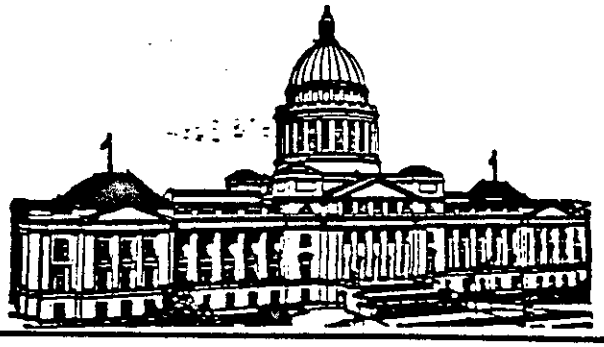
ARKANSAS REGISTER

Transmittal Sheet



Sharon Priest
Secretary of State
State Capitol Rm. 01
Little Rock, Arkansas 72201-1094

For Office Use Only: Effective Date _____ Code Number 016.20.00-009

Name of Agency Department of Human Services

Department Division of County Operations

Contact Person Roy D. Kindle, Jr. Phone 682-8251

Statutory Authority for Promulgating Rules P. L. 104-193, The Food Stamp Act of 1977

FSC-00-06

Intended Effective Date		Date
	Legal Notice Published	3-1-00
☐ Emergency	Final Date for Public Comment	3-30-00
☑ 10 Days After Filing	Filed With Legislative Council	3-1-00
☐ Other	Reviewed by Legislative Council	
_____	Adopted by State Agency	5-01-00

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted In Compliance with Act 434 of 1967 As Amended.

Ruth Whitney II
Signature

682-8375
Phone Number

Director
Title

Date

FILED
AR. REGISTER DIV.
00 MAR 30 PM 4:02
SHARON PRIEST
SECRETARY OF STATE
STATE OF ARKANSAS
BY

NOTICE OF RULE MAKING

Pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, the State of Arkansas will no longer operate a Simplified Food Stamp Program (SFSP) for Transitional Employment Assistance (TEA) families. This directive provides instructions for converting the participating SFSP cases to the Regular Food Stamp Program. This policy directive was filed under the emergency provisions of the Administrative Procedure Act, adopted by state agency March 01, 2000.

Copies of the revised policy may be obtained by writing to the Division of County Operations, Attention: Food Stamp Policy Section, P. O. Box 1437, Slot 1241, Little Rock, AR 72203-1437. All comments must be submitted within 30 days of the date of publication of this notice. If you need any material in a different format, such as large print, contact our Americans with Disabilities Act Coordinator at 682-8920 (Voice) or 682-8933 (TDD). The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and operates, manages and delivers services without regard to political affiliation, religion, disability, age, veteran status, sex, race, color or national origin.

Ruth Whitney
Director
Division of County Operations

DEPARTMENT OF HUMAN SERVICES
DIVISION OF COUNTY OPERATIONS
AMENDING LEGISLATIVE REGULATION
ARKANSAS LEGISLATIVE COUNCIL

NUMBER AND TITLE: FSC 00-06, Converting Cases from the SFSP to Regular Food Stamp Program

PROPOSED EFFECTIVE DATE: May 1, 2000

STATUTORY AUTHORITY: The Food Stamp Act of 1977 as amended by The Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

NECESSITY AND FUNCTION: The State of Arkansas will no longer operate a Simplified Food Stamp Program (SFSP) for Transitional Employment Assistance (TEA) families. This directive provides instructions for converting the participating SFSP cases to the Regular Food Stamp Program. This policy directive was filed under the emergency provisions of the Administrative Procedure Act, adopted by state agency March 01, 2000.

PAGES FILED: A total of 2 pages were filed.

Roy D. Kindle, Jr.
Assistant Director
Office of Program Planning and Development

PROMULGATION DATE: **May 1, 2000**

CONTACT PERSON:

Roy D. Kindle, Jr.
Assistant Director
Office of Program Planning and Development
P.O. Box 1437, Slot 1220
Little Rock, AR 72203-1437

(501) 682-8251

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL AND JOINT INTERIM COMMITTEE

DEPARTMENT/AGENCY HUMAN SERVICES

DIVISION COUNTY OPERATIONS

DIVISION DIRECTOR RUTH WHITNEY

CONTACT PERSON ROY D. KINDLE, JR.

