlier.

If field staff receives inquiries regarding this program, refer the woman to 2-1-1. Staff at 2-1-1 can assist the woman in locating a Breast and Cervical Cancer Services (BCCS) contractor near their residence who can determine if they have a qualifying diagnosis for MBCC and, if so, assist the woman in applying for MBCC.

X—130 Application Processing

Revision 12-3; Effective July 1, 2012

X—131 Application Procedures

Revision 17-3; Effective July 1, 2017

New applicants apply for MBCC using Form H1034, Medicaid for Breast and Cervical Cancer. New applicants cannot apply for MBCC using any other application.

Form H1034 can only be obtained through a contracted BCCS provider.

A woman can locate a contracted BCCS provider in her area at https://www.healthytexaswomen.org/find-a-doctor.

The BCCS provider assists the individual in completing the application.

A former MBCC recipient can reapply for MBCC, without going through a BCCS provider to be screened, using Form H2340, Medicaid for Breast and Cervical Cancer Renewal, and Form H1551, Treatment Verification, if it has been 12 months or less since the diagnosis date for breast or cervical cancer or the date her active treatment was last verified, whichever is later.

X—132 MBCC Forms

Revision 15-4; Effective October 1, 2015

Medicaid for Breast and Cervical Cancer uses the following specialized forms:

- Form H1034, Medicaid for Breast and Cervical Cancer
- Form H2340, Medicaid for Breast and Cervical Cancer Renewal
- Form H2340-OS, Medicaid for Breast and Cervical Cancer
- Form H1550, Out of State NBCCEDP Verification

- Form H1551, Treatment Verification

X—133 Women's Health Services (WHS) Procedures

Revision 16-3; Effective July 1, 2016

Form H1034, Medicaid for Breast and Cervical Cancer, is faxed by a contracted provider to HHSC's WHS unit. The WHS contact validates Form H1034 as having been received and completed by a contracted BCCS provider and indicates if the individual has a qualifying medical diagnosis. Once validated, WHS faxes the application to the vendor. Providers are not allowed to fax Form H1034 directly to the vendor or the HHSC eligibility staff.

Note: Do not process an application if it is not received from WHS without contacting WHS to determine if it is a valid MBCC application.

X—134 File Date

Revision 15-4; Effective October 1, 2015

The file date is the date the BCCS contractor determines the woman is presumptively eligible for MBCC. The contractor enters this date in Section 3 of the BCCS Contractor Certification page on Form H1034, Medicaid for Breast and Cervical Cancer. If the application is not forwarded to the HHSC vendor within five business days from the presumptive eligibility date, the file date is the date HHSC receives the application.

Document why a certain file date was used to determine eligibility when:

- the file date used differs from the received date on Form H1034; or
- Form H1034 has two received dates.

X—135 Interviews

Revision 10-2; Effective April 1, 2010

An interview is not required when applying for or renewing an application for the MBCC. Schedule a phone interview only if the individual requests an interview.

Note: Do not deny the application if the applicant misses her interview; continue determining eligibility.

X—136 Authorized Representatives (AR)

Revision 15-4; Effective October 1, 2015

An individual may designate an individual or organization as an AR, following the policy explained in A-170, Authorized Representatives (AR).

TWH, X-200, Household Composition

Revision 15-4; Effective October 1, 2015

X—210 General Policy

Revision 15-4; Effective October 1, 2015

Only the Medicaid for Breast and Cervical Cancer (MBCC) applicant is included in the budget and certified groups for MBCC-Presumptive and MBCC.

TWH, X-300, Citizenship

Revision 12-3; Effective July 1, 2012

X—310 General Policy

Revision 12-3; Effective July 1, 2012

Medicaid for Breast and Cervical Cancer (MBCC) follows the Medical Programs citizenship policy in A-300, Citizenship.

Applicants who are U.S. citizens and certain legally admitted alien residents are eligible for MBCC if they meet all other eligibility criteria.

Note: MBCC-Presumptive or MBCC recipients who are qualified immigrant or non-immigrant who meet the eligibility criteria in A-342, TANF and Medical Programs Alien Status Eligibility Charts, Chart D, who applied before their 19th birthday, remain eligible for MBCC through the duration of their cancer treatment or until they no longer meet all the other eligibility criteria, whichever is earlier.

TWH, X-400, Social Security Number (SSN)

Revision 15-4; Effective October 1, 2015

X—410 General Policy

Revision 15-4; Effective October 1, 2015

All applicants must provide an SSN or apply for one through the Social Security Administration. If the woman applied using Form H1034, Medicaid for Breast and Cervical Cancer, and did not provide an SSN or proof that she had applied for one, advisors certify the woman for MBCC-Presumptive while awaiting the information. If the woman applied using Form H2340-OS, Medicaid for Breast and Cervical Cancer, and did not provide an SSN, the advisor sends Form H1020, Request for Information or Action, requesting her SSN or proof that she has applied for one. If she does not provide the information, the advisor does not certify her for MBCC. Advisors use policy in A-400, Social Security Number, All Programs or Medical Programs.

TWH, X-500, Age

Revision 15-4; Effective October 1, 2015

X—510 General Policy

Revision 15-4; Effective October 1, 2015

A woman is eligible to receive Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC through the month of her 65th birthday. She becomes ineligible the month after her 65th birthday.

Note: The Texas Integrated Eligibility Redesign System (TIERS) automatically denies an MBCC-Presumptive or MBCC Eligibility Determination Group (EDG) at the end of the month in which the MBCC recipient turns age 65 and generates Form TF0001, Notice of Case Action, notifying the woman of the denial.

X—520 Verification Requirements

Revision 10-2; Effective April 1, 2010

Accept self-declaration as verification of age.

X—530 Documentation Requirements

Revision 10-2; Effective April 1, 2010

Document the individual's self-declaration establishing her age.

TWH, X-600, Relationship

Revision 12-3; Effective July 1, 2012

Relationship does not apply to Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC.

TWH, X-700, Identity

Revision 12-3; Effective July 1, 2012

X—710 General Policy

Revision 12-3; Effective July 1, 2012

To establish identity, follow policy for Medical Programs in A-600, Identity.

TWH, X-800, Residence

Revision 15-4; Effective October 1, 2015

X—810 General Policy

Revision 15-4; Effective October 1, 2015

Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive and MBCC follow Children's Medicaid (TP 33, TP 34, TP 35, TP 43, TP 44, TP 45 and TP 48) policy in A-700, Residence.

TWH, X-900, Medicaid Eligibility

Revision 18-1; Effective January 1, 2018

X—910 Screening and Active Treatment

Revision 12-3; Effective July 1, 2012

To qualify for Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC, applicants must have been screened and found to need active treatment for either breast or cervical cancer.

Related Policy
Screening, X-911

At each periodic review, MBCC recipients must provide verification that they continue to receive treatment for breast or cervical cancer.

Related Policy
Active Treatment, X-912

X—911 Screening

Revision 15-4; Effective October 1, 2015

A woman must be screened for breast and cervical cancer under the Centers for Disease Control and Prevention's (CDC's) National Breast and Cervical Cancer Early Detection Program (NBCCEDP). The Breast and Cervical Cancer Services (BCCS) contractor or provider, through the Texas Department of State Health Services (DSHS), is responsible for providing the Texas Health and Human Services Commission (HHSC) with verification that a woman has been screened and diagnosed using the NBCCEDP criteria.

A woman is considered screened under the NBCCEDP if:

- CDC Title XV funds paid for all or part of the cost of her screening services; or
- her particular clinical service has not been paid for by CDC NBCCEDP Title XV funds, but the:
  - service was provided by a provider and/or an entity funded at least in part by CDC Title XV funds;
  - service was within the scope of a grant, sub-grant or contract under that state program; and
  - state CDC Title XV grantee has elected to include such screening activities provided by the provider as screening activities pursuant to CDC Title XV.

The 80th Texas Legislature passed Senate Bill 10, the Medicaid Reform Act, which authorized any health care provider to refer eligible women in need of treatment for breast or cervical cancer to Medicaid. Beginning September 1, 2007, any woman diagnosed with breast or

cervical cancer may receive MBCC if they meet all eligibility requirements. The diagnosing provider refers the woman to a BCCS contractor who assists the woman in applying for MBCC.

If Form H1034, Medicaid for Breast and Cervical Cancer, is received and the woman does not have a qualifying medical diagnosis, deny the application due to the woman not having a diagnosis for breast or cervical cancer.

X—912 Active Treatment

Revision 15-4; Effective October 1, 2015

At reapplication and at each redetermination, the MBCC applicant or recipient must provide Form H1551, Treatment Verification, completed by her treating health professional verifying that she needs active treatment services for breast or cervical cancer. Active cancer treatment includes services related to the individual's condition as documented in her plan of care, such as:

- surgery,
- chemotherapy,
- radiation,
- reconstructive surgery, and
- medication (ongoing hormonal treatment).

These services also may include diagnostic services that are necessary to determine the extent and proper course of treatment and active disease surveillance for triple negative receptor breast cancer.

Women who are determined to require only routine health screening services for a breast or cervical condition (for example, annual clinical breast examinations, mammograms and pap tests as recommended by the American Cancer Society and the U.S. Preventative Services Task Force) are not considered to need treatment and are not eligible for MBCC. A woman may reapply for MBCC if she is later diagnosed with a new breast or cervical cancer, pre-cancerous condition or a metastatic or recurrent breast or cervical cancer.

If the woman’s treating health professional indicates on Form H1551 that she is not actively receiving treatment, deny the MBCC Eligibility Determination Group (EDG) due to the woman not actively receiving treatment.

X—920 Medicaid Coverage

Revision 15-4; Effective October 1, 2015

Women who are eligible for MBCC-Presumptive or MBCC receive full regular Medicaid benefits.

Before certifying a woman for MBCC-Presumptive or MBCC, Centralized Benefit Services (CBS) staff must complete inquiry into the Texas Integrated Eligibility Redesign System (TIERS) to verify whether the applicant is currently receiving Medicaid or Children's Health Insurance Program (CHIP) benefits. Deny the application if the woman is receiving other Medicaid coverage. **Exceptions:** Do not deny the application if it is determined that the other Medicaid coverage is ending or being denied.

Related Policy
Other Medical Assistance, X-932

X—921 Medical Effective Date (MED)

Revision 12-3; Effective July 1, 2012

Medicaid eligibility begins the date an applicant meets all eligibility criteria. The MED cannot precede the day after the diagnosis date.

For MBCC-Presumptive, the MED is the date the BCCS contractor determines the woman is presumptively eligible for MBCC, but no earlier than the date after the woman was diagnosed with breast or cervical cancer. If the woman provides information needed for MBCC eligibility, provide MBCC coverage for dates that precede the MBCC-Presumptive MED.

Related Policy
Prior Coverage, X-922

X—922 Prior Coverage

Revision 15-4; Effective October 1, 2015

A woman may be eligible for up to three months of prior coverage under MBCC if all other eligibility requirements are met. MBCC only covers unpaid medical bills for services received after the individual's breast and cervical cancer diagnosis date. If a woman indicates on Form H1034, Medicaid for Breast and Cervical Cancer, that she has unpaid medical bills that occurred during the three months before she applied for MBCC, assign an MED of the day after her diagnosis date. Do not require the woman to provide proof of the unpaid medical bills or a completed Form H1113, Application for Prior Medicaid Coverage.

For medical expenses incurred before or on her date of diagnosis, the client must apply for prior Medicaid coverage using Form H1010, Texas Works Application for Assistance — Your Texas Benefits; Form H1205, Texas Streamlined Application; or online at YourTexasBenefits.com. Refer the client to an HHSC eligibility office for the appropriate application or have the client call 2-1-1 to locate the nearest HHSC eligibility office.

Example One: The applicant was diagnosed on August 15 and applied for MBCC on November 21 indicating that she has unpaid medical bills for August, September, October and November. Assign an MED of August 16.

Example Two: The applicant was diagnosed on July 7 and applied for MBCC on July 21 indicating that she has unpaid medical bills for May and June. The individual is not eligible for prior coverage under MBCC since the unpaid medical bills were before her diagnosis date. Assign an MED of July 8.

Example Three: The applicant was diagnosed on January 31 and applied for MBCC on June 4 indicating she has unpaid bills for February. The woman is not eligible for prior coverage since her unpaid medical bills occurred prior to the three-month period before she applied for MBCC.

Note: If the applicant had creditable coverage before applying for MBCC and indicates she has unpaid medical bills for the months she was covered by insurance, the client is not eligible for prior coverage under MBCC. The client must apply for prior Medicaid coverage using Form H1010, Form H1205, or online at YourTexasBenefits.com to determine whether she meets all eligibility requirements for prior Medicaid. See A-831, Three Months Prior Coverage.

X—923 Medicaid Termination

Revision 10-2; Effective April 1, 2010

MBCC eligibility ends when the recipient first meets any of the following conditions. The recipient:

- becomes 65,
- obtains creditable coverage,
- is no longer receiving active treatment for breast or cervical cancer,
- no longer resides in Texas, or
- dies.

X—924 Types of Coverage

Revision 18-1; Effective January 1, 2018

People certified for MBCC-Presumptive receive their medical care via fee-for-service.

People certified for MBCC are enrolled in the STAR+PLUS managed care program.

Related Policy
Managed Care, A-821.2

Managed Care Plans, C-1116

X—930 Creditable Coverage

Revision 12-3; Effective July 1, 2012

X—931 General Overview

Revision 17-2; Effective April 1, 2017

A woman is ineligible to receive MBCC if she has creditable coverage. Deny an MBCC application if her plan covers breast or cervical cancer treatment.

Creditable coverage is defined as:

- group health insurance;
- health insurance coverage;
- Medicare (Part A or B);
- Medicaid;
- CHIP;
- armed forces insurance; or
- a state health risk pool.

Do not consider a plan with a limited scope of coverage such as dental, vision, long-term care, etc., or for only a specific illness/disease, such as drug/substance abuse, as creditable coverage. **Note:** Healthy Texas Women (TA 41) is not considered creditable coverage.

Consider a woman as having creditable coverage even if it has limits on benefits, such as limited drug coverage or limits on the number of outpatient visits, or high deductibles. A woman is considered to no longer have creditable coverage if she:

- is in a period of exclusion (such as pre-existing condition exclusions or a health maintenance organization [HMO] affiliation period) for treatment of breast or cervical cancer; or
- exhausts her lifetime limit on all benefits under the plan or coverage or her yearly benefits for breast or cervical cancer treatment. When the new plan year begins, determine if the woman has creditable coverage.

Note: Set a special review if it is known that the exclusion period of the creditable coverage will expire (pre-existing period has expired) or the woman's yearly benefits for breast or cervical cancer treatment will be reinstated before the next periodic review. See X-1930, Setting Special Reviews.

Women screened under BCCS are not subject to a waiting period if they had prior creditable coverage.

As long as the termination of the creditable coverage occurs before disposition, a woman is eligible to receive benefits under the MBCC program.

A woman is required to report when she has obtained creditable coverage.

If an MBCC applicant indicates she has health insurance but does not know whether it provides coverage for breast or cervical cancer, certify the woman for MBCC-Presumptive. Contact the insurance provider to verify whether the policy provides coverage for breast or cervical cancer.

X—932 Other Medical Assistance

Revision 17-2; Effective April 1, 2017

An MBCC applicant is not eligible to receive benefits if she is currently receiving Medicaid, Medicare Part A or B, or coverage through CHIP. If an application is received for a woman who receives Medicaid, Medicare (Part A or B) or CHIP, or if a Medicaid or CHIP application is certified before the MBCC application, deny the MBCC application.

Staff must verify via TIERS, the State Online Query (SOLQ) or the Wire Third-Party Query (WTPY) system that an applicant is not currently enrolled in Medicaid, Medicare Part A or B, CHIP, or Healthy Texas Women (HTW) before disposition. If a woman is eligible for MBCC and is currently receiving HTW, the HTW EDG must be denied.

X—932.1 Currently Receiving MBCC and Applies for Other Benefits

Revision 16-3; Effective July 1, 2016

A woman receiving MBCC-Presumptive or MBCC who is found eligible for another type of Medicaid program is ineligible to continue to receive MBCC-Presumptive or MBCC. The MBCC advisor receives a task to prospectively deny the MBCC-Presumptive/MBCC EDG so that the advisor processing the application can certify the woman for the other type of Medicaid. The MED for the other Medicaid type begins the first of the month following the MBCC-Presumptive/MBCC EDG denial.

When the other Medicaid type of assistance is denied, the woman may be eligible for MBCC if she continues to be in need of active treatment for breast or cervical cancer and she meets all other eligibility criteria. When the other type of Medicaid is denied (unless the denial is due to death, unable to locate or a move out of state), TIERS generates a reapplication packet if the woman is under age 65 and less than 12 months has passed since her diagnosis date or the date her active treatment was last verified, whichever is later. The reapplication packet contains:

- Form H1833, Cover Letter — Other Medicaid Ending or Form H1834, Cover Letter — Other Medicaid Denied;
- Form H2340, Medicaid for Breast and Cervical Cancer Renewal;
- Form H1551, Treatment Verification;
- a self-addressed envelope; and
- Form H0025, HHSC Application for Voter Registration.

The woman must return the completed Form H2340 and Form H1551 for her eligibility for MBCC to be reconsidered.

If more than 12 months have passed since the woman's diagnosis date or her active treatment was last verified, the woman must be screened and reapply for MBCC through a Breast or Cervical Cancer Services (BCCS) contractor using Form H1034, Medicaid for Breast and Cervical Cancer. TIERS generates either Form H1833-L, Other Medicaid Ending, or Form H1834-L, Other Medicaid Denied, informing the woman how to reapply for MBCC and provides the web address (http://txclinics.dshs.texas.gov/chcl/) where the woman can locate a BCCS contractor in her area.

X—940 New State Residents

Revision 13-4; Effective October 1, 2013

If a woman is screened in another state through the CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and moves to Texas, she may be eligible for MBCC in Texas. If a woman meets the MBCC eligibility criteria in Texas, her screening in another state does not prohibit her from receiving MBCC in Texas.

A new state resident requests MBCC in Texas by contacting 2-1-1. Form H2340-OS, Medicaid for Breast and Cervical Cancer, is mailed to the woman for her to complete and return.

Upon receipt of Form H2340-OS, CBS determines the woman's eligibility for MBCC. Staff must verify with the losing state the woman's screening under NBCCEDP and termination of any Medicaid benefits received in that state, if any, before certification. Use Form H1550, Out of State NBCCEDP Verification, to verify the applicants screening and diagnosis.

Related Policy
New Texas Residents, A-720
Medicaid Coverage for New State Residents, A-822

TWH, X-1000, Domicile

Revision 15-4; Effective October 1, 2015

Domicile requirements do not apply to Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC.

TWH, X-1100, Deprivation

Revision 12-3; Effective July 1, 2012

Deprivation does not apply to Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC.

TWH, X-1200, Child Support

Revision 12-3; Effective July 1, 2012

Child and medical support requirements do not apply to Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC.

TWH, X-1300, Resources

Revision 12-3; Effective July 1, 2012

X—1310 General Policy

Revision 12-3; Effective July 1, 2012

Resources do not apply to Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC.

TWH, X-1400, Income

Revision 15-4; Effective October 1, 2015

X—1410 General Policy

Revision 15-4; Effective October 1, 2015

The Texas Health and Human Services Commission does not test for financial eligibility for Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC.

The woman must meet the financial eligibility criteria for the Breast and Cervical Cancer Services (BCCS) program to be eligible for MBCC-Presumptive or MBCC. This financial eligibility criteria is household income at or below 200 percent of the federal poverty income limit. The BCCS contractor verifies the woman's financial eligibility for the BCCS program before referring a woman to MBCC.

TWH, X-1500, Deductions

Revision 12-3; Effective July 1, 2012

Deductions do not apply to Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC.

TWH, X-1600, School Attendance

Revision 12-3; Effective July 1, 2012

School attendance requirements do not apply to Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC.

TWH, X-1700, Management

Revision 15-4; Effective October 1, 2015

Management requirements do not apply to Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC.

TWH, X-1800, Reminders

Revision 15-4; Effective October 1, 2015"X

X—1810 General Policy

Revision 15-4; Effective October 1, 2015

Before certifying applicants and processing reviews, complete the following:

- Ensure the applicant completes each item and signs and dates Form H1034, Medicaid for Breast and Cervical Cancer, the application for assistance.
- During processing, note if the applicant indicates changes on Form H1034 or during the interview, if an interview is requested. Document the nature of the change and when the individual expects the change to occur. If other programs exist for the individual, report the change to the appropriate office.
- Give or mail the applicant Form H1019, Report of Change. Explain that she must report changes involving her address or creditable coverage within 10 days after knowing about the change. Indicate the appropriate reporting requirement on Page 1.
- Refer the applicant to other programs for which she might be eligible such as Family Planning; Supplemental Security Income or other benefits from the Social Security Administration; and Women, Infants and Children (WIC). Refer aged and individuals with disabilities who are ineligible for Medical Programs for children and families to the Texas Health and Human Services Commission's (HHSC's) Medicaid for the Elderly and People with Disabilities (MEPD) programs.
- Inform the applicant of her right to appeal any HHSC action that affects her eligibility.
- Inform the applicant that the information she provided is subject to verification by third parties.
- Instruct individuals to report any accident-related injuries requiring medical care or accident-related unsettled legal claims within 60 days.
- Mail Form H0025, HHSC Application for Voter Registration, with all applications and renewals. If the individual contacts the local office to decline the opportunity to register based on receipt of Form H0025, use Form H1350, Opportunity to Register to Vote, to

acknowledge the declination. Mail Form H1350 to the individual for her signature and, upon receipt, file a copy in the case record.

X—1820 Documentation Requirements

Revision 15-4; Effective October 1, 2015

Document that the application was mailed along with Form H0025, HHSC Application for Voter Registration, and Form H1350, Opportunity to Register to Vote.

TWH, X-1900, Case Disposition

Revision 15-4; Effective October 1, 2015

X—1910 Notice to Applicants

Revision 15-4; Effective October 1, 2015

Case disposition is the result of processing a request for assistance. Advisors must produce a notice of eligibility status. At the end of the interview, if one was requested by the client, or once Form H1034, Medicaid for Breast and Cervical Cancer; Form H2340, Medicaid for Breast and Cervical Cancer Renewal; or Form H2340-OS, Medicaid for Breast and Cervical Cancer, has been processed, mail the client one of the following notices to inform the individual that the case is pended, certified, sustained or denied.

Form H1020, Request for Information or Action

Form H1020 informs the individual the:

- reason the case is pending;
- action the individual or advisor must take;
- date by which the individual or advisor must take action; and
- date the advisor must deny the application/case if the individual does not take action, if applicable.

If all required proof/verification is not available when processing the application, the advisor allows the household at least 10 days to provide it. The due date must be a workday. Advisors determine what sources of proof/verification are readily available to the household and request those sources first if the advisor expects them to be sufficient proof/verification. If the applicant has an active or inactive Eligibility Determination Group (EDG) in the Texas Integrated Eligibility Redesign System (TIERS), the advisor checks to see whether any proof/verification previously provided on any other EDG can be used to determine eligibility for Medicaid for Breast and Cervical Cancer (MBCC).

Note: Verification previously provided on another case/EDG is only acceptable if it was provided within the 90 days preceding the file date.

Form TF0001, Notice of Case Action

If eligible for MBCC-Presumptive or MBCC, Form TF0001 informs the client of:

- the date benefits begin,
- her right to appeal, and
- the address and phone number of free legal services available in the area.

If the woman is certified for MBCC-Presumptive, a separate Form H1020 is sent informing her of the additional information needed to determine her eligibility for MBCC.

If ineligible for MBCC-Presumptive or MBCC, Form TF0001 informs the client of:

- the date of denial,
- her right to appeal, and
- the address and phone number of free legal services available in the area.

X—1911 Summary of Due Dates for Form H1020, Request for Information or Action

Revision 10-2; Effective April 1, 2010

Case Action	Due Date	Final Due Date
Application	10 days from the date issued	• 30 days, or • 10th day if 10 days end after 30th day
Renewal	10 days from the date issued	By cutoff of review month
Incomplete review	10 days from the date issued	10 days

X—1920 Length of Certification

Revision 13-2; Effective April 1, 2013

MBCC EDGS do not have a certification period.

TIERS calculates a review date from the date the advisor disposes the case action as follows:

- Applications – five months from the date of disposition.
- Renewals – six months from the date of disposition.

X—1930 Setting Special Reviews

Revision 13-1; Effective January 1, 2013

When processing an application or renewal, set a special review if it is known that before the next periodic review the exclusion period of the creditable coverage will expire (pre-existing condition period has expired) or the woman's yearly benefits for breast or cervical cancer treatment will be reinstated.

X—1940 Adverse Action

Revision 10-2; Effective April 1, 2010

Any household receiving a notice of adverse action has the right to request a fair hearing. In some situations, households may continue receiving benefits pending an appeal. After certification, give households advance notice of adverse action to deny benefits except for reasons listed in A-2344.1, Form TF0001 Required (Adequate Notice), and A-2344.2, No Form TF0001 Required.

For adverse action, use current policy found in A-2340, Adverse Action.

TWH, X-2000, Processing Time Frames

Revision 16-3; Effective July 1, 2016

X—2010 Applications

Revision 15-4; Effective October 1, 2015

Process the application within two business days of receipt, but no later than 15 business days from the application file date.

Re-open an application denied for failing to furnish information/verification if the missing information is provided. Use the date the missing information was provided as the new file date. Use the original Form H1034, Medicaid for Breast and Cervical Cancer, until it is 60 days old. If the information on Form H1034 has changed or is more than 45 days old, the client and advisor must update the form.

X—2020 Deadlines

Revision 12-3; Effective July 1, 2012

Provide Form TF0001, Notice of Case Action, the same day eligibility is determined. Determine eligibility no later than 15 days from the file date.

X—2030 Missed Appointments

Revision 12-3; Effective July 1, 2012

No appointment is required to process an application or renewal unless requested by the applicant or recipient. If requested, provide a telephone interview. If she fails to keep her appointment, do not deny the application or renewal; continue to process the application/renewal.

X—2040 Pending Information on Applications

Revision 15-4; Effective October 1, 2015

Advisors may not request additional information or documentation from clients unless such information is not available electronically or the information obtained electronically is not consistent with the information provided by the client.

Advisors must request documents that are readily available to the household if the advisor anticipates them to be sufficient verification. Each *Texas Works Handbook* section lists potential verification sources. C-900, Verification and Documentation, provides information on verification procedures.

In determining eligibility, the advisor must consider any information the individual reports between the application date and the decision date. Include any information the individual reports during the application decision process.

Note: Verification previously provided on another Eligibility Determination Group (EDG) is only acceptable if it was provided within the 90 days preceding the file date.

X—2050 Notice of Renewal

Revision 15-4; Effective October 1, 2015

The Texas Integrated Eligibility Redesign System (TIERS) generates a renewal packet to a recipient two months before the periodic review due date.

The renewal packet includes:

- Form H1830, Application/Review/Expiration/Appointment Notice;
- Form H2340, Medicaid for Breast and Cervical Cancer Renewal;
- Form H1551, Treatment Verification, to verify if the recipient is currently receiving treatment for breast or cervical cancer; and
- a self-addressed stamped envelope.

X—2060 Processing Renewals

Revision 15-4; Effective October 1, 2015

The file date is the date the Texas Health and Human Services Commission (HHSC) receives the renewal application. Process the renewal by mail or telephone.

Note: Send the individual Form H1020, Request for Information or Action, if the individual did not provide Form H1551, Treatment Verification, with Form H2340, Medicaid for Breast and Cervical Cancer Renewal.

A woman remains eligible for Medicaid for Breast and Cervical Cancer (MBCC) when it is verified that she:

- has not turned age 65;
- is actively receiving treatment, as defined in X-912, Active Treatment; and
- does not have creditable coverage as defined in X-930, Creditable Coverage.

Deny a recipient if it is verified that she has creditable coverage, is not actively receiving treatment or is age 65 or older.

X—2070 Processing Time Frames

Revision 16-3; Effective July 1, 2016

Advisors must process periodic reviews before cutoff in the month:

- the review date falls, if the review is due on or before cutoff; or
- after the review date, if the review is due after cutoff.

If the household must provide verification to complete the review, allow the household at least 10 days to provide it.

Advisors must reopen a renewal form denied for failing to furnish information or verification if the missing information is provided by the 60th day from the file date. The date the missing information/verification was provided is the new file date.

The original Form H2340, Medicaid for Breast and Cervical Cancer Renewal, can be used until it is 60 days old, following the policy explained in B-111, Reuse of an Application Form After Denial.

Advisors must consider a Form H2340 received after the last day of the certification period as an application using application processing time frames in X-2010, Applications, if it is received 12 months or less after the woman's breast or cervical cancer diagnosis date or the date active treatment was last verified, whichever is later.

TWH, X-2100, Changes

Revision 12-3; Effective July 1, 2012

X—2110 General Policy

Revision 12-3; Effective July 1, 2012

Recipients must report the following changes:

- moving out of state,
- obtaining creditable coverage,
- turning age 65,
- discontinuing treatment, or
- death.

Note: If a change for a Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC recipient is received in an eligibility office:

- without verification, staff take the change and enter it into the **State Portal-Report A TIERS Change** portlet and the system automatically creates and routes the change task appropriately.
- with verification, staff must complete an MI/Change Routing cover sheet and fax it to the vendor at 1-877-236-4123. The system creates and routes the change task appropriately.

X—2120 Actions on Changes

Revision 10-2; Effective April 1, 2010

Centralized Benefit Services staff follow change processing procedures and time frames in B-631, Actions on Changes, under All Programs.

TWH, X-2200, Fair Hearings

Revision 12-3; Effective July 1, 2012

X—2210 Appeals Procedures

Revision 12-3; Effective July 1, 2012

Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC applicants/recipients receiving a notice of adverse action are entitled to continued benefits if the recipient requests them and appeals the decision within the advance adverse action time frame.

All renewal denials must receive advance notice of adverse action.

Refer to B-1000, Fair Hearings, for specific appeals policy and procedures.

TWH, X-2300, Confidentiality

Revision 12-3; Effective July 1, 2012

X—2310 General Policy

Revision 12-3; Effective July 1, 2012

Medicaid for Breast and Cervical Cancer (MBCC)-Presumptive or MBCC follows policy in B-1200, Confidentiality, for confidentiality policy and procedures.

TWH Glossary

A B C D E F G H I K L M N O P Q R S T U V W

401(k) — A retirement plan allowing an employee to postpone receiving a portion of current income until retirement.

A B C D E F G H I K L M N O P Q R S T U V W

Able Bodied Adult Without Dependents (ABAWD) — An individual, beginning the month after the individual turns age 18 and ending the month the individual turns age 50, who receives Supplemental Nutrition Assistance Program (SNAP) benefits and is physically and mentally able to work at least an average of 20 hours per week, is not a member of a SNAP Eligibility Determination Group (EDG) where a household member on the SNAP EDG is under age 18, and is not pregnant.

Absent Parent — A child's parent who is not living in the home.

Accessibility Date — The date that benefits are deposited into an Electronic Benefit Transfer (EBT) account.

Account Transfer — The manner in which an applicant's information moves between the Marketplace and the Texas Health and Human Services Commission (HHSC) when applying for medical programs. The account transfer from the Marketplace to HHSC, and from HHSC to the Marketplace, will include the information the applicant submitted through the original application in addition to information from verifications performed by either the Marketplace or HHSC.

Active Duty Military Member — An individual currently serving in the U.S. Armed Forces/Reserves (Army, Marine Corps, Navy, Air Force or Coast Guard), National Guard (Army, Marine Corps, Navy, Air Force, Coast Guard or Reserve Guard) or the State Military Forces/Texas State Guard.

Adequate Notice — A notice of adverse action that expires the same day it is sent.

Administrative Renewal — The method used to redetermine eligibility for most Medical Programs, including Medicaid for the Elderly and People with Disabilities (MEPD) and the Children's Health Insurance Program (CHIP). The automated process uses existing client information, electronic data source information, and reasonable compatibility when income verification is required. This results in:

- an automated eligibility determination; or
- the requirement of additional information from the client to manually process the redetermination.

Administrative Review — A desk review of the fair hearing record by a Health and Human Services (HHS) attorney to determine whether the hearing officer's decision is correct. A request for an administrative review must be submitted in writing within 30 calendar days from the date of the hearing officer's decision.

Administrative Terminal Application (ATA) — A software program accessible on one or more Texas Health and Human Services Commission (HHSC) desktop computers in each office and used for Electronic Benefit Transfer (EBT) card issuance and replacement. The ATA allows access to the EBT system and may also be used for inquiry on EBT-related information, expedited Supplemental Nutrition Assistance Program (SNAP) benefit authorization, and account transaction updates to the EBT database.

Advance Notice — A notice of adverse action that expires 13 days after it is sent.

Advanced Authentication —Personal security questions generated by third-party software to perform authentication of an applicant's identity before granting the individual an account through YourTexasBenefits.com with Case Visibility.

Advanced Nurse Practitioner — A registered nurse with additional training and certification in a specific area of medicine. Examples include certified nurse-midwives, clinical nurse specialists, and pediatric nurse practitioners.

Advanced Premium Tax Credit (APTC) — The payment of a tax credit by the federal government, provided on an advanced basis or at tax filing time, to an eligible individual enrolled in a qualified health plan (QHP) through the Marketplace.

Adverse Action — Any Texas Health and Human Services Commission (HHSC) action resulting in denial, suspension, reduction, or termination of assistance. The term also applies to decisions regarding protective and restricted payments.

Agriculturally Related Activities — Employment:

- on a farm or ranch performing field work related to planting, cultivating, or harvesting operations; or
- in canning, packing, ginning, seed conditioning, or related research or processing operations.

Aid — A benefit, coverage, or service in programs that the Texas Health and Human Services Commission (HHSC) administers.

Alert — A system or user-generated reminder that action needs to be taken on a case or a notification that an action has taken place.

Alerts — A functional area on a navigation bar that allows eligibility staff to request alerts and view outstanding and processed alerts.

Alien Sponsor — A person who signed an affidavit of support (U.S. Citizenship and Immigration Services [USCIS] Form I-864 or I-864-A) on or after December 19, 1997, agreeing to support an alien as a condition of the alien's entry into the U.S.

Note: Not all aliens must obtain a sponsor before being admitted into the U.S.

Alimony — Payments received from a spouse or former spouse under a divorce or separation decree. It is also referred to as spousal support.

Alimony Paid — Payments to a spouse or former spouse under a divorce or separation decree. It is also referred to as spousal support paid.

Alternate Payee — An individual who receives the benefits for the Eligibility Determination Group (EDG) when the EDG is unable or ineligible to receive them. Types of alternate payees include a court appointed guardian, Electronic Benefit Transfer (EBT) representative, Financial Management Information System (FMIS) payee, long-term care (LTC) payee, protective payee, and representative payee.

Annualize — Averaging income over a 12-month period.

Annuity — A series of payments paid under a contract and made at regular intervals over more than one full year. Payments may be either fixed (under which one receives a definite amount) or variable (not fixed). An individual may buy the contract alone or with the help of an employer.

Annulment — A court order declaring a marriage invalid.

Appeal — A request for a fair hearing concerning an Texas Health and Human Services Commission (HHSC) action. Appeals are logged and updated in the "Hearing" functional area on the navigation bar.

Application — A form that an individual or household uses to apply for assistance, such as Form H1010, Texas Works Application for Assistance — Your Texas Benefits, or Form H1205, Texas Streamlined Application.

Application Registration — The functional area in which an individual's application for assistance is recorded.

Application Visibility — Type of YourTexasBenefits.com account given to an applicant who has selected not to go through Advanced Authentication. Individuals with Application Visibility accounts may only apply for benefits and view and modify applications created under their user name.

Applied Income — The countable amount of income after allowing deductions for tax dependents, child support, alimony, and persons a legal parent is legally obligated to support.

Assets — All items of monetary value owned by an individual.

Assignable — Time periods that are available to be used to schedule appointments using the "Scheduling" functional area.

Authorization Code — A code that identifies a retailer as a Food and Nutrition Service (FNS)-participating store. The code is used to request permission to use the Lone Star Card in a transaction.

Authorized Representative (AR) —

An individual or organization designated by an applicant or recipient to take the following actions on the applicant's behalf:

- sign an application;
- complete and submit a renewal form;
- receive copies of the applicant's/client's notices in the preferred language selected on the application, and other communications from the agency;
- designate a health plan; and
- act on behalf of the applicant/client in all other matters with the agency, such as reporting changes.

Automated Income Check Process — The first step in a periodic income check (PIC). During this step, information from electronic data sources is automatically requested and a reasonable compatibility test is run. This process occurs without advisor action.

Automated Renewal Process — The first step in an administrative renewal. During this step, information from electronic data sources is automatically requested, reasonable compatibility is run when income verification is required, and correspondence is sent to the client. This process occurs without advisor or specialist action.

Availability Date — The date that benefits are deposited into the Electronic Benefit Transfer (EBT) account.

A B C D E F G H I K L M N O P Q R S T U V W

Balance Receipt — A paper receipt that shows the available balance in an individual's cash and/or food account.

Basic Utility Allowance (BUA) — Deduction given to a household that has utility costs, but does not qualify for the standard utility allowance (SUA).

Batch Processing — Actions postponed until a later time when they can be processed by the system more efficiently. In many instances batch processing occurs overnight, when Texas Health and Human Services Commission (HHSC) offices are closed and the system is not being heavily used throughout the state. Examples of batch processing include scheduling system-generated correspondence to be printed at and mailed from a central site; mailing out review packets at scheduled intervals from the central mail facility; and gathering information and sharing it through interfaces with other agencies.

Batch Scheduling — The inclusion of an appointment date and time with eligibility staff within application packets mailed from the central mail facility. See batch processing.

Bendex (Beneficiary Data Exchange) — A computer tape from the Social Security Administration that provides Social Security and Medicare information about Texas Health and Human Services Commission (HHSC) individuals. The system generates an alert when the amount on file does not match the information on the Bendex file.