ADDRESS Donaghey Plaza South, P.O. Box 1437, Slot 1220, Little Rock, AR 72203-1437

PHONE NO. 682-8251

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule below.
D. Submit two (2) copies of this questionnaire attached to the front of two (2) copies of your proposed rule and mail or deliver to:

Donna K. Davis
Subcommittee on Administrative Rules and Regulations
Arkansas Legislative Council
Bureau of Legislative Research
Room 315, State Capitol
Little Rock, AR 72201

FILED
AR. REGISTER DIV.
00 MAR 30 PM 4:02
SHARON J. PRIEST
SECRETARY OF STATE
STATE OF ARKANSAS
BY

****

1. What is the short title of this rule?
FSC 00-06

2. What is the subject of the proposed rule?
Converting Cases from Simplified Food Stamp to the Regular Food Stamp Program

3. Is this rule required to comply with federal statute or regulations? ___ YES **XXX** NO
If yes, please provide the federal regulation and/or the statute citation.

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? **XXX** YES ___ NO

If yes, what is the effective date of the emergency rule? **March 01, 2000**

When does the rule expire? **May 01, 2000**

Will this emergency rule be promulgated under the regular provisions of the Administrative Procedure Act? **XXX** YES ___ NO

5. Is this a new rule? **XXX** YES ___ NO

Does this repeal an existing rule? **XXX** YES ___ NO

Is this an amendment to an existing rule? _____Yes XXX NO

Is this an amendment to an existing rule? If yes, please attach a markup showing the changes in the existing rule and a summary of the substantive changes.

6. What state law grants the authority for this proposed rule? If codified, please give Arkansas Code citation.
The Personal Responsibility and Work Opportunity Reconciliation Act of 1996

7. What is the purpose of this proposed rule?
The State of Arkansas will no longer operate a Simplified Food Stamp Program (SFSP) for Transitional Employment Assistance (TEA) families. This directive provides instructions for converting the participating SFSP cases to the Regular Food Stamp Program.

8. Will a public hearing be held on this proposed rule? ___ YES XXX NO

9. When does the public comment period end? 3-30-00

10. What is the proposed effective date of this proposed rule? 5-1-00

11. Do you expect this rule to be controversial? ___ YES XXX NO

If yes, please explain.

12. Please give the names of persons, groups, or organizations which you expect to comment on these rules. Please provide their position (for or against) if known.

NAME	GROUP/ORGANIZATION	ADDRESS
David Manley Attorney at Law	Legal Services of Arkansas	209 West Capitol, Suite 36 Little Rock, AR 72201

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT HUMAN SERVICES

DIVISION COUNTY OPERATIONS

PERSON COMPLETING THIS STATEMENT Helen Davis

TELEPHONE NO. 682-8283 FAX NO. 682-1469

FINANCIAL IMPACT STATEMENT

To comply with Act 884 of 1995, please complete the following Financial Impact Statement and file with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE FSC 00-06

1. Does this proposed, amended, or repealed rule or regulation have a financial impact?

____ YES XXX NO

If you believe that the development of a Financial Impact Statement is so speculative as to be cost prohibited, please explain.

N/A

3. If the purpose of this rule or regulation is to implement a federal rule or regulation, please give the incremental cost for implementing the regulation.

1999-2000 Fiscal Year		2000-2001 Fiscal Year	
General Revenue	$ 0	General Revenue	$ 0
Federal Funds	$ 0	Federal Funds	$ 0
Cash Funds	$ 0	Cash Funds	$ 0
Special Revenue	$ 0	Special Revenue	$ 0
Other	$ 0	Other	$ 0
Total	$ 0	Total	$ 0

FILED
AR. REGISTER DIV.
00 MAR 30 PM 4:02
BY
SHARON E. PRIEST
SECRETARY OF STATE
STATE OF ARKANSAS

4. What is the total estimated cost by fiscal year to any party subject to the proposed, amended, or repealed rule or regulation?