Beneficiary — The person named to receive benefits.

Benefit Issuance — The functional area that supports the issuance and tracking of benefits that were calculated in the Eligibility Determination Benefit Calculation (EDBC) and authorized by staff in disposition. See dispose.

Birth Verification System (BVS) — The inquiry system used by eligibility staff to verify birth information.

Blocked — Time periods that are designated for specific purposes and cannot be used to schedule appointments using the Scheduling functional area.

Boarder — A person paying reasonable compensation for room and meals. A boarder can receive Supplemental Nutrition Assistance Program (SNAP) benefits only with the household in which he or she boards. **Note:** This does not include anyone who otherwise qualifies as a resident of a drug/alcohol treatment center, federally subsidized housing for the elderly, a qualifying group living arrangement, a shelter for battered persons, or a shelter for the homeless.

Bona Fide Agent — A person who is familiar with an individual applicant and knowledgeable of the individual's financial affairs.

Budgetary Needs — The full basic needs amount as defined by Texas Health and Human Services Commission (HHSC) necessary for a family to obtain food, clothing, housing, utilities, and incidentals such as telephone, laundry, and recreation. This calculation is based on family size and is used in the Temporary Assistance for Needy Families (TANF) 100 percent budgetary needs gross income test.

Budgeting — The method used to determine eligibility and benefits for Temporary Assistance for Needy Families (TANF), Medical Programs, and the Supplemental Nutrition Assistance Program (SNAP) by calculating income and deductions.

A B C D E F G H I K L M N O P Q R S T U V W

Cafeteria Plan — Flexible fringe benefit plans offered to employees by their employers.

Canceled Debts — Debts that have been canceled, forgiven, or discharged. The canceled amount is included as countable income on federal income tax returns. Examples include loan foreclosures and canceled credit card debt.

Capital Gains — A profit from the sale of property or of an investment when the sale price is higher than the initial purchase price, such as profits from the sale of stocks, bonds, or real estate.

Capital Goods — The accumulated possessions (property, goods and products) used to produce income or other goods.

Cardholders — Persons authorized to use the Lone Star Card to access benefits in the household's Electronic Benefit Transfer (EBT) account(s). There are two types of cardholders: primary cardholders and secondary cardholders.

Card Sleeve — A durable paper envelope folded to the dimensions of the plastic EBT card so that the card can be slid in and out of the sleeve. The primary use of the sleeve is to protect the magnetic stripe from being damaged by scratches. The sleeve also has important information printed on it for easy reference, such as the Lone Star Help Desk number.

Caretaker — For:

- Temporary Assistance for Needy Families (TANF) — An adult whose needs are included in a TANF grant because the adult is within the required degree of relationship and is financially eligible according to TANF policy.
- Type Program (TP) 08, Parents and Caretaker Relatives Medicaid — A person who supervises and cares for a dependent child. The person must be a legal parent(s) or other caretaker relative within the required degree of relationship who meets the income limits for that program.

Caretaker Relative — For:

- Temporary Assistance for Needy Families (TANF) — a disqualified legal parent, second parent, or a non-parent relative certified as caretaker.
- For Type Program (TP) 08, Parents and Caretaker Relatives Medicaid — A relative within the required degree of relationship, other than a legal parent, caring for a dependent child who meets the income limits for that program.

Carryover Standby List — Applicants from a previous day's standby list who have not been interviewed.

Cascade Logic — A hierarchy of logic used to build Eligibility Determination Groups (EDGs) and evaluate eligibility for Texas Health and Human Services Commission (HHSC) programs and types of assistance. The EDG is built and eligibility is established at the highest level. If there are no eligible members after cascade logic is applied, the household is ineligible for the program. See EDBC, rebuild EDG, run EDBC and Wrap Up.

Case — All the persons living together, and alien sponsors, who are related by Eligibility Determination Group (EDG) affiliation. The persons may or may not be included in EDGs as certified members.

Case Mode — Status of a case that identifies that:

- action has been initiated on an Eligibility Determination Group (EDG) in a case (Intake, Complete Action, Change Action, Special Review, Conversion);
- all of the EDGs in a case are approved (Ongoing); and
- all of the EDGs in a case are denied (Ongoing).

Case Number — A unique 10-digit number that identifies a group of Eligibility Determination Groups (EDGs). See Case.

Case Visibility — Type of YourTexasBenefits.com account given to an applicant who has been through Advanced Authentication and is therefore granted a Case Visibility level account. With this type of access, individuals can view and modify an application created under their user name and any case data for cases in which they are the head of household, an adult member within the household, or an authorized representative.

Catchment Area — The area covered by service.

Categorically Eligible Household — Households in which all members are either eligible for or receive benefits from Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), or state-financed general assistance programs and have already gone through the eligibility determination for those programs. These households may bypass the income and resources tests and are deemed financially eligible. There are two types of categorically eligible households:

1. A Supplemental Nutrition Assistance Program (SNAP) household whose members are all approved for TANF or SSI. A household member is a TANF or SSI recipient if the individual is approved for TANF or SSI but the benefit:
    - has not yet been received**;**
    - is suspended; or
    - is being recouped.
2. A SNAP household that includes members authorized to receive TANF non-cash services and whose household gross income is less than 165 percent of the Federal Poverty Income Limit (FPIL) for its size and meets the resource criteria.

Certificate of Coverage — A certificate that serves as proof of a Medicaid recipient's most recent period of Medicaid coverage. The certificate, a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), is sent to denied recipients by the Texas Department of State Health Services (DSHS). Former Medicaid recipients may request a certificate within 24 months after their Medicaid is denied by calling 1-800-723-4789.

Certification Date — The date that eligibility staff dispose the Eligibility Determination Group (EDG) to certify an applicant as eligible.

Certification Period — The period of time of eligibility established at disposition. Not all Texas Health and Human Services Commission (HHSC) programs and types of assistance have certification periods.

Certified Group — The members in an Eligibility Determination Group (EDG) who are eligible for a given program.

- Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) — Multiple individuals may be certified on a single EDG.
- Medical Programs that follow modified adjusted gross income (MAGI) rules, except Children’s Health Insurance Program (CHIP) perinatal — Only one individual is certified on the EDG.
- CHIP perinatal — The mother and child will be certified on a single EDG during the month the child is born. After the child is born, only the child will be certified on the EDG.

Change Action — A data collection interview mode that allows eligibility staff to navigate to pages on which they want to record information. See Case Mode.

Child — A child is an adoptive, step, or natural child who is under age 19.

Child in a Two-Parent Family — For:

- Temporary Assistance for Needy Families (TANF) — A child who lives with either one or both parents, or a parent and stepparent, and one or both of the parents/stepparent do not receive TANF benefits.
- TANF-State Program (SP) — A child who lives with both parents, or a parent and stepparent, and both parents and stepparent (if included in the certified group) receive TANF benefits.

Child Support — A payment made from a biological or adoptive parent to a biological or adoptive child. Child support may be:

- Formal – court-ordered or legally mandated; or
- Voluntary – not court-ordered and given voluntarily when the child's caretaker or the person making the payment states the purpose of the payment is to support the child.

Child Support Disregard — The first $75 of the total child support collected in a month that is subtracted before determining TANF eligibility or benefits. After certification, the Office of Attorney General (OAG) sends the individual the first $75 received on monthly child support collections. If the total collection is less than $75, then the amount of the collection is sent to the individual.

Children's Health Insurance Program (CHIP) — Medical coverage for children under age 19 whose family income exceeds the limits for Children's Medicaid.

Children's Medicaid — Medical coverage for children whose family income is under the applicable income limit. In most instances, Children's Medicaid relates to comprehensive policy for Type Programs (TPs) 43, 44, 45, and 48, unless specifically stated otherwise in a particular handbook section.

CHIP Perinatal — Medical services to unborn children of pregnant women ineligible for Medicaid due to income or alien status.

Choices County Service Levels — Counties designated by the Texas Workforce Commission (TWC) as Choices counties. TWC has designated all counties in Texas as Choices counties, and the Local Workforce Development Boards (LWDBs), after coordination with the Texas Health and Human Services Commission (HHSC) state office, assign a service level designation for each county depending upon services available in that county. The two levels of service are:

- full service — having a significant presence of Choices staff; or
- minimum service — has little or no presence of Choices staff.

Claim — An amount owed by an individual for an overpayment of benefits.

Clearinghouse — A centrally located site that processes medical bills submitted by applicants for Medically Needy with Spend Down. Functions of the clearinghouse include:

- determining if a medical bill can be counted for spend down;
- corresponding with the applicant about eligible and ineligible medical bills;
- determining if and when the applicant meets spend down; and
- notifying the applicant and the eligibility system when spend down is met.

Collateral Contact — A person the advisor can contact to verify an individual's information. The person must have no vested interest in the household's situation.

Colonias — Unincorporated and unregulated settlements (neighborhoods) along the U.S./Mexico border.

Combat Pay — Supplemental incentive payments for hazardous duty and special pay for duty subject to hostile fire or imminent danger.

Combat Zone — The geographic area or country to which a military member is deployed for combat.

Commingled Resources — Resources of a Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI) recipient combined with those of a non-TANF or SSI household member.

Common Law Marriage — Relationship in which the parties age 18 or older:

- are free to marry;
- live together; and
- hold out to the public that they are married.

A minor child in Texas is not legally allowed to enter a common law marriage unless the claim of common law marriage began before September 1, 1997.

Communal Dining — A public or non-profit establishment approved by Food and Nutrition Services (FNS) that prepares and serves meals to elderly persons or individuals who receive Supplemental Security Income (SSI) and their spouses.

Community Supervision — The placement of a misdemeanor or felony offender under supervision for a specified length of time ordered by the court. Sentences are served in the community rather than in jail or prison. Also formally known as (adult) probation.

Complete Action — A data collection interview mode that sets up the driver flow for a complete review of all eligibility requirements in an ongoing case. See case mode and interview mode.

Complete Review — A re-evaluation of ongoing eligibility.

Comprehensive Energy Assistance Program (CEAP) — A utility assistance program funded annually by the Low Income Home Energy Assistance Program (LIHEAP). CEAP replaced the Home Energy Assistance Program (HEAP).

Continued Benefits — Continuing or restoring benefits to the level authorized immediately before the notice of adverse action.

Continuing Scheme — A situation in which a recipient commits two or more acts, such as falsifying a document or a statement or providing false information in an interview, with the intent to commit fraud. Failure to report a required Texas Health and Human Services Commission (HHSC) program change in conjunction with one or more of the aforementioned acts may be considered a basis to commit fraud.

Continuous Eligibility — A period of time during which an individual remains eligible during a continuous eligibility period regardless of any change in circumstances, except for:

- attaining the maximum age for that specific program;
- death;
- voluntary disenrollment;
- change in state residence;
- state error in the eligibility determination; or
- fraud, abuse, or perjury attributed to the individual or individual's representative.

Convertible Bond — A bond that can be converted to cash according to program policy. Convertible bonds are countable resources.

Copayment — Payment made directly to a provider according to a fee schedule.

Correspondence — The functional area in which system- and user-generated notices and forms are processed. The notices and forms that are processed in this functional area are also called correspondence. All notices and forms processed in this functional area are linked to a specific case. System-generated correspondence cannot be deleted. See batch processing, pending correspondence, print mode, print type, system-generated and user-generated.

Cost-Sharing Reductions — Federal payments toward out-of-pocket costs made for an eligible individual enrolled in a qualified health plan (QHP) through the Marketplace.

Court Awards — Taxable money that an individual receives as the result of a lawsuit, such as compensation for lost wages or punitive damages awards.

Crime Victim's Compensation — Payments from the funds authorized by state legislation to assist a person who:

- has been a victim of violent crime;
- was the spouse, parent, sibling or adult child of a victim who died as a result of a violent crime; or
- is the guardian of a victim of a violent crime.

The payments are distributed by the Office of the Attorney General (OAG) in monthly payments or in a lump-sum payment.

A B C D E F G H I K L M N O P Q R S T U V W

Data Broker — An intranet application used by eligibility staff to access online data about individuals. The information is compiled from a number of sources. This information is compared to the application and details from the interview to identify case discrepancies, reducing the possibility of case error and fraud. See permissible purpose.

Data Collection — The functional area where individual household, non-financial, resource, income, and deduction information is recorded for use in building Eligibility Determination Groups (EDGs) and determining eligibility for types of assistance. See EDBC and driver flow.

Deductible Part of Self-Employment Tax — A federal income tax deduction for self-employed individuals paying self-employment taxes.

Deferred Adjudication — A type of probation where the decision for a conviction is postponed until the end of the probationary period.

Dependent Child — For:

- Temporary Assistance for Needy Families (TANF) — A child who meets the definition of deprivation and who lives with a relative who meets the relationship requirement.
- For Type Program (TP) 08, Parents and Caretaker Relatives Medicaid – A child who is under age 18, or is age 18 and a full-time student meeting the school attendance requirement.

Deprivation — Loss of parental support caused by death, incapacity, continued absence of one or both natural or adoptive parents, or because of unemployment or underemployment of both parents in a two-parent family.

Derivative Citizenship — U.S. citizenship that is claimed by a person born outside of the U. S. to one or both U.S. citizen parents.

Detail Page — Click the Edit or View icon to edit or view details of a record listed on a Summary Page.

Discovery Date — The date an individual learns of a change. The discovery date is compared with the report date to determine whether a change is reported timely.

Dispose — To process an Eligibility Determination Group (EDG) so eligibility is established or denied.

Disqualified Person — Someone who normally would be considered a participating member of a household but whose needs are not considered because the person failed to meet or comply with a program requirement.

Domestic Production Activities Deduction — A federal income tax deduction that individuals may receive for certain qualified production activities, such as construction of real property or lease, rental, license, sale, exchange, or other disposition of personal property, computer software, sound recordings, produced films, produced electricity, natural gas, or potable water.

Domicile — A residence maintained or being established, as evidenced by continuation of responsibility for day-to-day care of the child, by the relative with whom the child is living.

Dormant Account — An active Electronic Benefit Transfer (EBT) account that has not been accessed by an individual for:

- three consecutive months for Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP); or
- six consecutive months when the household received a SNAP issuance of less than $20 for the previous calendar month.

Dormant EDG — An EDG becomes dormant when the EBT account is dormant. See Dormant Account.

Driver Flow — The logical sequence of data collection pages that appear as a case is completed or read. The driver flow is determined by the programs, types of assistance, and answers to questions as the case is worked. In some interview modes, staff cannot advance to pages that have not yet been accessed as part of the driver flow.

Duplicate Application — An application filed after another application has already been filed and:

- does not include a request for programs different from programs requested on the initial application submitted;
- does not include a request for programs different from programs currently received by the applicant; and
- is not needed for a redetermination.

A B C D E F G H I K L M N O P Q R S T U V W

Earned Income — Income an individual receives for a certain activity or work.

Earned Income Tax Credits (EIC) — Payments from the Internal Revenue Service (IRS) to people with tax dependents and gross monthly earnings at or below levels established by the IRS.

Educational Expenses/Student Loan Interest — A federal income tax deduction for individuals paying interest on student loans or for individuals with education expenses such as tuition, fees, room and board, books, and other supplies.

Educator Expenses — Expenses for which educators, kindergarten through grade 12 teachers, counselors, principals, or aids can receive a federal income tax deduction. Qualified expenses include purchased books, supplies, equipment, and other classroom materials.

Effective Month — The first month benefits can be affected based on the monthly cutoff date or applicable policy regarding advance and adequate notice of adverse action.

Electronic Benefit Transfer (EBT) — A system that uses electronic technology to complete some or all of a benefit program's functional requirements. EBT involves computers, a variety of cards or types of cards, electronic funds transfer techniques, automated teller machines (ATMs), point-of-sale terminals or other types of terminals, and software to complete the EBT process without the loss of program integrity or individual confidentiality.

Electronic Benefit Transfer (EBT) Account — A benefit account established by the EBT system in which HHSC deposits the household's benefits. There are two types of benefit accounts:

- a food account that contains the household's Supplemental Nutrition Assistance Program (SNAP) benefits; and
- a cash account that contains the household's Temporary Assistance for Needy Families (TANF) grant amount.

The individual or his representative uses the Lone Star Card and a personal identification number (PIN) to access benefits in the account(s).

Electronic Benefit Transfer (EBT) Card — A plastic card called the Lone Star Card issued to primary and secondary cardholders that allows the cardholders access to the benefits in the EBT system. A stripe of magnetic material, which is machine-readable and allows for the activation of point-of-sale equipment, is affixed to the back of the card at the time of manufacture.

Electronic Benefit Transfer (EBT) Coordinator — A regional manager designated to lead regional planning and to be a point of contact for EBT.

Electronic Benefit Transfer (EBT) Issuance Staff — An HHSC employee who answers EBT questions and accomplishes EBT card and personal identification number (PIN) issuance for individuals in the local HHSC office.

Electronic Benefit Transfer (EBT) Regional Manager — A regional manager designated to oversee, monitor, lead regional planning, and act as a point of contact for EBT.

Electronic Benefit Transfer (EBT) Representative — A primary cardholder other than the case name. This person has access to the EBT account for the Eligibility Determination Group (EDG). This may be a Temporary Assistance for Needy Families (TANF) representative payee or protective payee or a Supplemental Nutrition Assistance Program (SNAP) authorized representative for a resident of a Drug/Alcohol Treatment Center or Group Living Arrangement. See alternate payee.

Electronic Benefit Transfer (EBT) Vendor — One of the companies that performs EBT-related services for the state of Texas.

Electronic Data Sources (ELDS) — Verification sources that are available electronically and presented to advisors in the Texas Integrated Eligibility Redesign System (TIERS) during Data Collection.

Eligibility — The functional area that supports Eligibility Determination Benefit Calculation (EDBC).

Eligibility Determination Benefit Calculation (EDBC) — The process of applying program policy to household, non-financial, resource, income and deduction information entered in the Data Collection functional area. This information is used in the EDBC process to build Eligibility Determination Groups (EDGs) and determine eligibility for programs and types of assistance. See cascade logic.

Eligibility Determination Group (EDG) — Members of a household whose needs, resources, income, and deductions are considered in determining eligibility for benefits. The EDG includes members who are eligible and may include members who are not certified for benefits.

Emancipated Minor — A person under age 18 who has been married. The marriage must not have been annulled.

Emergency Medicaid — All types of emergency Medicaid coverage programs for individuals who are nonimmigrants, undocumented aliens, or certain legal permanent residents who have emergency medical conditions and who, except for alien status, would be Medicaid-eligible. When the term is used in the handbook, it means all of the following programs combined:

- Type Assistance (TA) 31, Parents and Caretaker Relatives – Emergency
- Type Program (TP) 32, Medically Needy with Spend Down – Emergency
- TP 33, Children 1-5 – Emergency
- TP 34, Children 6-18 – Emergency
- TP 35, Children Under 1 – Emergency
- TP 36, Pregnant Women – Emergency

Emergency Medical Condition — An eligibility requirement for Emergency Medicaid for nonimmigrants, undocumented aliens and certain legal permanent resident aliens. It is a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably have been expected to result in:

- placing the patient's health in serious jeopardy;
- seriously impairing the patient's bodily functions; or
- causing serious dysfunction of any bodily organ or part.

Employable Household Member — A person whose earnings are countable and:

- is age 16 through 59;
- does not meet the criteria in B-432, Definition of Disability; and
- is currently unemployed.

Employer-Paid Taxes — Taxes that are paid by the employer on behalf of the employee rather than deducting the tax amount from the employee's wages. The amount the employer pays is counted as part of the individual's gross income.

Employment Services Program (ESP) — The program for employment assistance and work registration of Temporary Assistance for Needy Families and Supplemental Nutrition Assistance Program individuals. ESP includes Choices and Employment and Training (E&T).

Equity — The fair market value of an item minus all money owed on it and the cost associated with its sale or transfer.

Essential Person — The need for a particular member of a household to be in the home on a continuous basis because another member has a (certified) mental or physical impairment.

Evaluative Conclusion — An advisor's decision, subject to supervisory approval, to accept something other than a birth or hospital certificate or baptismal record as proof of age and relationship.

Excess Payment — A payment sent to a Temporary Assistance for Needy Families (TANF) recipient by the Office of the Attorney General (OAG). When the OAG receives a child support collection on the current monthly obligation and that payment exceeds the TANF grant plus any unreimbursed assistance, the excess is sent to the individual.

Excluded Provider — A Medicaid provider who is not allowed for a period of time to continue participating in the Texas Medicaid program because of fraud conviction, program abuse, and other reasons.

Expedited Service — Special, faster processing of Supplemental Nutrition Assistance Program (SNAP) applicants who qualify for an emergency food allotment, for active duty military members and their dependents applying for medical coverage, and for pregnant women applicants who qualify for current or ongoing medical coverage.

Expenses of Fee-Basis Government Officials — Federal income tax deductible employment-related expenses paid for or accrued by employees of a state or political subdivision who are compensated on a fee basis.

Expenses of Performing Artists — Federal income tax deductible expenses for qualified performing artists paid or accrued through performances while serving as an employee in the performing arts.

Expenses of Reservists — Federal income tax deductible expenses for National Guard and military reserve members who traveled more than 100 miles from home for service.

Expunged Benefits — Benefits that are removed from an Electronic Benefit Transfer (EBT) account by the issuer of the benefits.

A B C D E F G H I K L M N O P Q R S T U V W

Fair Hearing — A meeting conducted by a regional hearing officer with an applicant or individual who disagrees with and wishes to appeal some action taken on the individual's case.

Fair Market Value — Amount of money an item would bring if sold in the current local market.

Falsified Document — Form H1010, Texas Works Application for Assistance — Your Texas Benefits; Form H1019, Report of Change; or another signed and dated document that does not report all current income or circumstances.

Falsified Interview — An interview with agency personnel at which time the individual does not report all current income or accurate circumstances.

Falsified Statement — A statement made by an individual, orally or in writing, that is not true, such as claiming to have been without work since a certain date, when the individual was employed during that time period.

Family Violence — An act by a member of a family or household against another member of the family or household that is:

- intended to result in physical harm, bodily injury or assault, or that is a threat that reasonably places the member in fear of imminent physical harm or bodily injury or assault, not including defensive measures to protect oneself; or
- intended to inflict emotional harm, including an act of emotional abuse.

File Clearance — This feature determines whether an applicant has a case record with HHSC. When an individual is added, File Clearance can be processed in Application Registration. If File Clearance is not processed in Application Registration, the system will perform it in Data Collection. File Clearance compares the individual's demographic information against databases for potential matches. These databases contain information for individuals who are currently on assistance and for individuals who have applied for or received assistance in the past.

First Cousin Once Removed — A person who is either one's first cousin's child or the parent's first cousin.

Fixed Income — Unearned income that does not vary.

Flexible Support Payments — Financial assistance provided to relative caregivers in the conservatorship of the Texas Department of Family and Protective Services (DFPS). The purpose of the payments is to reimburse caregivers for expenses such as summer school tuition, tutoring, school supplies, school activities, car insurance for adolescents, and other necessary expenses. The amount of the reimbursement will not exceed $500 annually per child.

Fluctuating Income — Income in which the amount varies because of an increase or decrease in hours worked, rate of pay, or inclusion of a bonus.

Four Months Post-Medical — Medicaid coverage extended for a maximum of four months after denial of a case because of spousal support income.

Fugitive — An individual fleeing to avoid prosecution of or confinement for a felony criminal conviction or found by a court to be violating federal or state probation or parole.

Functional Area — Functions and processes that appear in the Texas Integrated Eligibility Redesign System (TIERS) Left Navigation area and represent a particular business process. Each functional area contains pages that allow authorized staff to perform activities related to the business process. The functional areas that are available to the user are determined by the user's job title and security role(s).

A B C D E F G H I K L M N O P Q R S T U V W

General Equivalency Diploma (GED) — A high school equivalency certificate issued after an individual completes a State Board of Education-approved high school equivalency program.

General Residential Operations Facility — Residential care facilities that provide a live-in house parent model of care for children under their care. The house parent assumes responsibility and acts in lieu of the parent in meeting the children's ongoing needs. These facilities have limited power of attorney to obtain health care and educational services for the children under their care.

Good Cause — A term used to indicate that an individual has an acceptable reason for not complying with a program requirement.

Grandparent Payment System (GPS) — An electronic, web-based data system used to inquire, request, and record the issuance of one-time grandparent payments.

Grant in Jeopardy — The Office of the Attorney General's (OAG's) designation for a case that is potentially ineligible for the Temporary Assistance for Needy Families (TANF) grant because the OAG received a child support collection on the current monthly obligation and it equals or exceeds the TANF grant plus the disregard.

A B C D E F G H I K L M N O P Q R S T U V W

Health Insurance Premium Payment (HIPP) — A reimbursement program administered by the Texas Health and Human Services Commission's (HHSC's) Third-Party Resource Unit, which pays for the cost of premiums, coinsurance, and deductibles. The program reimburses the policy holder for private health insurance payroll deductions for Medicaid-eligible persons when HHSC determines that it is cost-effective.

Health Savings Account — A savings account for medical-related expenses that is available to taxpayers. The money contributed to these accounts is not subject to federal income tax at the time of deposit.

Hearing — The functional area where individual appeals are recorded and tracked.

HHSC — The Texas Health and Human Services Commission.

High School Diploma — Certification issued by a state-accredited school to a student who successfully completes the curriculum requirements for secondary school as approved by the State Board of Education.

Historical Correspondence — Records of forms and notices that have been printed. See Correspondence, Print Mode and Print Type.

Historical Data — Records of case, Eligibility Determination Groups (EDGs) and individual information.

Home Energy Assistance Program (HEAP) — A federal program that pays benefits to help eligible people pay utility costs.

Home School — A type of education in which children are taught by their parents, or someone acting in parental authority, at home, using a set curriculum. The parent oversees the curriculum and ensures that the children are actually being educated.

Homeless Household — Households that have no regular nighttime residence or that live in:

- a supervised shelter that provides temporary living quarters;
- a place not intended for regular sleeping quarters; or
- temporary quarters in another person's residence for 90 days or less. After 90 days in the same person's residence, the household is no longer considered homeless.

Hotline (TANF/SNAP Complaints) — Toll-free number (1-800-252-9330) where staff receive complaints for Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP) cases.

Housing and Urban Development (HUD) — U.S. Department of Housing and Urban Development.

A B C D E F G H I K L M N O P Q R S T U V W

Identical Application — One or more exact copies of an application previously submitted by an applicant.

Illegally Present Alien — A non-citizen living in the U.S. without proper approval from the U.S. Citizenship and Immigration Services (USCIS) and who has received a final order of deportation.

Immigrant — An alien who abandons residence in a foreign country to live in the U.S. as a permanent resident, for example a lawful permanent resident (LPR).

Inaccessible Resources — Resources not legally available to the individual.

Independent Child — A child who does not live with a parent and who is:

- able to apply for Medicaid on the child's own behalf; or
- eligible for Medicaid because a responsible person who is not within the degree of relationship required for Temporary Assistance for Needy Families (TANF) applies on the child's behalf.

Independent Living Payments — Payments from Title IV-E funds that are distributed by Child Protective Services to certain individuals when they leave foster care. Payments:

- are received for a minimum of three months,
- cannot exceed $300 a month,
- cannot total more than $800, and
- are intended for expenses other than room and board.

Indian Tribal Household — A household in which at least one household member is recognized as a tribal member by any Indian tribe.

Indigent Alien — An indigent alien is a sponsored alien whose total income in the month of application does not exceed 130 percent of the poverty income guidelines for the alien's household size. The following factors are considered in determining the alien's total income:

- the alien's own income,
- cash contributions of the sponsor or others, and
- the value of in-kind assistance provided by the sponsor or others.

Individual Development Accounts (IDAs) — An account similar to a savings account that enables an individual to save earned income for a qualifying purpose. IDAs are generally matched dollar-for-dollar with funds from private citizens, corporations, banks, communities, or charitable organizations. The matching funds are inaccessible to the individual if the funds are paid directly to a bank or loan institution, an individual selling a home, or a business account.

Individual Number — A unique nine-digit number that identifies any person known to the Texas Integrated Eligibility Redesign System (TIERS).

Individual Retirement Account (IRA) — An account in which an individual contributes an amount of money to supplement retirement income, regardless of the individual’s participation in a group retirement plan.

Individual Retirement Account (IRA) Deduction — A federal income tax deduction for individuals who contributed to a traditional IRA.

Individually Identifiable Health Information — Information that either identifies or could be used to identify an individual and that relates to the:

- past, present or future physical or mental health or condition of the individual;
- provision of health care to the individual; or
- past, present or future payment for the provision of health care to the individual.

Ineligible Alien — A non-citizen whose alien status makes the individual ineligible for program benefits.

Initial Benefits — Benefits issued for the first month of eligibility. Also benefits issued for the first month of eligibility after a break in eligibility of at least one month.

In-Kind Contribution — Any gain or benefit to a person that is not in the form of money payable directly to the individual such as clothing, public housing, or food.

Inquiry — Refers to the functional area that allows users to view case, Eligibility Determination Group (EDG), and individual information.

Institution of Higher Education — Any college (public or private), community college, junior college, technical institute, or university that usually requires a high school diploma or equivalency certificate such as general equivalency diploma (GED) to enter.

Integrated Voice Response (IVR) — A dial-in inquiry system that provides access to automated account information via a digital telephone. This is a toll-free number (2-1-1 or 1-877-541-7905) that individuals may call and inquire about their case, next appointment time, or whether the Texas Health and Human Services Commission (HHSC) received information. The client’s case number or the case name’s Social Security number (SSN) is used to access information. (Also known as the Automated Voice Response [AVR] system.)

Intentional Program Violation (IPV) — The act of intentionally making a false or misleading statement, or misrepresenting, concealing or withholding facts for the purpose of receiving assistance under the Supplemental Nutrition Assistance Program (SNAP), Temporary

Assistance for Needy Families (TANF) or Medicaid program. Also, the act of trafficking in SNAP benefits. A household member may be charged with an IPV even if the individual has not actually received benefits to which the individual is not entitled.

Interfaces — The functional area that exchanges information with other systems and agencies.

Interview Mode — A designation in Data Collection that queues the driver flow through appropriate pages for a type of action.

A B C D E F G H I K L M N O P Q R S T U V W

Judicial Review — A review of the fair hearing decision by a district court in Travis County to determine whether the agency decision is correct. A petition for judicial review must be filed by the appellant in a district court in Travis County within 30 calendar days after the date the administrative decision is issued.

Jury Duty Pay — Taxable income received as compensation for jury duty.

A B C D E F G H I K L M N O P Q R S T U V W

Keogh — An individual retirement account (IRA) for a self-employed individual.

A B C D E F G H I K L M N O P Q R S T U V W

Left Navigation — The list of functional areas that appears on the left side of the Texas Integrated Eligibility Redesign System (TIERS) page. A user can click the plus sign next to a functional area or sub-functional area to display the names of pages available within that area.

Legal Parents — Mother, by having given birth to the child, by proof of adoption, legal document or court adjudication; father, by proof of adoption, legal document, court adjudication or his acknowledgement of paternity.

Legal Requirements — The non- financial eligibility requirements for a Temporary Assistance for Needy Families(TANF) or Medicaid child, such as age, relationship, domicile, citizenship, Social Security number (SSN), and deprivation.

Legally Obligated Child Support — Court order or a legally recorded document requiring the payments of child support to be made in the form of cash, medical support, or to a third party. The official document indicates to and for whom the support is paid, the frequency and the amount of payment.

Licensed Practitioner — A person who has met certain educational requirements and passed an examination to be licensed in the state of Texas and regulated by a state board.

Life Estate — Income an individual receives from ownership of property that an individual only possesses for the duration of one's life, such as rental income.

Liquid Resources — Resources that are readily negotiable, such as cash, checking or savings accounts, Electronic Benefit Transfer (EBT) cash account, savings certificates, stocks, or bonds.

Lock-in — A status created by the Texas Health and Human Services Commission (HHSC) for certain individuals to help contain Medicaid costs, which allows additional review of high Medicaid users. Those who see several doctors each month and make questionable visits to hospital emergency rooms are limited to seeing one doctor or using one pharmacy for a minimum of six months. Individuals with illnesses that require expensive treatment are not subject to lock-in status.

Logical Unit of Work (LUW) — A set of Texas Integrated Eligibility Redesign System (TIERS) pages that must be completed before information entered on these pages is saved. The LUW is represented by a set of tabs at the top of a TIERS page. To ensure that information has been saved in an LUW in Data Collection, the user can click on the Next button that advances the user to the next LUW or on the Previous button that returns the user to the previous LUW. On the Case Assignment page, the user has reached the end of the driver flow and must use the Left Navigation to return to pages in the case. Clicking the Add, Update or Submit button saves information on specific pages.

Lone Star Card — See Electronic Benefit Transfer (EBT) card.

Low Income Home Energy Assistance Act (LIHEAA) — The federal act that funds assistance for energy costs for low-income households.

Lump-Sum Payment — A financial settlement that often involves funds accumulated over an extended period and that is paid in a single payment.

A B C D E F G H I K L M N O P Q R S T U V W

Manage Office Resources (MOR) — The functional area that supports the administrative structure in the Texas Integrated Eligibility Redesign System (TIERS) and relationships between regional offices and their local offices, units, and employees.

Managed Care — A health care delivery system with the aim of controlling costs, which relies on a primary care physician who acts as a gatekeeper through whom the patient goes to obtain other health services such as specialty medical care, surgery, or physical therapy. Models of managed care include the health maintenance organization (HMO) and the primary care case management (PCCM) models.

Management — The manner in which a household pays its expenses with available income.

Managing Conservator — A person designated by a court to have daily legal responsibility for a child.

Manual Voucher Transaction — A paper-based debit transaction completed by the food retailer when the automated Electronic Benefit Transfer (EBT) system is down or unavailable. A transaction may also be pre-authorized via telephone.

Marketplace — The governmental entity that makes qualified health plans available to qualified individuals and/or qualified employers. The Marketplace in Texas is operated by the U.S. Department of Health and Human Services. The Marketplace is also known as the Exchange, Health Insurance Marketplace, and Federally Facilitated Marketplace (FFM).

Marriage — A legally or formally recognized union between two people. A same-sex marriage that occurred before June 26, 2015, is considered valid effective June 26, 2015. A same-sex marriage that occurred on or after June 26, 2015, is considered valid on the date it occurred.

Married Minor — An individual, age 14-17, who is married. These individuals must have parental consent or court permission. An individual under age 18 may not be a party to an informal (common law) marriage.

Meal delivery services — A non-profit establishment approved by Food and Nutrition Services (FNS) that prepares and delivers meals to elderly persons or persons who are housebound, have a physical handicap, or otherwise have a disability that prevents the person from adequately preparing all their meals.

Medicaid — A state and federal cooperative program authorized under Title XIX of the Social Security Act (United States Code [U.S.C.], Title 42, §1396 et seq.) and Texas Human Resources Code, Title 2, Subtitle C, Chapter 32, that pays for certain medical and health care costs for people who qualify. Medicaid is also known as the medical assistance program.

Medicaid Card – An identification card issued to individuals determined eligible for Medicaid that verifies Medicaid coverage.

Medicaid Report – (Form H1146) — A form completed by a transitional Medicaid household in the fourth, seventh and tenth months of medical coverage to report earnings and household composition changes.

Medical Programs — Medicaid for:

- Children Under 1 (TP 43)
- Children 1-5 (TP 48)
- Children 6-18 (TP 44)
- Newborn Children (TP 45)
- Pregnant Women (TP 40)
- Parents and Caretaker Relatives (TP 08)
- Medically Needy with Spend Down (TP 56)
- Children Under 1 – Emergency (TP 35)
- Children 1-5 – Emergency (TP 33)
- Children 6-18 – Emergency (TP 34)
- Pregnant Women – Emergency (TP 36)
- Parents and Caretaker Relatives – Emergency (TA 31)
- Medically Needy with Spend Down – Emergency (TP 32)

Medical Support — Health insurance that absent parents will be ordered to obtain for their children who receive Medicaid when it is available at reasonable cost. Available at reasonable cost is usually defined as being available through the employer.

Migrant Farmworker in the Workstream — Farmworkers who travel to work in agriculture or a related industry and who are presently employed away from their permanent residence or home base.

Migrant Farmworker Not in the Workstream — Farmworkers who travel to work in agriculture or a related industry during part of the year, but who are presently residing at their permanent residence or home base.

Military Member — An individual in the U.S. Armed Forces/Reserves (Army, Marine Corps, Navy, Air Force or Coast Guard), National Guard (Army, Marine Corps, Navy, Air Force, Coast Guard or Reserve Guard) or the State Military Forces/Texas State Guard.

Minor Child — A person under age 18.

Minor Parent — A person under age 18 who has a dependent.

Modified Adjusted Gross Income (MAGI) — The rules used to determine financial eligibility for certain Medical Programs that are based on Internal Revenue Service (IRS) tax rules.

Modified Adjusted Gross Income (MAGI) Financial Eligibility — The result of a comparison between an applicant's or recipient's MAGI household income to the applicable Medicaid or Children's Health Insurance Program (CHIP) income limit based on the Federal Poverty Income Limit (FPIL) and the MAGI household size.

Modified Adjusted Gross Income (MAGI) Household Composition — The individuals whose income and needs are considered when determining eligibility for an applicant or recipient for certain Medical Programs based on tax status, tax relationships, living arrangement, and family relationships.

Modified Adjusted Gross Income (MAGI) Household Income — The sum of every individual's MAGI individual income within an applicant's or recipient's MAGI household composition, from which is subtracted the standard MAGI disregard.

Modified Adjusted Gross Income (MAGI) Household Size — The number of individuals in an applicant's or recipient's MAGI household composition, including the number of unborn children, if applicable.

Modified Adjusted Gross Income (MAGI) Individual Income — The sum of certain income received by an individual in a MAGI household composition, from which certain expenses are subtracted.

Molar Pregnancy — Also known as hydatidiform mole, a molar pregnancy is considered to be a degenerating pregnancy. Conception occurs, but no fetus ever develops. A molar pregnancy is considered a normal pregnancy that terminates early because of miscarriage or abortion.