1999-2000 Fiscal Year $ 0 2000-2001 Fiscal Year $ 0

5. What is the total estimated cost by fiscal year to the agency to implement this regulation?

1999-2000 Fiscal Year $ 0 2000-2001 Fiscal Year $ 0

MANUAL TRANSMITTAL
Arkansas Department of Human Services
Division of County Operations

☐	Policy	☐	Form	☒	Policy Directive

Issuance Number	00-06
Issuance Date	3/1/00
Expiration Date	Until Superseded

Food Stamp Certification & TEA **Manual**

From: Ruth Whitney
Director

Subj: Converting Cases From the SFSP to the Regular Food Stamp Program

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The State of Arkansas will no longer operate a Simplified Food Stamp Program (SFSP) for Transitional Employment Assistance (TEA) families. This directive provides instructions for converting the households participating in the SFSP to the regular Food Stamp Program.

PROVIDING FOOD STAMP BENEFITS TO TEA APPLICANTS

Food stamp benefits continue to be a vital means of assistance to families participating in the TEA Program. In order to insure that food is immediately available to households that submit a TEA application, the following rules will become effective March 1, 2000.

Rule 1: Counties will no longer certify households under SFSP rules. The household will be asked to complete and submit both an *Application for Transitional Employment Assistance* (DCO-180) and a *Food Stamp Application* (DCO-220). The DCO-180 has been revised to remove questions related to food stamp eligibility. See Attachment 1. NOTE: As ANSWER becomes operational, one integrated application form will be used. Counties will be provided specific instructions regarding that form when ANSWER is implemented.

Rule 2: Counties will be allowed, but not required, to conduct a joint interview for TEA and food stamp benefits. If a joint interview is not conducted, the household should not be required to return on another day or at another time to be interviewed for food stamp benefits. Rather, the county office should schedule both interviews on the same day unless:

a) The household requests an interview on another day;
b) The household is entitled to expedited service (see rule 3 below); or
c) The household can be seen for the food stamp interview sooner than the date scheduled for the TEA interview and agrees to be seen on another day.

Under no circumstances should the food stamp interview be held on a day later than the TEA interview.

Rule 3: Coordination of interview times will not apply if the household is entitled to expedited service. Instead, the household will be interviewed, and the food stamp application processed in accordance with the policy governing expedited processing.

CONVERTING EXISTING SFSP CASES TO THE REGULAR FOOD STAMP PROGRAM

1. Conversion Period

Effective March 1, 2000, households will be allowed to continue participating in the SFSP only until the end of the household's current certification period; until any case action occurs in the TEA or food stamp case or until September 30, 2000, whichever occurs first.

Many households currently participating in the SFSP will become subject to quarterly reporting. (See FSC 11510 for a list of households exempt from the quarterly reporting requirements. According to FSC 11520, a household may enter quarterly reporting only when an initial application or an application for recertification is approved. Therefore, if SFSP conversion occurs at a case action other than an application approval (initial or recertification), the household will not become subject to quarterly reporting. Instead, the household will be subject to the occasional reporting requirements described in FSC 11350.

In order to insure that all former SFSP households are properly classified as a quarterly reporting household or an occasional reporting household, all households participating in the SFSP as of March 1, 2000, must be recertified by September 30, 2000. (This applies even if the household was converted from the SFSP to the regular Food Stamp Program.) At the time of recertification, the household's situation will be evaluated to determine if the household is subject to quarterly reporting.

2. Method of Conversion

Households converting from the SFSP to the regular Food Stamp Program will experience changes in the way the budget is calculated. Income will be handled differently with some income that is excluded under SFSP rules being counted under regular Program rules. The county standard will no longer be used as the household's shelter costs. Also, households will be required to report changes under Food Stamp Program rules rather than SFSP rules. To convert a case, the household's budget must be recalculated using regular Food Stamp Program rules.

a) **Resources** - Households containing at least one member who receives a TEA benefit are classified as categorically eligible households. See PD FSC 99-21. Categorically eligible households do not have to meet the Food Stamp Program resource limits.

b) **Income** – Categorically eligible households do not have to meet gross or net income limits. However, the worker must insure that the income declared by the household is not handled differently under regular Food Stamp Program rules. For example, if a member of the SFSP household is an eligible student, some income disregarded under SFSP rules may be counted under regular Food Stamp Program rules. See FSC 5000 for an explanation of countable income.

c) **Deductions** – The worker must carefully examine the household's most recent application (DCQ-180 or DCO-220) to determine if there is adequate information to determine the household's current deductible expenses. This includes dependent care costs, medical costs for disabled members and/or members age 60 or older, and shelter costs. The rules for determining allowable deductions under regular Food Stamp Program rules may be found in the 6000 section of the Food Stamp Certification Manual.