Monthly Obligation — The amount of child support which the absent parent has been ordered to pay each month.

Moving Expenses — Federal income tax deductible expenses an individual may claim for relocating for a job or business.

A B C D E F G H I K L M N O P Q R S T U V W

Newborn Child — A child receiving Type Program (TP) 45, Medical Assistance for Newborn Children, because the child's mother was eligible for and received Medicaid coverage at time of the child's birth or whose mother was eligible for and received Medicaid coverage retroactively for the time of the child's birth. The newborn Medicaid coverage can continue through the month of the child's first birthday as long as the child continues to reside in Texas.

Non-Continuous Eligibility — A period of time during which changes in circumstances may affect an individual's eligibility.

Nonconvertible Bond — A bond that cannot be converted to cash according to program policy. Nonconvertible bonds are exempt resources.

Non-Employment and Training (E&T) Counties — Those Texas counties in which the Texas Workforce Commission (TWC) determines it does not have sufficient offices to assist individuals who are mandatory work registrants. Supplemental Nutrition Assistance Program (SNAP) applicants and individuals in these counties are still subject to E&T work registration requirements with TWC, but are exempt from E&T participation and are not subject to SNAP federal time limits.

Non-Immigrant — An alien temporarily admitted to the U.S. for a purpose other than permanent residency, such as a religious worker or the fiancé/fiancée of a U.S. citizen.

Nonliquid Resources — Resources such as vehicles, buildings, land, or certain other property that are considered countable, except as explained in the vehicles portion of resource policy or unless the resource is specifically exempted.

Non-Public Assistance (NPA) Household — Supplemental Nutrition Assistance Program (SNAP) households in which no one receives Temporary Assistance for Needy Families (TANF) or only some of the members receive TANF.

Non-Secure Facility — A publicly operated community residence that serves no more than 16 residents, such as a county emergency shelter or non-public group or foster home.

Non-Traditional Retailer — A food retailer who operates in a farmer's market or as a roadside vendor.

Normal Living Expense — Items necessary for a Supplemental Nutrition Assistance Program (SNAP) household to carry on its normal daily activities. These items include housing, utilities, deposits for housing or utilities, food, clothing, and incidentals. Incidentals include such things as normal day-to-day transportation, telephone, laundry, medical supplies not paid by Medicaid, home remedies, recreation, and household equipment.

Notice of Adverse Action — A notice provided to the household on TF 0002 explaining the proposed adverse action, reason for the action, right to a fair hearing, availability of continued benefits, etc.

Office of Inspector General (OIG) — A division of the Texas Health and Human Services Commission (HHSC) created by the 78th Texas Legislature, Regular Session, 2003, to prevent and reduce waste, abuse, and fraud within the Texas Health and Human Services system.

Off-Line Transaction — The processing of Electronic Benefit Transfer (EBT) transactions using a manual voucher.

One-Time Integration Payment — Financial assistance provided to relative caregivers of children in the conservatorship of the Texas Department of Family Protective Services (DFPS). The purpose of the one-time payment of not more than $1,000 for a sibling group is to defray costs incurred by the caregiver for essential child care items at the time of placement, such as the costs for beds, bedding, clothing and other necessities. The payment is provided once to each sibling group. No additional payments are made if the group moves to the home of another relative.

Ongoing Benefits — Benefits issued for months after the initial benefit month.

Opportunity to Participate — Providing a certified applicant with benefits, a Lone Star Card, personal identification number (PIN), and Electronic Benefit Transfer (EBT) training material.

Other-Related Temporary Assistance for Needy Families/Medical Program (TANF/MP) Child — An eligible child living with a relative other than the child's legal parent.

Overpayment — The amount of benefits issued in excess of what should have been issued.

Override — A Texas Integrated Eligibility Redesign System (TIERS) procedure that allows the user to make a change to the system-determined Eligibility Determination Group (EDG) results. This procedure can be used when policy has changed and TIERS has not yet been updated to process the policy change correctly. Overrides always require Second Level Review before they can be disposed.

A B C D E F G H I K L M N O P Q R S T U V W

Parent — An individual with either a natural, biological, adopted, or stepchild.

Parental Control — A minor living with an adult is under parental control if one of the following conditions applies:

- the adult provides more than half of the minor's total support (housing is not included as support);
- the adult states that the adult has parental control of the minor; or
- the minor lives with an adult other than the minor's parent or legal guardian and the minor's parent or legal guardian states that the adult has parental control of the child.

  Texas Department of Family and Protective Services (DFPS) foster care parents have parental control of the foster child even if the foster child's parent moves into the home. The name of the foster parent is displayed as Alternate Payee on the foster care Eligibility Determination Group (EDG) summary page in the Texas Integrated Eligibility Redesign System (TIERS).

Parole — The discretionary and conditional release of an eligible offender sentenced to serve the remainder of the sentence under supervision in the community rather than prison.

Participation Status — The designation of an Eligibility Determination Group (EDG) member as an eligible or ineligible member of the certified group. The participation status indicates whether the individual is considered an adult or a child according to policy.

Passive Renewal — A process by which the Texas Integrated Eligibility Redesign System (TIERS) automatically recertifies a Former Foster Care in Higher Education (FFCHE) active Eligibility Determination Group (EDG) for another certification period. This process occurs through a mass update and does not require advisor action.

Payee — A person to whom the Temporary Assistance for Needy Families (TANF) benefits are issued if no one in the household qualifies or wants to be a caretaker. The payee must be within the required degree of relationship.

Payments to Civilians Relocated During Wartime — Payments made to Aleuts or individuals of Japanese ancestry (or their heirs) who were relocated during World War II.

Penalty on Early Withdrawal — A federal income tax deduction for individuals who withdrew money from a time-deposit savings account prior to the certificate maturing and who were charged a penalty for early withdrawal.

Pending — Awaiting conclusion.

Pending Correspondence — Forms or notices that have been generated on a case and are waiting to be processed in batch. All system-generated correspondence is sent to pending correspondence, but it can be retrieved and printed locally. Once correspondence is printed, whether in batch or locally, the record of the printing is stored in History Correspondence. See Print Mode.

Periodic Income Check (PIC) — The process to determine whether electronic data indicates that there has been a change in the Modified Adjusted Gross Income (MAGI) household income that could make the client ineligible for certain Medical Programs. Changes in income

identified through this process may impact eligibility for other programs.

Permissible Purpose — A federal requirement that allows staff to legally request a credit report from the Data Broker system only for the purpose of eligibility determination. Permissible purpose means the individual whose credit report is requested must be:

- an applicant or a certified Temporary Assistance for Needy Families (TANF);
- Supplemental Nutrition Assistance Program (SNAP), or Medical Program household member (or a member who would be certified but is disqualified); or
- a Medical Program Modified Adjusted Gross Income (MAGI) household member.

Staff who request credit information without permissible purpose are subject to fines and/or imprisonment in addition to disciplinary action from the Texas Health and Human Services Commission (HHSC).

Personal Account Number (PAN) — The 19-digit number on the front of the Lone Star Card representing the individual's Electronic Benefit Transfer (EBT) account number on the EBT database. The PAN is not related to the individual's Texas Health and Human Services Commission (HHSC) case number.

Personal Identification Number (PIN) — A four-digit numeric code assigned to each cardholder and used to control access to the individual's account. The PIN must be entered on a key pad before any electronic transaction can be processed.

Personal Identification Number (PIN) Security — Actions cardholders should take to prevent others from gaining access to their PIN and Electronic Benefit Transfer (EBT) account. Instructions include not writing their PIN on the card sleeve or anything they carry in their purse or wallet, not revealing their PIN to anyone, or letting anyone use their card.

Personal Possessions — Possessions that include furniture, appliances, jewelry, clothing, livestock, farm equipment, and other items that an applicant uses to meet personal needs essential for daily living.

Personal Representative — An individual who can represent another individual's rights with respect to individually identifiable health information. Only an individual's personal representative may authorize the use or disclosure of individually identifiable health information or obtain individually identifiable health information on behalf of an individual.

Personal Responsibility Agreement (PRA) — A requirement for Temporary Assistance for Needy Families (TANF) that certain individuals must be in compliance with the conditions of the agreement. Noncompliance with the PRA results in a sanction.

Point-of-Sale (POS) Transaction — An electronic transaction using an Electronic Benefit Transfer (EBT) card to make a purchase, a cash withdrawal, or inquiry.

Power of Attorney (POA) — Written legal authorization to represent or act on another's behalf in private affairs, business, or some other legal matters.

Practitioner — An individual who holds a license to practice medicine, including a physician (M.D.), osteopathic medical physician (D.O.), dentist (D.D.S.), advanced nurse practitioner (A.N.P.) or registered nurse (R.N.).

Note: A licensed vocational nurse or licensed practical nurse does not meet the definition of practitioner.

Prepaid Burial Insurance — Insurance that pays for a specific funeral arrangement. Also known as a pre-need plan or prepaid funeral agreement.

Preschool Children — Children who are under age six.

Presumptive Eligibility (PE) — Short-term Medicaid coverage provided to individuals determined potentially eligible for regular Medicaid by a qualified hospital or a qualified entity. This coverage is provided while the Texas Health and Human Services Commission (HHSC) determines eligibility for regular Medicaid.

Primary Cardholder (PCH) — The person designated to receive and be responsible for the household's Lone Star Card. A household may designate a secondary cardholder who has a Lone Star Card and access to the household's Electronic Benefit Transfer (EBT) account. The primary cardholder is usually the Eligibility Determination Group (EDG) name, but the EDG may have an alternate payee who is the primary cardholder.

Print Mode — Indicates where historical correspondence was printed. Batch and Online are the types of print modes. Batch is correspondence managed by batch processing and printed at a central mail facility. All system-generated correspondence is scheduled for batch printing although it can be retrieved from Pending Correspondence and printed locally.

Print Type — Classification of historical correspondence as the original record or a reprint of the original. Each original correspondence is given a unique Correspondence ID (identifying number). Each reprint of an original has the same Correspondence ID as the original.

Priority Supplemental Nutrition Assistance Program (SNAP) Issuances — Expedited SNAP benefits, benefits issued on or after the 25th day from the date of application, and issuances ordered by a hearing officer decision that must be made available in order to meet fair hearing timeliness requirements. These issuances are available to the individual the same day the Eligibility Determination Group (EDG) is disposed.

Processing Time Frames — Number of days eligibility staff has to complete a particular action.

Proration — Portion of total monthly benefits a household is entitled to receive.

- Temporary Assistance for Needy Families (TANF) proration is based on the number of days between the begin date of eligibility and the end of the first month of eligibility.
- Supplemental Nutrition Assistance Program (SNAP) proration is based on the number of days between the file date and the end of the month.

Prospective Budgeting —Determination of eligibility for and the amount and type of benefits using the best estimate of the household's current and future circumstances and income.

Protective Payee — Person selected to receive and manage the Temporary Assistance for Needy Families (TANF) benefit when the caretaker is not using the TANF payments for the children's benefit. See alternate payee.

Prudent Person Principle — Reasonable decision made by staff based on the best information available and common sense in a particular situation.

Public Assistance (PA) Household — A Supplemental Nutrition Assistance Program (SNAP) Eligibility Determination Group (EDG) in which:

- all eligible members receive Temporary Assistance for Needy Families (TANF) or Refugee Cash Assistance (RCA); or
- some eligible members receive TANF or RCA, and all other eligible members receive Supplemental Security Income (SSI), including SSI essential persons.

Public Institution — A facility that is either an organizational part of a governmental entity or over which a governmental unit exercises final administrative control. Examples of public institutions include county and city jails and Texas Department of Corrections prisons. Inmates of facilities that meet the definition of public institution are not eligible for Temporary Assistance for Needy Families (TANF) or Medicaid.

Note: See Publicly Operated Community Residence for additional information about a public facility not considered to be a public institution.

Publicly Operated Community Residence — A facility designed to serve no more than 16 residents and to provide some services beyond food and shelter, such as social services, training in socialization, and life skills. An example of a publicly operated community residence that is not a public institution is a county homeless shelter with a capacity of no more than 16 people. Residents of a publicly operated community residence are potentially eligible for Temporary Assistance for Needy Families (TANF) and Medicaid. They are not considered inmates of a public institution.

Even if designed to serve no more than 16 residents, the following facilities are not considered publicly operated community residences:

- a facility located on the grounds of or immediately adjacent to any large institution or multi-structure complex;
- an educational or vocational training institution; and
- a correctional or holding facility for individuals who:
  - are prisoners;
  - have been arrested or detained pending disposition of charges; or
  - are held under court order as material witnesses or juveniles.

A B C D E F G H I K L M N O P Q R S T U V W

Qualified Entity (QE) — A Medicaid provider (in most instances, but can also be an organization such as a school or clinic) that notifies the Texas Health and Human Services Commission (HHSC) of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations for pregnant women only, per HHSC policies and procedures. Qualified entities that are also Breast and Cervical Cancer Services (BCCS) contractors with the Texas Department of State Health Services (DSHS) may make presumptive eligibility determinations for Medicaid for Breast and Cervical Cancer (MBCC) applicants.

Qualified Health Plan (QHP) — A private insurance plan that is certified by the Marketplace, provides essential health benefits, follows established limits on cost-sharing (such as deductibles, copayments, and out-of-pocket maximum amounts), and meets certain other requirements.

Qualified Health Professional — A person who provides care under the supervision of a licensed practitioner or a medical or dental practice that is state regulated.

Qualified Hospital (QH) — A Medicaid provider that notifies the Texas Health and Human Services Commission (HHSC) of its intent to make presumptive eligibility determinations and agrees to make PE determinations per HHSC policies and procedures. The qualified hospital may choose to make PE determinations for pregnant women, children under age 19, parents and caretaker relatives of dependent children under age 19, and former foster care children.

Quality Control — The functional area that supports the state's approach to quality control and allows authorized staff to enter sample selection criteria. Based on the criteria, the Texas Integrated Eligibility Redesign System (TIERS) generates a sample list.

Questionable Information — Information that is contradictory or incomplete.

A B C D E F G H I K L M N O P Q R S T U V W

Radiation Exposure Payments — A program to compensate individuals for injury or death resulting from the exposure to radiation from nuclear testing and uranium mining. When the affected individual is deceased, payments are made to the surviving spouse, children, parents, grandchildren or grandparents.

Range of Payment — The highest to the lowest representative pay amounts used to determine the current ongoing budget.

Reactivation Date — The effective date on which benefits for an Eligibility Determination Group (EDG) should be reinstated. This date is entered for various situations including denied in error, continued benefits for a denied EDG, reinstating Transitional Medicaid Assistance (TMA), and reactivating an EDG without requiring a new application form.

Real Property — Land and any improvements on it.

Reapplication —

- Timely – Supplemental Nutrition Assistance Program (SNAP) application filed by the 15th of the last month of certification. This is also called a timely recertification or redetermination.
- Untimely – SNAP application filed after the 15th of the last certification month. An untimely reapplication is treated the same as an initial application.

Note: Verification requirements are the same for both timely and untimely applications.

Reapplication Date — Date a new application for redetermination or complete review of eligibility is received by the Texas Health and Human Services Commission (HHSC).

Reasonable Compatibility — The method of verification used for Medical Programs that compares a client's statement of income against income provided by electronic data sources.

Reasonable Opportunity — The 95-day period following the date on which a notice is sent to an individual to provide a source of citizenship or alien status verification for certain Medical Programs.

Rebuild EDG (Eligibility Determination Group) — A button in the Wrap Up management group used to apply cascade logic by reforming EDGs until eligibility or ineligibility is established. See EDBC and run EDBC.

Reception Log — The functional area in the Texas Integrated Eligibility Redesign System (TIERS) where office contacts by telephone, mail, fax and in-person can be recorded.

Recognizable Needs — The maximum needs amount allowed by the Texas Health and Human Services Commission (HHSC) when determining eligibility.

Recoupment — Withholding part of an individual's current benefit because of a previous overpayment.

Redetermination — A complete action to determine eligibility for a new certification period in a program.

Reimbursement — Repayment for a specific item or service.

Reinstatement — Process of providing Transitional Medical Assistance (TMA) to a household that was denied because of failure to return a complete Medicaid Report.

Report Date — The date on which information is reported to the Texas Health and Human Services Commission (HHSC). Eligibility Determination Benefit Calculation (EDBC) uses the discovery and report dates to determine whether a required report of change is reported timely.

Reports — The functional area that collects information from throughout the Texas Integrated Eligibility Redesign System (TIERS) and produces reports that meet Texas Health and Human Services Commission (HHSC), state and federal reporting requirements.

Representative Payee — In Temporary Assistance for Needy Families (TANF), a person designated to receive and manage the household's benefits for an individual who is incapacitated or incompetent. See alternate payee.

Resident Seasonal Farmworkers — Farmworkers who do not leave their permanent residence to work in agriculture or a related industry.

Resources — Both liquid and nonliquid assets an individual can convert to meet immediate needs.

Restored Benefits — Full or partial months of benefits for a past month that are owed to a household due to an agency error.

Retroactive Benefits — Initial benefits issued for a month before the application is certified.

Review — Temporary Assistance for Needy Families (TANF) evaluative interview that must take place before the individual receives a seventh warrant.

Royalty — A payment to an individual for permitting another to use or market property (such as mineral rights, patents, or copyrights).

RSDI — Retirement, Survivors and Disability Insurance benefits (RSDI) paid by the Social Security Administration.

Run EDBC (Eligibility Determination Benefit Calculation) — A process in the Wrap Up eligibility management group used to determine eligibility of the Eligibility Determination Group (EDG). See EDBC.

A B C D E F G H I K L M N O P Q R S T U V W

Sanction — Either a disqualification or a penalty applied to a case program because an individual failed to comply with a program requirement.

Scheduling — The functional area that manages eligibility staff's appointments. See Batch Scheduling.

Second Chance Home — An adult-supervised living arrangement that provides independent living services to teen mothers and their children. Independent living services may include, but are not limited to, case management, counseling, mentoring, parenting skills, child development, child care services, school-to-work transition services and family reunification services.

Second Level Review — Review of a case by a second party before the Eligibility Determination Group (EDG) is disposed. The second party selects the Second Level Review interview mode.

Second Parent — The parent who is not the caretaker, when a child lives with both legal parents and both parents are requesting and are eligible for coverage.

Secondary Cardholder — A person designated by the individual (primary cardholder) as eligible to access the individual's Electronic Benefit Transfer (EBT) account with a second EBT card and personal identification number (PIN).

Secure Facility — Secure boot camp settings, such as a county holding facility for juveniles or a facility over which a government unit exercises final administrative authority.

Self-Employed Health Insurance — A federal income tax deduction for self-employed individuals paying for health insurance for themselves, their spouse, their tax dependents, or their child under age 27.

Self-Employed Individual Retirement Account (IRA), Simple IRA, and Qualified Plan Deductions — A federal income tax deduction for self-employed individuals or for partners in a business.

Self-Employment Income — Earned or unearned income available from one's own business, trade or profession rather than from an employer.

Self-Service Portal (SSP) — A web-based application, at www.YourTexasBenefits.com, available to applicants and Community Partners assisting applicants to:

- perform initial self-screening to check for potential eligibility;
- apply for benefits online;
- check application status;
- check benefit/appointment status;
- upload supporting documents;
- make case changes;
- submit redeterminations; and
- view general benefit program information.

Also referred to as YourTexasBenefits.com.

Sibling — Brother or sister, including legally adopted and half-brothers and half-sisters.

Special Review — A procedure to explore one or more areas of eligibility, such as management, medical, etc., at a specified time other than at application or complete action. A special review is conducted in Special Review mode. See Interview Mode and Case Mode.

Spend Down — The amount of excess income that the applicant must deplete with incurred medical bills before the individual can be certified as medically needy.

Spouse — A person who:

- is married; or
- lives with another person and they represent themselves to the community as married.

Standard MAGI Income Disregard — An income disregard equal to five percentage points of the Federal Poverty Income Limit (FPIL) for the applicable Modified Adjusted Gross Income (MAGI) household size.

Standard Medical Expense — A $137 deduction applied to a Supplemental Nutrition Assistance Program (SNAP) budget and given to an elderly household member and/or a household member with a disability who incurs medical expenses of more than $35 but less than or equal to $137.

Standard of Need — Basic needs of Temporary Assistance for Needy Families (TANF) families represented by a figure predetermined by the state of Texas according to the number of certified persons in the group. This figure represents food, clothing, housing, utilities, and incidentals. Incidentals include such things as normal day-to-day transportation, telephone, laundry, medical supplies not paid by Medicaid, home remedies, recreation and household equipment.

Standard Utility Allowance (SUA) — A standard deduction for the cost of utilities given to a household that either incurs a heating or cooling cost separate from the rent, or receives or anticipates receiving assistance under the Low Income Home Energy Assistance Act (LIHEAA) in any of the next 12 months. For households that receive the SUA based on LIHEAA assistance, allow the SUA even if the household does not have an out-of-pocket expense.

Standby List — Applicants who are awaiting an interview without a specific appointment. See Carryover Standby List.

State Data Exchange (SDX) — Computer tape from the Social Security Administration that provides Supplemental Security Income (SSI) and Medicaid information on Texas Health and Human Services Commission (HHSC) individuals. Social Security information is also available on individuals who receive SSI and/or Medicaid. SDX information can be used as a source of verification and is available to advisors in the Texas Integrated Eligibility Redesign System (TIERS).

Step Grandparent — The spouse of a blood-related grandparent.

Streamlined Reporting (SR) —Households in which all adults are exempt from the 18-50 work requirements due to disability, having a child under age 18 (or is a member of a Supplemental Nutrition Assistance Program [SNAP] Eligibility Determination Group [EDG] where a household member is under age 18), or being pregnant meet the SR criteria. These households receive a six-month certification period.

Subsistence — Life supporting; survival.

Sufficient Employment — Earnings from a job, other than seasonal work such as migrant or seasonal farm work, that would result in Temporary Assistance for Needy Families (TANF) ineligibility without including the 90 percent earned income disregard.

Summary Page — A page that lists a summary of all records available for that Texas Integrated Eligibility Redesign System (TIERS) page. See Detail Page.

Supplemental Benefit — Additional benefits for a current month provided to a household during a month that the Texas Health and Human Services Commission (HHSC) already issued initial or ongoing benefits.

Supplemental Nutrition Assistance Program (SNAP) — Program previously called the Food Stamp Program.

Supplemental Nutrition Assistance Program Combined Application Project (SNAP-CAP) — A demonstration project that outreaches elderly Supplemental Security Income (SSI) recipients who are not currently certified for SNAP.

Supplemental Nutrition Assistance Program – Supplemental Security Income (SNAP-SSI) Caseload — The Centralized Benefit Services (CBS) unit administers the SNAP-SSI caseload. Households are automatically converted to the SNAP-SSI caseload following an initial certification by a local eligibility office if all household members receive SSI and there is no earned income in the case. There is no age requirement, and households are certified for three years.

Supplemental Security Income (SSI) — A needs-tested program administered by the Social Security Administration providing monthly income to aged individuals and individuals who are blind or have a disability.

Suspended Benefits — The Eligibility Determination Group (EDG) is flagged to prevent the ongoing issuance of benefits until eligibility staff review the EDG.

System-Generated — Created by a computer system programmed with given parameters. For example, a notice is system-generated when an Eligibility Determination Group (EDG) is disposed. The notice contains programmed information based on the program, type of assistance, and eligibility result. See user-generated.

A B C D E F G H I K L M N O P Q R S T U V W

TALX — A verification of employment and income database created by the TALX Corporation, also known as The Work Number system.

Tax Dependent — An individual who expects to be claimed by someone else as a dependent on a federal income tax return for the taxable year in which Medicaid or Children's Health Insurance Program (CHIP) eligibility is requested.

Taxable Year — The 12-month period that an individual uses to report income for federal income tax purposes. For most individuals, their tax year is the calendar year. A calendar tax year is 12 consecutive months beginning January 1 and ending December 31.

Taxpayer — An individual or a married couple who expects:

- to file a federal income tax return for the taxable year in which Medical Program eligibility is requested;
- if married, to file a joint federal income tax return for the taxable year in which Medical Program eligibility is requested;
- that no other taxpayer will be able to claim the individual or the couple as a tax dependent on a federal income tax return for the taxable year in which Medical Program eligibility is requested; or
- to claim a personal exemption deduction on the taxpayer's federal income tax return for one or more applicants. This may or may not include the individual or the individual's spouse.

Temporary Assistance for Needy Families (TANF) – Basic — Cash assistance for families that include a dependent child and no more than one eligible adult. The Eligibility Determination Group (EDG) name must be within the required degree of relationship to the dependent child.

Temporary Assistance for Needy Families (TANF) Certified Child — A child who is included in a TANF grant.

Temporary Assistance for Needy Families – Non-Cash (TANF-NC) — Consists of services for family planning; adult education; the prevention and treatment of substance abuse; employment services; domestic violence; and Women, Infants, and Children (WIC) nutrition.

Temporary Assistance for Needy Families (TANF) Redirect — A Texas Works message to TANF applicants delivered up front by Texas Health and Human Services Commission (HHSC) staff before the application process begins, explaining that:

- TANF is temporary and has time limits;
- there are other alternatives and options for the applicant instead of TANF benefits;
- an applicant should consider jobs and other resources (such as child support) before pursuing TANF;
- if an applicant chooses to apply for assistance, the individual is requesting help finding a job; and
- even if an applicant chooses not to apply for TANF, the individual can still apply for Medical Programs and the Supplemental Nutrition Assistance Program (SNAP) to support employment while working toward self-sufficiency.

Temporary Assistance for Needy Families – State Program (TANF-SP) — Cash assistance for families with a dependent child and at least two adults. Adults on the Eligibility Determination Group (EDG) must be legal parents (including a certified stepparent) to the dependent child. This includes legal parents/stepparents who are disqualified for one of the reasons listed in A-222, Who Is Not Included, No. 4, Disqualified Members, unless that disqualification is due to not meeting citizenship requirements.

Ten-Ten-Thirteen Concept — Time periods used to determine the first month of an overissuance claim. The individual has 10 days to report the change; the advisor has 10 days to act on the change; and the notice of adverse action expires in 13 days.

Texas Health Steps (THSteps) — A health-care program of prevention, diagnosis, and treatment for Medicaid individuals.

Texas Integrated Eligibility Redesign System (TIERS) — A computer system that:

- stores individual and case information;
- processes eligibility determinations for multiple programs based on data provided through direct input and interfaces with other systems;
- generates benefit issuance;
- assists users in monitoring and managing workload; and
- creates correspondence and reports based on system- and user-requested criteria.

Texas Workforce Commission (TWC) — The state governmental agency charged with overseeing and providing workforce development services to employers and job seekers of Texas. TWC is part of a local/state network dedicated to developing the workforce of Texas. The network is comprised of the statewide efforts of TWC along with planning and service provision by 28 local workforce boards on a regional level.

The Workforce Information System of Texas (TWIST) — The computer system used by the Texas Workforce Commission (TWC) for intake, eligibility determination, assessment, service tracking, and reporting of TWC-administered programs, such as child care, Supplemental Nutrition Assistance Program (SNAP), Employment and Training, Choices, and the Workforce Innovation and Opportunity Act.

Third Party — Person or organization outside the certified household.

Third-Party Resource — A source of payment of medical expenses other than the recipient or the Texas Health and Human Services Commission (HHSC).

Three Months Prior — The three-month period before the Medicaid application month. Applicants who meet eligibility requirements during any of the months in this period receive Medicaid benefits for the eligible month(s).

Time Limit — The functional area where Temporary Assistance for Needy Families (TANF) state and federal time-limited months can be viewed. Authorized staff can correct months in this functional area.

Timely Disposed — An Eligibility Determination Group (EDG) that is disposed in accordance with program timeliness standards.

Tip Income — Income earned in addition to wages that is paid by patrons to people employed in service-related occupations (beauticians, waiters, valets, pizza delivery staff, etc.).

Trade Adjustment Assistance Act Program — A program for workers displaced by foreign workers.

Trafficking Supplemental Nutrition Assistance Program (SNAP) —

- The buying, selling, stealing, or otherwise effecting an exchange of SNAP benefits issued and accessed via Electronic Benefit Transfer (EBT) cards, card and personal identification numbers (PINs), or by manual voucher and signature, for cash or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone;
- Attempting to buy, sell, steal, or otherwise effect an exchange of SNAP benefits issued and accessed via EBT cards, card numbers and PINs, or by manual voucher and signature, for cash or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone;
- The exchange of firearms, ammunition, explosives, or controlled substances, as defined in Section 802 of Title 21, United States Code, for SNAP benefits;
- Purchasing a product with SNAP benefits that has a container requiring a return deposit with the intent of obtaining cash by discarding the product and returning the container for the deposit amount, intentionally discarding the product, and intentionally returning the container for the deposit amount;
- Purchasing a product with SNAP benefits with the intent of obtaining cash or consideration other than eligible food by reselling the product, and subsequently intentionally reselling the product purchased with SNAP benefits in exchange for cash or consideration other than eligible food; or
- Intentionally purchasing products originally purchased with SNAP benefits in exchange for cash or consideration other than eligible food.

Transitional Medical Assistance (TMA) — Medicaid coverage provided after denial of certain Eligibility Determination Groups (EDGs) because of new or increased earnings or new or increased spousal support income. EDGs denied because of new or increased earnings will receive a maximum of 12 months of coverage. EDGs denied because of new or increased spousal support income will receive a maximum of four months of coverage.

Trust — Property held by one person for the benefit of another.

Tuition or GI Bill Deduction — A federal income tax deduction for individuals who paid qualified tuition fees to eligible post-secondary educational institutions for themselves, their spouse, or their dependents.

Type of Assistance (TOA) — The specific aid for one or more individuals in an Eligibility Determination Group (EDG). For example, the Supplemental Nutrition Assistance Program (SNAP) has two types of assistance: PA (public assistance) and NPA (non-public assistance).

A B C D E F G H I K L M N O P Q R S T U V W

Underpayment — Issuance of fewer benefits than an individual is entitled to receive.

Undocumented Alien — An alien living in the U.S. without the knowledge and permission of the U.S. Citizenship and Immigration Services (USCIS).

Unearned Income — Payments received without performing work-related activities, including benefits from other programs.

Unreimbursed Assistance — Money paid in prior months in the form of public assistance under the Title IV-A program (that is, under the current Temporary Assistance for Needy Families [TANF] program or the former Aid to Families with Dependent Children [AFDC] program) that has not yet been recovered from collections that are applied to assigned arrears.

U.S. Citizenship and Immigration Services (USCIS) — The government agency that oversees lawful immigration to the U.S. In 2003, USCIS officially assumed responsibility for the immigration service functions of the federal government. The Homeland Security Act of 2002 dismantled the former Immigration and Naturalization Service (INS) and separated the former agency into three components within the Department of Homeland Security. The:

- USCIS provides immigrant services;
- Immigration and Customs Enforcement handles immigration enforcement; and
- Customs and Border Protection is responsible for border security functions.

User-Generated — Action generated directly by an individual's computer input. For example, a user can:

- request an alert and send it to another user;
- generate manual correspondence on a case; and

- generate a manual issuance of benefits outside the normal eligibility process.

User Guide — A Texas Integrated Eligibility Redesign System (TIERS) help tool accessed by clicking on the Help icon in the upper right corner of TIERS pages. The User Guide includes information about numerous TIERS topics.

A B C D E F G H I K L M N O P Q R S T U V W

Vendor Payment — Payment made directly to the individual's creditor or person providing the service by a person or organization outside the household.

Vested Interest — A situation or circumstance to which a person has a strong personal commitment.

Vested Retirement Account — An account to which an employee makes contributions for a specified period of time as defined by the employer. The employer does not match the money contributed by the employee until the defined period of time ends.

Voluntary Quit — Leaving a job without good cause.

A B C D E F G H I K L M N O P Q R S T U V W

Waiver Counties — Texas counties with an unemployment rate over 10 percent. Supplemental Nutrition Assistance Program (SNAP) applicants and individuals in these counties are not subject to SNAP federal time limits because of the job market. They are still required to be registered for work with the Texas Workforce Commission (TWC) and are mandatory participants if they do not meet work registration exemption requirements.

Waiver of Continued Benefits — An individual option to allow eligibility staff to process an adverse action during the individual's appeal process.

Welfare-to-Work — A federal program designed to support state and local efforts to move hard-to-employ Temporary Assistance for Needy Families (TANF) recipients into unsubsidized jobs and promote their self-sufficiency.

Workforce Innovation and Opportunity Act — A federal program to streamline state workforce development systems combining job training, adult education and literacy, and vocational rehabilitation. The Workforce Innovation and Opportunity Act replaced the Workforce Investment Act of 1998.

Wrap Up — The Texas Integrated Eligibility Redesign System (TIERS) program page in Data Collection where Eligibility Determination Groups (EDGs) are built and the Eligibility Determination Benefit Calculation (EDBC) is run to determine the highest level of eligibility or ineligibility. See Cascade Logic, Rebuild EDG, and Run EDBC.

TWH, Forms

ES = Spanish version available.

Number	Title	
AT-Report	Administrative Terminal Report	
G-845	Verification Request	
G-845 Supplement	Supplement Verification Request	
H0003	Agreement to Release Your Facts	ES
H0004	Consent for a Person Sponsoring an Immigrant	ES
H0025	HHSC Application for Voter Registration	ES
H0050	Parent Profile Questionnaire	
H0070	Food Stamps Streamlined Reporting (Income Calculation Worksheet)	
H0901	HHSC Enhanced Data Gathering Worksheet	
H0920	Notice from the Community Organization Helping You	
H0926-CP-AA	Sharing Facts About Me and My Case	ES
H0926-CP-CA	Sharing Facts About Me and My Case	ES

Number	Title	
H1000-A	Notice of Application	
H1001	Application for Benefit Assistance From the Voluntary Agency (VOLAG) Fax Coversheet - Applications ONLY (Form H1010)	
H1003	Appointment of an Authorized Representative	ES
H1004	Cover Letter: Authorized Representative Not Verified	ES
H1008	Authorization for Cancellation or Issuance of Public Assistance Warrants	
H1008-A	Warrant Inquiry/EBT Benefit Conversion and Affidavit for Non-receipt of Warrant	
H1009	TANF/Food Stamp Benefits Notice of Eligibility	
H1009-A	TANF/Food Stamp Notice of Eligibility - Client Rights/Responsibilities Information	
H1010	Texas Works Application for Assistance - Your Texas Benefits (English and Spanish)	ES
H1010-MR	MAGI Renewal Addendum	ES
H1010-R	Your Texas Works Benefits: Renewal Form	
H1011-A	Medical Renewal Form for Youth Transitioned from Foster Care or an Approved Unaccompanied Refugee Minor's Resettlement Program	ES
H1012	Immunization Record	
H1013	Electronic Correspondence Confirmation Letter	ES
H1014-A	Children's Health Care Benefits - Final Reminder	ES
H1015	Electronic Correspondence Failed Delivery	ES
H1016	Supplemental Security Income Referral	
H1017	Notice of Benefit Denial or Reduction	
H1017-A	Notice of Benefit Denial or Reduction - Client Rights/Responsibilities	
H1017-B	Transitional Medicaid	
H1017-P	Notice of Benefit Denial/Personal Responsibility Agreement (PRA) Reasons	ES
H1018	Overpayment Claim	
H1019	Report of Change	ES
H1019-F	Reporting Changes to Your Case	ES
H1020	Request for Information or Action	ES
H1020-A	Sources of Proof	
H1021	Payment Agreement - Verbal Authorization for One-Time Debit of an Active Lone Star Food Account	
H1022	Notice to Apply Benefits in a Dormant Lone Star Food Account to a Food Stamp Claim	
H1023	Installment Payment Agreement - Debit of a Lone Star Food Account	
H1024	Subject: Self-Declaration Notice	
H1026	Verification of Railroad Retirement Benefits	
H1026-FTI	Verification of Railroad Retirement Benefits - FTI	
H1027-A	Medicaid Eligibility Verification	
H1027-B	Medicaid Eligibility Verification - MQMB	
H1027-C	Medicaid Eligibility Verification - QMB	
H1027-F	Proof of Health Care Coverage	
H1028	Employment Verification	ES
H1029	Notice of Case Action	
H1030	Supplemental Nutrition Assistance Program (SNAP) Lone Star Card Assistance	ES

Number	Title	
H1036	Refugee Cash Assistance Verification Form	
H1038	Medical Facility Referral	
H1039	Medical Insurance Input	
H1040-A	Application Suspense File Card	
H1040-B	Review Suspense File Card	
H1040-C	Change Suspense File Card	
H1041	Worker Activity Log	
H1042	Modified Adjusted Gross Income (MAGI) Worksheet: Medicaid and CHIP	
H1044	Standby Log	
H1046	Inpatient Medical Services Certification	ES
H1049	Client's Statement of Self-Employment Income	ES
H1050	Check Verification	
H1057	Declaration of Informal Marriage	
H1059	Interview Observation Instrument	
H1060	Case Preparation Guide	
H1061	Birth Outcome Letter	ES
H1062	Birth Outcome Reminder Letter	ES
H1063	Request for Review Outcome Letter	ES
H1064	CHIP Continued Enrollment Letter	ES
H1065	Tuition and Fee Exemption Letter	
H1071	Family Violence Exemption for Medicaid and CHIP	ES
H1072	One Time Temporary Assistance for Needy Families (OTTANF) Acknowledgement	
H1073	Personal Responsibility Agreement	ES
H1074	SNAP Force Change Request	
H1075	Welfare Reform Force Change Request	
H1076-A	Notice of TANF State Time Limits	
H1076-B	Notice of TANF State Time Limit Months Used/Changed/Corrected	
H1076-C	Notice of End of TANF State Time Limit/Hardship Exemption	
H1077	Notice of TANF Federal Time Limits	
H1079	Qualifying Quarters of Social Security Earnings	
H1082	TANF Grandparent Supplement Payment Request	
H1084	Certification for Warrants Lost, Destroyed, Stolen or Not Received	
H1086	School Attendance Verification	
H1087	Verification of Texas Health Steps (THSteps) Checkup	
H1088	Verification of Parenting Skills Training	
H1093	THSteps Extra Effort Referral	
H1094	Notice of TANF-SP Time Limit	ES
H1095	Treatment Facility Fraud Referral	
H1096	Notification Letter	
H1097	Affidavit for Citizenship/Identity	ES

Number	Title	
H1100	Addendum Income Worksheet	
H1101	TANF Worksheet	
H1102	TANF Worksheet for Special Reviews and Denials	
H1103	Verification of TANF Eligibility	
H1104	90% Earned Income Deduction (EID) Eligibility and Tracking	
H1105	SNAP Expedited Screening Sheet	
H1106	Enumeration Referral	ES
H1106-A	Proofs You Need to Apply for a Social Security Number Card	
H1107	Request for Forced Change of Medical Coverage	
H1111	Card Order Discrepancy Verification	
H1113	Application for Prior Medicaid Coverage	
H1118	Spend Down Information Sheet (Medically Needy Program)	
H1119	Medical Programs Income Worksheet	
H1120	Medical Bills Transmittal/Insurance Information	
H1122	Medicaid Action Notice	
H1122-A	Medicaid Information - Client Rights/Responsibilities	
H1131	Individually Identifiable Health Information Fax Transmittal	
H1133	Account Verification	
H1134	Assistance Statement Verification	
H1135	Child Care Expense Verification	
H1136	Child Support Verification	
H1137	Confirmation of Office Visit Work/School Excuse	
H1138	Living Arrangement Verification	
H1139	Medical Expense Verification	
H1140	Verification of Benefits	
H1146-M	Medicaid Report (Manual)	
H1155	Request for Domicile Verification	
H1161	Eligibility Case Reading	
H1162	Lone Star Card Insert	
H1163	TWC Employment Registration	
H1172	EBT Card, PIN and Data Entry Request	
H1173	EBT Card Issuance and PIN Self-Selection/Issuance Log	
H1174	Inventory of EBT Cards/PIN Packets	
H1175	Authorization for Administrative Terminal Application Action	
H1177	Transmittal and Receipt for Controlled EBT Documents	
H1182	TANF Client Fee Notification Letter	
H1184	Here Is Your Lone Star Card	
H1185	Important Information About Your Lone Star Card	
H1186	OIG Match Action Alert	
H1187	Welcome to Texas Health Steps Medicaid!	