Example 1 – A household contains a member who receives SSI. The household is currently using its actual shelter costs in place of the county shelter standard. No medical expenses or dependent care costs were declared. This case contains adequate information to determine the household's current expenses.

Example 2 – No member of the household receives SSI benefits, and on the most recent application, the household declared a rent amount but no utility costs. This case does not contain adequate information to determine the household's current expenses.

If additional information is needed to determine the household's current expenses, the worker must use the attached notice with a *Notice of Action* (DCO-1) to request the needed information. See Attachment 2. The household will be allowed ten days to provide the requested information. If the information is not provided, the expense will be disallowed. The case will not be closed solely because the household failed to provide requested information about expenses.

When a household is converted from the SFSP to the regular Food Stamp Program prior to recertification, either the household's actual utility costs or the utility standard will be used in the budget. Any costs incurred by the household for rent or mortgage payments, real estate taxes on the home or homeowner's insurance will also be allowed as a shelter cost.

Based on the information provided by the household on the notice, the worker will determine if the household is entitled to use the utility standard of $172 when the food stamp budget is calculated.

If the household is not entitled to the utility standard, the household's actual declared utility expenses will be used in the budget. When actual utility costs are allowed, the telephone standard of $25 must be used as the telephone cost if the household incurs a telephone expense.

If the household is entitled to the utility standard, the worker will determine if the household's actual declared utility expenses (including the $25 telephone standard for households that incur a telephone expense) amount to more than the utility standard of $172. If yes, the actual utility costs will be used in the budget. If no, the utility standard will be used in the budget.

d) **Issuance of Benefits** – A categorically eligible household with one or two members will always receive at least $10 in food stamp benefits. Categorically eligible households with three or more members will receive a minimum benefit of $2.00 only if the Thrifty Food Plan reduced by 30% of the household's net income is at least $1.00. If the benefit calculation is less than $1.00, the household will not receive benefits and will be handled as an otherwise eligible household as explained in FSC 8641.

e) **Change Reporting Requirements** – Prior to conversion from the SFSP to the regular Program at recertification, SFSP cases will be subject only to the TEA reporting requirements. See TEA 10300 for an explanation of handling changes reported to the TEA worker.

Once a household is converted back to the regular Program, that household becomes subject to both the TEA reporting requirements and the Food Stamp Program reporting requirements. See FSC 11100 – 11200 for an explanation of the food stamp reporting requirements.

If the household is being converted prior to recertification, the worker must issue to the household a *Change Report Form* (DCO-234) and a business reply mail (BRM) envelope. If the household is being converted at recertification and will become subject to quarterly reporting as explained in FSC 11510, the worker must issue to the households a copy of the pamphlet, *Food Stamp Quarterly Reporting* (Pub-360). The worker should briefly cover the information in the pamphlet with the household. Former SFSP households not subject to quarterly reporting will be given a *Change Report Form* (DCO-234) and a business reply mail (BRM) envelope. The worker should explain to the household the items to be reported for TEA purposes and the items to be reported for food stamp purposes.

f) **Certification Periods** – At the time of conversion, the worker must note the household's certification period. If the last month in the certification period is October 2000 or later, the worker must shorten the certification period at the time of conversion. Enter the new ending month and year of certification via the automated system in use in your county. DO NOT REKEY THE BEGINNING MONTH OF CERTIFICATION.

g) **Notices/Forms** – At the time the case is converted from the SFSP to the regular Food Stamp Program, the household must be notified of the change in reporting requirements. If the household's food stamp benefit amount will change, the household must be notified of this change. If the household will receive fewer benefits as the result of the change, the notice must act as an advance notice of adverse action. A notice has been prepared to use with the *Notice of Action* (DCO-1) to serve this function. See Attachment 3. At any recertification, the household must be issued a copy of the pamphlet, *Food Stamp Program, Your Rights and Your Responsibilities* (PUB-279). See FSC 10540.