Number	Title	
H1188	Common Questions Asked About Texas Health Steps and Your Child's Medicaid	
H1190	Ending TANF Five Year Freeze Out Disqualification	
H1205	Texas Streamlined Application	ES
H1213	Children's Health-Care Benefits: More Facts Needed from the Parent Who Has Custody	ES
H1240	Request for Information from Bureau of Veterans Affairs and Client's Authorization	
H1265	Presumptive Eligibility (PE) Worksheet	
H1266	Short-term Medicaid Notice: Approved	ES
H1267	Short-term Medicaid Notice: Not Approved	ES
H1350	Opportunity to Register to Vote	
H1550	Out of State NBCCEDP Verification	
H1551	Treatment Verification	
H1701	Child Support, TANF Foster Care and TANF/Medicaid Case Information Exchange	
H1706	Good Cause Recommendation and Family Violence Exemption	
H1708-A	Report of Noncooperation (Automated)	
H1710	Payment Identification/Identificacion Pagado	
H1712	Explanation of Child/Medical Support, Family Violence and Good Cause	ES
H1713	Service Plan for Family Violence Option and Report of Good Cause	ES
H1800	Receipt for Application/Medicaid Report/Verification/Report of Change	
H1801	SNAP Worksheet	
H1802	Voluntary Withdrawal from Temporary Assistance for Needy Families (TANF)	
H1803	Food Stamp Identification Card	
H1805	SNAP Food Benefits: Your Rights and Program Rules	ES
H1806	Parole/Community Supervision Report	ES
H1808	SNAP Work Rules	ES
H1816	SNAP E&T Noncompliance Report	
H1817	Food Stamp E&T Information Transmittal	
H1822	ABAWD E&T Work Requirement Verification	
H1825	Entitlement to Restored Benefits	ES
H1826	Case Information Release	ES
H1830	Application/Review/Expiration/Appointment Notice	
H1830-I	Interview Notice (Applications or Reviews)	
H1830-L	Children's Health Care Benefits Renewal Notice	ES
H1830-R	Texas Works Renewal Notice	
H1830-W	Texas Women's Health Program Review/Expiration Notice	
H1831	Adjunctive Eligibility Letter	ES
H1832	Affidavit for Meal Providers to the Homeless	
H1833	Your Medicaid Benefits Are Ending - Cover Letter	ES
H1833-L	Your Medicaid Benefits Are Ending	ES
H1834	Your Medicaid Benefits Have Ended - Cover Letter	ES
H1834-L	Your Medicaid Benefits Have Ended	ES

Number	Title	
H1836-A	Medical Release/Physician's Statement	ES
H1836-B	Medical Release/Physician's Statement	ES
H1837	Physician's Statement of Permanent Disability	
H1840	SNAP Food Benefits Renewal Form	ES
H1841	SNAP-CAP Application	ES
H1842	SNAP-CAP Renewal Application	ES
H1843	FNS Authorized SNAP-CAP Benefit Increase Notice	
H1844	Refugee Cash Assistance Employment Services Contractor Referral	
H1844-A	Contractor Receipt Log for Initial RCA Referrals (Form H1844)	
H1845	Drug and Alcohol Treatment (D&A)/Group Living Arrangement (GLA) Facility Review	
H1846	Facility Authorized Representative Interview	
H1847	Reminder to Submit Form H1852	
H1851	Reference Guide for Drug and Alcohol Treatment (D&A)/Group Living Arrangement (GLA) Facilities	
H1852	List of Resident Participants in the Supplemental Nutrition Assistance Program (SNAP)	
H1853	Documentation of Findings for Form H1852	
H1855	Affidavit for Nonreceipt or Destroyed Food Stamp Benefits	
H1856	SNAP Out-of-State Intentional Program Violations	
H1857	Landlord Verification	
H1858	Items We Might Need from Anyone on Your Case	ES
H1859	Social Security Administration Benefits for People with Disabilities Receiving TANF	
H1860	TANF Social Security Outreach Letter	
H1861	Federal Tax Information Record Keeping and Destruction Log	
H1862	Federal Tax Information Transmittal Memorandum	
H1863	Federal Tax Information Removal Log	
H1864	Federal Tax Information Fax Transmittal	
H1867	Texas Women's Health Program Application Form	ES
H1867-R	Texas Women's Health Program Application	ES
H1869	Renewal for Health Care Benefits	ES
H1870	School Enrollment Verification Form	ES
H1898	Restored Benefits Documentation	
H1901	TIERS Data Collection Worksheet	
H2067	Case Information	
H2340-OS	Medicaid for Breast and Cervical Cancer	ES
H2580	TANF Employment Services Notice	ES
H2581	Choices Noncooperation Report	
H2583	Choices Information Transmittal	
H2588	Workforce Orientation Referral	
H2776	Job Search Worksheet for TANF Employment Hardship Exemption	ES
H3037	Report of Pregnancy	
H3038	Emergency Medical Services Certification	ES

Number	Title	
H3038-P	CHIP Perinatal - Emergency Medical Services Certification	ES
H4100	Money Receipt	
H4701	HHSC Out Card	
H4800	Fair Hearing Request Summary	
H4800-A	Fair Hearing Request Summary (Addendum)	
H4803	Notice of Hearing	
H4804	Request and Authorization for Fair Hearing Record to Remain Open	
H4807	Action Taken on Hearing Decision	
H4837	Fair Hearings Evidence Packet Cover Letter	
H4857	Notice of Decision, Administrative Disqualification Hearing	
H4870	Client Complaint of Discrimination (English-Spanish Version)	
H5799	TANF Warrant/Envelope	
LSC	Lone Star Card	
LSCRS	Lone Star Card Registration Sticker	
LSCS	Lone Star Card Sleeve	
RG-83	SSN Maintenance Memorandum	
SCRF	Second Cardholder Form	
SSA-2853	Message From Social Security	
SSA-3288	Social Security Administration Consent for Release of Information	

TWH, Revisions

TWH, 18-1, January Quarterly Revision

18-1, January Quarterly Revision

Archived Revision 17-4, Effective October 1, 2017

Archived Revision 17-3, Effective July 1, 2017

Archived Revision 17-2, Effective April 1, 2017

Archived Revision 17-1, Effective January 1, 2016

(All programs) Alien Status Policies - Updates the handbook to reflect the alien status policy updates that were released in Texas Works Bulletin 17-5, Aligning MEPD and Texas Works Alien Status policy, dated April 26, 2017. (A-330; A-341; A-342; A-343)

(CHIP) Request for Review - Specifies that a household has 30 business days to submit a request for review. (D-1920; D-1921)

(TANF and SNAP) Electronic Benefit Transfer (EBT) Updates - Updates contact information, forms and applicable procedures to reflect current EBT processes. (A-116.4; B-200 TOC; B-234; B-234.3; B-235.1; B-236; B-236.1; B-237; B-239.1; B-239.1.1; B-239.2; B-241; B-242.1; B-242.2; B-243.4; B-261.3.2; B-261.7; B-281; B-282: B-341.1; B-350; B-381; B-382.1; B-382.2; B-382.3; B-382.4; C-1131; C-1132)

(**All Programs**) **Applications Submitted by Employees –** Updates language to clarify special processes for handling applications submitted by employees including Medicaid for the Elderly and People with Disabilities (MEPD) employees as well as Texas Works employees. (A-100 TOC; A-114.1)

(MP) Request for Review Address - Corrects the P.O. Box and zip code used for Requests for Reviews for the Former Foster Care Children in Higher Education (FFCHE) program. (F-2310)

(MP) Managed Care Updates - Incorporates information from Texas Works Bulletin 17-9, Updates to Managed Care Enrollment for Medicaid for Breast and Cervical Cancer, Adoption Assistance, Permanency Care Assistance, and Former Foster Care Children Types of Assistance, dated Aug. 1, 2017, related to Managed Care updates for Medicaid for Breast and Cervical Cancer (MBCC) and Former Foster Care Children (FFCC). Additionally, adds information about the STAR Kids managed care program and a listing of the STAR Kids managed care plans. (A-821.2; C-1116; E-1012; X-900 TOC; X-924)

(**All Programs) MyGoals Payments** - Adds policy introduced with Texas Works Bulletin 17-7, MyGoals for Employment Success Participant Payments, dated June 1, 2017, to count MyGoals payments as cash contributions. (A-1326.1; A-1326.27; A-1371; W-1411.6.1; W1411.6.23)

(All Programs) New Non-Covered Wages Amounts – Updates the minimum amount in non-covered wages an individual must earn to be counted as an earned quarter of employment, based on the Social Security Administration's specification. (A-354.2)

(MP) Pregnancy Verification - Clarifies that self-attestation of an applicant's (including the case name or authorized representative) pregnancy is an acceptable pregnancy verification source, unless staff determine that the self-attestation is questionable. (A-144.5; A-870; D-231)

(TANF/MP) Residence - Revises policy to remove the requirement that an individual must live in Texas with the intention to remain "permanently or for an indefinite period" in order to meet the residency requirement. The individual meets the residency requirement if they are living in Texas with the intention to remain in Texas. The update is made as a result of a change in federal regulations regarding residency. (A-710)

(MP) Retroactive Medicaid - Adds policy introduced with Texas Works Bulletin 17-8, Retroactive Medicaid for Inpatient Psychiatric Services, dated July 7, 2017, to allow Centralized Benefits Services (CBS) staff to provide retroactive Medicaid to children abandoned in psychiatric hospitals and subsequently taken into state conservatorship by the Texas Department of Family and Protective Services (DFPS). (A-834)

(All Programs) Refugee Medical Assistance - Removes references to the Refugee Medical Assistance (RMA) program that is no longer administered by HHSC as indicated in Texas Works Bulletin 16-17, Refugee Medical Assistance (RMA) Program Update, dated Dec. 29, 2016. (A-132.1; A-340; B-400 TOC; B-474.1.1; B-474.1.2.6; C-1150; C-1471)

(All Programs) Expired I-766, Employment Authorization Document - The United States Citizenship and Immigration Services (USCIS) automatically extends certain I-766s, Employment Authorization Document, for up to 180 days when a renewal application is received for the document. When an I-766 is extended, the Systematic Alien Verification for Entitlements (SAVE) Program response will automatically contain the new expiration date even though the I-766 may appear expired on its face. Policy clarifies that individuals should not be disqualified when a SAVE response is received showing that the document has been extended. (A-311; A-314; A-352)

(SNAP) Verification Sources for Deductions – Updates policy to include State Online Query (SOLQ) or Wire Third-Party Query (WTPY) as verification sources for medical expense deductions. Added county tax office websites and removed the Data Broker System as verification sources for property tax deductions. (A-1441)

(All Programs) Social Security Administration Online Services - Provides the web address for individuals to request a replacement Social Security card or obtain proof of Retirement, Survivor's Disability Insurance (RSDI) or Supplemental Security Income (SSI) benefits online. (A-411; A-1371)

(TANF) TANF State Time Limit County Hardship List – Updates the TANF State Time Limit County Hardship Lists to reflect the current quarter and the last three previous quarterly dates only. Updated employment statistics require no counties to be added or removed to the TANF State Time Limit Hardship County List. The Texas Health and Human Services Commission (HHSC) updates the list every three months as needed. (C-321; C-322)

(TANF) - Who Is Included - Updates this section to remove the reference to TP 08. Effective Jan. 1, 2014, children are certified on the age appropriate Medicaid program and no longer certified on TP08. (A-221)

(MP) THSteps Updated Fax Number - Corrects the fax number where staff fax Form H1087, Verification of Texas Health Steps (THSteps) Checkup, and Form H1093, THSteps Extra Effort Referral. (A-1531.4; A-2124.3)

(MP) Medicaid for Halfway Houses Residents- Adds policy introduced with Texas Works Bulletin 17-6, Medicaid for Residents of the Texas Juvenile Justice Department and Juvenile Probation Department Halfway Houses, dated May 22, 2017, which allows Texas Juvenile Justice Department/Juvenile Probation (TJJD/JPD) youth placed in a halfway house to be eligible for Medicaid if the halfway house meets certain criteria. (A-241.3.1; B-474.1.2.1.1)

(All Programs) - Budgeting Earned Income using Texas Workforce Commission Quarterly Wage Information – Adds policy released in Texas Works Bulletin 15-03, Budgeting Earned Income using Texas Workforce Commission (TWC) Quarterly Wage Information, dated Dec. 12, 2014. When using the TWC quarterly wage information as verification for weekly and bi-weekly income, staff must indicate the number of pay periods in the selected quarter to more accurately calculate the income. (A-1355.2)

TWH, 17-4, October Revision

Revision Notice 17-4, Effective October 1, 2017

Archived Revision 17-3, Effective July 1, 2017

Archived Revision 17-2, Effective April 1, 2017

Archived Revision 17-1, Effective January 1, 2017

Archived Revision 16-4, Effective October 1, 2016

The revision consists of the policy changes and updates detailed below:

(MP) Housing Allowance - Clarifies that a housing allowance paid to a member of the clergy is excluded as income if the employing church or organization officially designates the payment as a housing allowance before making the payment, the total allowance does not exceed the cost of renting or purchasing the home and the allowance does not exceed the service value. (A-1326.20)

(SNAP) School-Based Savings Accounts - Adds policy from Texas Works Bulletin 17-5, 3. SNAP Exclusion for School-Based Savings Accounts, released April 26, 2017, regarding treatment of School-Based Savings Accounts when determining eligibility for SNAP. (A-1231.7)

(SNAP) ABAWD Exemptions - Adds policy to determine if an ABAWD is considered physically and mentally unfit to work, including policy introduced with MEPD and Texas Works Bulletin 17-5, 4. ABAWD Time Limit Exemption for Veterans Receiving Disability Payments, released April 26, 2017. Updated policy allows an ABAWD work requirement exemption for recipients of Veterans Affairs (VA) disability payments, regardless of disability percentage rating. (A-1942)

(All Programs) Relay Texas - Updates contact information for interpretation and translation services including Relay for Texas contact information. (A-131.2.1)

(SNAP) Revised ABAWD Work Requirement Waiver County List - Updates the current and previous SNAP ABAWD Work Requirement Waiver County lists. There are no waiver counties for October 2017. (C-331; C-332)

(TANF) TANF State Time Limit County Hardship List - Updates the TANF State Time Limit County Hardship Lists to reflect the current quarter and the last three previous quarterly dates only. Updated employment statistics require no counties to be added or removed to the TANF State Time Limit Hardship County List. The Texas Health and Human Services Commission (HHSC) updates the list every three months as needed. (C-321; C-322)

(SNAP) Revised SNAP Employment and Training County Charts - Adds Aransas, Bailey, Bandera, Brewster, Brooks, Deaf Smith, Garza, Gillespie, Hutchinson, Jim Hogg, Karnes, Kendall, Lampasas, Medina, Milam, Presidio, Refugio, Scurry and Zapata counties to the SNAP Employment and Training County chart as described in Texas Works Bulletin 17-10, SNAP Employment and Training County Change. (C-340; C-341)

(SNAP) Revised Income Limits and Deductions - Adds policy from Texas Works Bulletin 17-10, Revised SNAP Income Limits, Deductions, and Allotments. (C-121; C-121.1; C-1431)

(TANF) Increased TANF Grant Amount - Adds policy from Texas Works Bulletin 17-10, Revised TANF Maximum Grant Amounts and TANF Chart. (C-111)

TWH, 17-3, July Quarterly Revision

17-3, July Quarterly Revision

Archived Revision 17-2, Effective April 1, 2017

Archived Revision 17-1, Effective January 1, 2017

Archived Revision 16-4, Effective October 1, 2016

Archived Revision 16-3, Effective July 1, 2016

The revision consists of the policy changes and updates detailed below:

(All Programs) Standard Mileage Rate – Updates the handbook to reflect the standard mileage rate decrease from 54 to 53.5 cents as released in TWB 16-17. The rate is set by the Texas Comptroller of Public Accounts. (A-1323.4.5; A-1428.1)

(SNAP/TANF/MP) Documentation for Authenticating Callers - Clarifies that staff must document responses to questions according to requirements in Section A-2050, Documentation Requirements. (A-2020.1)

(SNAP/TANF) Corrects Term- Corrects the term "advisor" to "household" as the party responsible for reporting the change. (Does not apply to SNAP Streamlined Reporting (SR) Households). (B-621)

(MP) Provider Referral Process for Newborn Coverage - Adds policy about the process for creating MA - Newborn Coverage (TP 45) for a newborn whose mother is Medicaid eligible upon notification of a child's birth from a hospital, birthing center, or Federally Qualified Health Center, State Office Data Integrity (SODI). (A-820; A-825)

(MP) Housing Allowance - Clarifies that medical programs policy follows the TANF and SNAP policy when determining how to count a housing allowance. Previously, the section stated that housing allowances are counted as unearned income. (A-1326.20)

- Follow policy in A-1323.3 Military Pay Allotments and Allowances, or A-1324.4 Government Housing Assistance for specific types of assistance.
- Treat all other housing allowances as unearned income.

(TANF) Referral- Clarifies that only one identification card is needed in both one and two parent families to acceptably verify parenting skills training for Women, Infants and Children (WIC). Updates the instructions to find parenting skills classes to use 211Texas.org. (A-2127.3)

(TANF) Form H1075, Welfare Reform Force Change Request- Form H1075 Welfare Reform Force Change Request is no longer used when requesting corrections to TANF data for an individual. Form H1075 is being end dated in TIERS and removed. The references to the use of the form are updated accordingly to instruct staff to contact the TIERS helpdesk for assistance. (A-1821.5.2; A-1921; A-2411; A-2431.1; A-2451.2; A-2530; A-2533.2)

(TANF) TANF State Time Limit County Hardship List – Removes Jim Hogg County from the TANF State Time Limit Hardship County List to comply with updated employment statistics. No counties are added. The Texas Health and Human Services Commission (HHSC) updates the list every three months. Use this list for budget months beginning July 1, 2017. Exception: For restored benefits, use the county list that was applicable for the restored month(s). (C-321; C-322)

(SNAP) Program Manager Responsibilities-Updates the address program managers must use when sending Form H1853 Documentation of Findings for Form H1852 to align with the current address included in the form instructions. Program Managers must send the Form H1853 to Eligibility Services Field Operations, Health and Human Services Commission, 909 West 45th Street, Mail Code: 992-6, Austin, TX 78751. (B-443.2)

(SNAP) Required Verification for SNAP- Removes the verification requirement for SNAP E&T exemption for women three to nine months pregnant, as the exemption is no longer valid. This policy was released in TWB 16-10 on June 30, 2016. (C-912)

(MP) Breast and Cervical Cancer Services (BCCS) Clinic Locator Update - Updates the BCCS provider locator link. Women who wish to apply for Medicaid for Breast and Cervical Cancer (MBCC) must use Form H1034 Medicaid for Breast and Cervical Cancer which can only be obtained through a BCCS contractor. (X-131)

(MP) Type of Assistance Chart- Adds Type of Assistance (TOA) chart C-1150 to the Table of Contents (TOC) for easy navigation.

Forms and Reports

(SNAP) Federal Update to Mandatory Non-Discrimination Language – Updates a number of forms to include the 2015 federally mandated nondiscrimination statement for SNAP Only forms. The following forms are affected:

- H1840 SNAP Food Benefits Renewal Form
- H1841 SNAP-CAP Application
- H1842 SNAP-CAP Renewal Application
- H1805 SNAP Food Benefits: Your Rights and Program Rules
- H1184 Here Is Your Lone Star Card
- LSC Lone Star Card
- LSCS Lone Star Card Sleeve
- SCRF Second Cardholder Form

(TANF) Form H1075 Welfare Reform Force Change Request and Instructions - Deletes Form H1075 as staff are no longer required to use this form.

(All Programs) Other updates to forms - Updates certain forms to split combined English/Spanish language forms into separate documents and references newer versions of forms where applicable:

- LSCR, Lone Star Card Registration Sticker
- H1084 Certification for Warrants Lost, Destroyed, Stolen, or Not Received
- H1106 Enumeration Referral

TWH, 17-2, April Quarterly Revision

17-2, April Quarterly Revision

Archived Revision 17-1, Effective January 1, 2017

Archived Revision 16-4, Effective October 1, 2016

Archived Revision 16-3, Effective July 1, 2016

Archived Revision 16-2, Effective April 1, 2016

The revision consists of the policy changes and updates detailed below:

(TANF) TANF State Time Limit County Hardship List — Updated employment statistics require Sabine and Jim Hogg Counties to be added to the TANF State Time Limit Hardship County List. The Texas Health and Human Services Commission (HHSC) updates the list every three months. Use this list for budget months beginning April 1, 2017. **Exception:** For restored benefits, use the county list that was applicable for the restored month(s). (C-321, C-322)

(MA, CHIP) ACA - Telephonic Signatures — Updates current policy to clarify which forms individuals receive when they sign or decline to sign a combined application by telephone for TW Medical and MEPD programs (A-122.1; W-122)

(MP) Choices Non-Cooperation for a TP 08 Recipient — Clarifies that when an individual who is certified for both TANF and TP 08 non-cooperates with Choices, the individual's TP 08 should be terminated. (A-825; A-1843; A-2146)

(MP) Healthy Texas Women (HTW) Updates — The handbook is being updated to include the HTW changes in Texas Works Bulletin 16-09 Texas Women's Health Program Changes and Texas Works Bulletin 16-10 Healthy Texas Women (HTW) Updates. (C-1150; C-1471; F-910; W-110; W-111; W-112; W-113, W-121; W-123; W-124; W-200; W-212; W-310; W-510; W-810; W-910; W-911; W-912; W-913; W-914; W-920; W-1010; W-1100; W-1200; W-1300; W-1410; W-1411.3.1; W-1413; W-1420; W-1431; W-1432; W-1600; W-1700; W-1810; W-1910; W-2010; W-2050; W-2061; W-2070; W-2080; W-2110; W-2111; W-2130; W-2210; W-2400; W-2410; W-2420; W-2430; W-2440; W-TOC; X-931; X-932)

(MA) Expedited CHIP Enrollment — Adds policy from Texas Works Bulletin 16-13 Expedited Children's Health Insurance Program (CHIP) Enrollment, released on August 30, 2016, regarding transferring from certain Medicaid programs to CHIP due to certain case actions. These households may be eligible for expedited CHIP enrollment. (A-825; A-2341; A-2342; B-123.4; B-631; B-637; D-1711; D-1720.1; D-1723.4; D-1761; D-1821)

(MA) Transitioning from Medicaid for Pregnant Women (TP 40) — Adds policy from Texas Works Bulletin 16-11 Transition from Medicaid for Pregnant Women, released on August 08, 2016, regarding individuals whose pregnancy terminates prior to the end of their original certification period and are retested automatically. (A-825; A-2341)

(MP) Children Placed In and Released from a Juvenile Facility — Adds policy from Texas Works Bulletin 16-11 Suspension and Reinstatement of TP 44 and Termination of Medicaid or Children's Health Insurance Program (CHIP) Eligibility of Certain Children Placed in a Juvenile Facility, released on August 8, 2016 and Texas Works Bulletin 16-12 Suspension of TP 44 and Termination of Medicaid or Children's Health Insurance Program (CHIP) Eligibility of Certain Children Placed in a Juvenile Facility, released on August 8, 2016, which provides new policy relating to Medicaid and CHIP for children placed in and released from a juvenile facility. Additionally, information related to Medical Programs administered by the Centralized Benefit Services unit in B-400, Special Households, is re-formatted for clarity. (A-116.7.4; A-121; A-241.3.1; A-251; A-800; A-820; A-825.2; A-826; A-941; B-122.4; B-474.1.2; B-474.1.2.1; B-474.1.2.2; B-474.1.2.2.1; B-474.1.2.2.2; B-474.1.2.3; B-474.1.2.4; B-474.1.2.5; B-474.1.2.6; B-474.1.2.7; B-474.1.2.8; B-631; B-637; B-641; C-841; D-310; D-1433.1; D-1433.2; D-1731)

(MP) 2017 Federal Poverty Income Limits (FPIL) and Internal Revenue Service (IRS) -Filing Thresholds — Updates FPIL and IRS Filing Threshold amounts. (C-131.1; C-131.3; C-131.4; C-131.5)

(MP) Guidelines for Providing Retroactive Coverage for Children and Medical Programs — Updates applicable income charts (C-1114).

TWH, Bulletins

The purpose of this section is to make the most current policy and procedures readily available via a single resource. Memoranda containing policy or procedural information will be placed on this list at the time of distribution. They will remain on the list until the information contained is completely incorporated into the handbook.

Please note: As of October 30, 2015, all content from Texas Works Bulletin (TWB) 14-05, Federally Required Eligibility Changes for Medicaid and Children's Health Insurance Program (CHIP) (September 2015 Update), has been incorporated into the Texas Works Handbook. Texas Works staff may review this document (access limited to staff) to see where content previously contained in TWB 14-05 can be found in the handbook.

Release Date	Bulletin Number	Title
02-20-18	18-2	1. Mileage Rate Increase 2. 2018 Federal Poverty Level
01-23-18	18-1	1. Relative and Other Designated Caregiver Program Payments 2. TIERS Updates - Counting Social Security Benefits for MAGI
12-11-17	17-16	1. Clarification when Counting Social Security Benefits for Modified Adjusted Gross Income (MAGI) Programs 2. Federal Benefits 2018 Cost-of-Living Adjustment (COLA) 3. Asset Verification System (AVS) Consent Policy
10-04-17	17-15	1.Counting Social Security Benefits for Modified Adjusted Gross Income Programs 2.Social Security Number Validation 3.Determining Good Cause for SNAP Employment and Training Noncompliance
09-19-17	17-14	1. Texas Lottery Commission 2. Medicaid After Supplemental Security Income Denial
09-18-17	17-13	Statewide - Hurricane Harvey - Disaster Supplemental Nutrition Assistance Program (D-SNAP) Policy Attachment - DSNAP Application Sites Revised
09-14-17	17-12	1. SNAP Employment and Training County Changes 2. Revised SNAP Income Limits, Deductions, and Allotments 3. Revised TANF Maximum Grant Amounts Attachment - SNAP Allotment Charts
09-14-17	17-11	Implementation of Disaster Supplemental Nutrition Assistance Program (D-SNAP) for Hurricane Harvey - Phase I - 11 Counties. Revised - Implementation of Disaster Supplemental Nutrition Assistance Program (D-SNAP) for Hurricane Harvey - Phase I - 11 Counties.
08-22-17	17-10	In-Home and Family Support Program
08-01-17	17-9	Updates to Managed Care Enrollment for Medicaid for Breast and Cervical Cancer, Adoption Assistance, Permanency Care Assistance, and Former Foster Care Children Types of Assistance
07-07-17	17-8	Retroactive Medicaid Coverage for Children Abandoned in Psychiatric Hospitals
06-01-17	17-7	1. Spousal Dependent Allowance Adjustment 2017 2. MyGoals for Employment Success Participant Payments
05-22-17	17-6	Medicaid for Residents of the Texas Juvenile Justice Department and Juvenile Probation Department Halfway Houses
04-26-17	17-5	1. Aligning MEPD and Texas Works Alien Status Policy 2. Verifying Fleeing Felons and Parole/Probation Violators for SNAP and TANF 3. SNAP Exclusion for School-Based Savings Accounts 4. ABAWD Time Limit Exemption for Veterans Receiving Disability Payments
03-13-17	17-4	Data Broker Resolutions 1. Accessing Data Broker 2. Case Processing 3. Suspended Cases- Business Process Redesign

Release Date	Bulletin Number	Title
02-23-17	17-3	Updated Data Broker Procedures
02-17-17	17-2	Data Broker Update- Phase I 1. Data Broker Reports- TIERS and the Stand-Alone Portal 2. Residence Verification 3. Real Property Value Verification 4. Vehicle Verification 5. Asset Verification
02-14-17	17-1	1. 2017 Federal Poverty Income Limits 2. Mileage Rate Decrease
12-29-16	16-17	Refugee Medical Assistance (RMA) Program Update
12-07-16	16-16	2017 Cost-of-Living Adjustment (COLA) for Federal Benefits
09-16-16	16-15	Extension of Certification Periods for Certain Households
09-1-16	16-14	1. Revised Supplemental Nutrition Assistance Program (SNAP) Income Limits and Deductions 2. Revised Temporary Assistance for Needy Families (TANF) Maximum Grant Amounts and TANF Chart Attachment - SNAP Allotment Charts
08-30-16	16-13	Expedited Children's Health Insurance Program (CHIP) Enrollment Attachment - Sample Welcome Letter
08-08-16	16-12	1. Former Foster Care Children (FFCC) Updates (CBS Staff) 2. Medicaid for Transitioning Foster Care Youth (MTFCY) Updates (CBS Staff) 3. Suspension and Reinstatement of TP 44 and Termination of Medicaid or Children's Health Insurance Program (CHIP) Eligibility of Certain Children Placed in a Juvenile Facility (CBS Staff)
08-08-16	16-11	1. Suspension and Reinstatement of TP 44 and Termination of Medicaid or Children's Health Insurance Program (CHIP) Eligibility of Certain Children Placed in a Juvenile Facility 2. Transition from Medicaid for Pregnant Women (TP 40)
06-30-16	16-10	1. School-Based Savings Accounts 2. Achieving a Better Life Experience (ABLE) Program 3. ACA - Telephonic Signatures 4. Ending Supplemental Nutrition Assistance Program (SNAP) Employment and Training (E&T) Exemption for Pregnancy 5. Healthy Texas Women (HTW) Updates
06-06-16	16-09	Texas Women's Health Program Changes
05-18-16	16-08	Implementation of Disaster Supplemental Nutrition Assistance Program (SNAP) for Newton County Residents - Revised Attachment - Affidavit for Supplemental Benefits
04-20-16	16-07	1. Mileage Rate Decrease 2. 2016 Federal Poverty Income Limits (FPILs) and Internal Revenue Service (IRS) Filing Thresholds 3. Affordable Care Act (ACA)—Updates to Inclusion of the Needs of Unborn Children in the CHIP (TA 84) Modified Adjusted Gross Income (MAGI) Household Composition - Revised Attachment 1 - 2016 Federal Poverty Income Limits (FPIL) Attachment 2 - Federal Poverty Income Limits (FPIL) Transitional Medicaid Attachment 3 - Standard Modified Adjusted Gross Income (MAGI) Disregard Attachment 4 - Internal Revenue Service (IRS) Monthly Income Thresholds
01-15-16	16-06	1. SNAP Verification of Compliance with Parole or Community Supervision for Individuals with Felony Drug Convictions 2. SNAP Combined Application Project (SNAP-CAP) Shelter Threshold and Allotment Changes

Release Date	Bulletin Number	Title
12-18-15	16-05	All Programs 1. Affordable Care Act (ACA)—Counting Self-Employment Correctly SNAP 2. Supplemental Nutrition Assistance Program (SNAP) Eligibility for Residents of Institutions 3. SNAP Eligibility for Individuals with Felony Drug Convictions Medical Programs 4. ACA—Updates to Modified Adjusted Gross Income (MAGI) Household Composition 5. ACA—Update to Administrative Renewals Correspondence 6. ACA—Eligibility of a Spouse for Parent and Caretaker Relatives Medicaid 7. Medically Needy with Spend Down Deeming Newborns 8. Transitional Medicaid—Adding Spousal Support to Type Program (TP) 20 9. Medicaid for Breast and Cervical Cancer (MBCC)
03-08-16	16-04	Returned Mail Task Process for Medicaid for Transitioning Foster Care Youth (MTFCY) and Former Foster Care Children (FFCC) - Revised
12-14-15	16-03	2016 Cost-of-Living Adjustment (COLA) for Federal Benefits
09-18-15	16-02	1. Texas Department of Criminal Justice Match Process 2. National Directory of New Hires 3. Elimination of Same-Sex Marriages Contingency Processing Method
09-11-15	16-01	Business Process Redesign – Flexible Appointments (BPR Locations Only)
08-31-15	15-12	1. Supplemental Nutrition Assistance Program (SNAP) Eligibility for Individuals with Felony Drug Convictions 2. Revised SNAP Income Limits and Deductions 3. Revised Temporary Assistance for Needy Families (TANF) Maximum Grant Amounts and TANF Chart
08-25-15	15-11	Recognition of Same-Sex Marriages
08-14-15	15-10	Recognition of Same-Sex Marriages
04-03-15	15-09	1. Updates to Authorized Representatives 2. Electronic Correspondence 3. Preferred Languages for Correspondence
02-17-15	15-08	2015 Texas Women's Health Program (TWHP) Income Limits
02-03-15	15-07	Presumptive Eligibility (PE) Determined by Qualified Hospitals and Qualified Entities
12-30-14	15-06	Medicaid Coverage for Amerasians
12-09-14	15-04	2015 Federal Cost-of-Living Adjustment (COLA): Retirement, Survivors, and Disability Insurance (RSDI); Supplemental Security Income (SSI); Railroad Retirement (RR) Benefits; Medicare Part B Premiums
12-12-14	15-03	Budgeting Earned Income using Texas Workforce Commission (TWC) Quarterly Wage Information
10-01-14	15-02	Interstate Compact on the Placement of Children (ICPC)
09-02-14	15-01	1. Revised Supplemental Nutrition Assistance Program (SNAP) Income Limits, Deductions, and Benefit Allotment Chart 2. Revised Temporary Assistance for Needy Families (TANF) Maximum Grant Amounts and TANF Chart 3. Revised Able Bodied Adult Without Dependents (ABAWD) Waiver Counties Charts Attachment - 2015 SNAP Allotment Charts
06-02-14	14-11	1. Supplemental Nutrition Assistance Program (SNAP) Electronic Benefit Transfer (EBT) Card Monitoring and Replacements 2. Low Income Home Energy Assistance Program (LIHEAP)

Release Date	Bulletin Number	Title
		Attachment - Excessive Card Replacement Notice - English Attachment - Excessive Card Replacement Notice - Spanish
03-03-14	14-08	1. Mileage Rate Decrease 2. Authentication of Caller Identity for Interviews, Texas Integrated Eligibility Redesign System (TIERS) Automation 3. 2014 Texas Women's Health Program (TWHP) Income Limits
12-06-13	14-06	Pilot – Expanded Use of Texas Workforce Commission (TWC) Quarterly Wage Information (QWI) to Budget Earned Income
09-01-15	14-05	Federally Required Eligibility Changes for Medicaid and CHIP (September 2015 Update)
08-13-14	14-04	Returned Mail Policy and Procedure Changes - Revised
11-12-13	14-03	Online Texas Women's Health Program (TWHP) Application Submission
04-02-13	13-08	1. New DataMart Report Instructions 2. Data Broker Alien Status Verification 3. Clarification – Identity Verification and Mail Issuance of EBT Cards 4. Updates to the Texas Works Manager's Guide 5. Mileage Rate Increase 6. Medicaid for Inmates of a Public Institution
03-26-13	13-07	Medicaid for Inmates of a Public Institution
03-04-13	13-06	Texas Health Steps Informing Materials
10-08-12	13-02	1. Name and Funding Source Change for the Women's Health Program (WHP) 2. Texas Health Steps Informing Materials 3. Health Care Orientation 4. Correction to Texas Works Handbook October 2012 Quarterly Revision Attachment - SNAP Allotment Charts
07-19-12	12-10	Form H1106, Enumeration Referral
05-17-12	12-09	1.Authorized Representatives and Alternate Payees for Independent Children 2. Social Security Administration/Bureau of Vital Statistics Death Match Processing

TWH, Contact Us

For technical or accessibility issues with this handbook, please email: handbookfeedback@hhsc.state.tx.us

For questions about Texas Works programs, please email: contact@hhsc.state.tx.us