SHORTENING CERTIFICATION PERIODS

If a household participating in the SFSP has a certification period ending in October 2000 or later, that household's certification period must be shortened to end in September 2000 or earlier. Each county office will be allowed to determine how to schedule the recertifications for these households. A report was supplied to each county office accompanied by a memorandum of instruction. This report furnished the following information:

- Casehead Name
- Casehead SSN
- SFSP Code
- Categorical Eligibility Status Code
- Certification Beginning and Ending Dates
- TEA Amount

Copies of this report were maintained in the Food Stamp Section.

A second report will identify each household not classified as a SFSP household if the household meets the SFSP criteria and has been assigned a 12-month certification but is not subject to QR. This report, which will only be generated once, is intended to help the county office identify cases that are being handled as SFSP cases even though the case is improperly coded. If the county is handling the case as a SFSP case, the coding must be corrected. If the certification period ends in July or later, the household's certification period should be shortened using the county office's predetermined criteria. If the household should not be classified as a SFSP case, the county office should determine if the household should have been assigned a 12-month certification period according to FSC 8710. If not, the certification period should be shortened. To shorten a certification period, the worker must enter the new ending month and year of certification. THE BEGINNING MONTH OF CERTIFICATION MUST NOT BE REKEYED.

On the night of the third workday, A *Notice of Expiration* (DCO-239) is automatically generated for all households with a certification period ending the following month. For example, on February 3, DCO-239s will be generated for all households with a certification period ending in March. If shortening the household's certification period means that a DCO-239 will not automatically be generated, the county office must manually prepare a DCO-239 to be issued to the household. See FSC 11430 for additional information about shortening certification periods. See FSC 10210 for instructions about completion of the DCO-239.

The DCO-239 and an application must be mailed to the household so that the household will receive the form any day of the next to last month of the shortened certification period. (Example – If the certification period ends in May, the household must receive a notice of expiration any day during the month of April.)

MAINTAINING SFSP RECORDS

All records pertaining to a household's participation in the SFSP must be maintained for three full years from the month of origin in either the food stamp case file or the TEA case file.

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MAINTAINING SFSP RECORDS

All records pertaining to a household's participation in the SFSP must be maintained for three full years from the month of origin in either the food stamp case file or the TEA case file.

POLICY ISSUES

1. Changes Reported to the TEA Worker

Changes reported to the TEA worker are considered to be information known to the agency. These changes must be reflected in the food stamp case even if the household is subject to quarterly reporting. See FSC 12300 to FSC 12330 for instructions on processing changes reported to the TEA worker and issuing notices to these households.

2. Special Payments

Any Employment Bonus (FSC 5701.2) must be counted in the food stamp budget in the month of anticipated receipt. Any Extended Support Transportation Payment (FSC 5701.3) must be counted in the food stamp budget in the month of anticipated receipt to the extent that the payment does not exceed the household's actual job-related costs of transportation. These rules apply to both quarterly reporting and occasional reporting households.

Inquiries to: Betty Helmbeck, Food Stamp Section, (501) 682-8284

ATTACHMENT 1

Arkansas Department of Human Services (DHS)
Division of County Operations (DCO)

FOR OFFICE USE ONLY

		ACES REG #	APP DT	COUNTY	CAT.	ADULTS	CHILD	WORKER #	WORKER NAME	MRT	KEY DATE	OP. INT
REG	1											
	2											

		WORKER #	DENIAL DATE	REASON	CATEGORY	CN	KEY DATE	OP. INT
DEN	1							
	2							

Application For Transitional Employment Assistance

- If you need this material in a different format, such as large print, contact your DHS county office.

INSTRUCTIONS - Please fill out as much of the application as you can and return it to the DHS county office. The date the DHS county office receives the application is your date of application.

- You must have an interview with a case manger before your application for TEA can be processed.

- Please answer all questions as completely and as accurately as possible. If you do not understand a question the caseworker you speak with will help you. If you do not have enough space for your answer, attach another sheet of paper to this application.

SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	MI	BIRTH DATE	RACE	SEX	

MEDICARE NUMBER	MARITAL STATUS	TELEPHONE NUMBER WHERE YOU CAN BE REACHED

STREET ADDRESS	CITY	STATE	ZIP CODE

MAILING ADDRESS (IF DIFFERENT)	CITY	STATE	ZIP CODE

Please list everyone in your home and complete each space by their name:

Social Security Number	Name Last	First	Birthdate	Race	Sex	Relationship to you	Is this person a US Citizen	Legal Alien	Other	Office Use Only MRT
	APPLICANT									

Does anyone in your household have earned income? YES ☐ NO ☐
If yes, enter gross amount $_____.
Does anyone in your household have unearned income (such as Social Security, SSI, Child Support, Unemployment benefits)?
YES ☐ NO ☐
If yes, enter the name of the person who receives any type of income listed above and the total monthly payment.

Name _____ Amount _____
Do you expect a change in any of the above? YES ☐ NO ☐ If yes, what and when?_____

Family Planning - I may be eligible for Family Planning Services and:

- ☐ I do want Family Planning Services
- ☐ I want more information
- ☐ I do not want Family Planning Service

Is anyone in your household pregnant? ☐ YES ☐ NO

Child Health Services (Health Checkups) The health checkup program has been explained to me and:

- ☐ I do want this service for all eligible persons
- ☐ I do want this service for only the following persons: _____
- ☐ I do not want this service.

Unpaid Medical Expenses

Do you have any unpaid medical expenses from the past 3 months? ☐ YES ☐ NO

Would you like to register to vote? ☐ YES ☐ NO

DO YOU HAVE?	YES	NO	OWNER'S NAME	Total Value	OTHER
Cash or savings				$	
Certificates of Deposit (CD) Credit Union Accounts				$	
				$	Bank Name
Checking accounts				$	Bank Name
Stocks, bonds, IRAs Keogh Plans, Mutual Funds				$	
Real Estate other than your home				$	Location Amount Owed $
Other (Prepaid burial plans, trust funds, etc.)				Total Value $	Description -

How many cars, trucks and vans do you and the members of your household have? _____

Please list below:

Make & Year	Amount Owed	Who Owns	Medical Benefits
			YES ☐ NO ☐
			YES ☐ NO ☐

- Do you or anyone in your home own or are you buying other buildings or property? ☐ YES ☐ NO
- How have you been meeting your expenses for the past 6 months? _____
- Do you or any other household member pay money for a room or meals to a person with whom you live? YES ☐ NO ☐
- Are you or any other household member now disqualified, or have you or any other household member ever been disqualified from the AFDC or TEA Program for providing incorrect information or for failing to provide information that affected eligibility and benefits? YES ☐ NO ☐
  If yes, which program? _____
- Have you or a member of your household been found guilty of or plead guilty or nolo contendere to a felony offense involving the manufacture or distribution of a controlled substance on or after July 1, 1997? YES ☐ NO ☐

READ THE FOLLOWING CAREFULLY BEFORE YOU SIGN THIS APPLICATION.

I understand that I must help establish my eligibility by providing as much information as I can about my circumstances.

I authorize DCO to obtain information from other state agencies and other sources to confirm the accuracy of my statements.

I understand that no person may be denied TEA or Medicaid benefits on the grounds of race, color, sex, age, handicap, religion, national origin, or political belief.

I may request a hearing from DHS if a decision is not made on my case within the proper time limit or if I disagree with the decision.

I agree to notify the DHS county office within 10 days if I or any of my dependents cease to live in my home, if I move, if I become employed or my earnings change, or if any other changes occur in my circumstances.

I authorize DHS to examine all records of mine or records of those who receive or have received Medicaid benefits through me to investigate whether or not any person has committed Medicaid fraud, or for use in any legal, administrative or judicial proceeding.

I understand that cash assistance will be limited to twenty-four (24) months of my lifetime.

CHILD SUPPORT ENFORCEMENT REQUIREMENTS

TRANSITIONAL EMPLOYMENT ASSISTANCE (TEA) - I understand that if I accept TEA cash assistance, by state law, I will have assigned all rights, title, and interest in any support that I have in my own behalf or in behalf of any other person for whom I am receiving TEA. I understand that all support payments including those received by me directly from the absent parent, are to be paid to the Office of Child Support Enforcement. I understand that this assignment ends when I no longer receive TEA except as to any unpaid support obligation that has accrued at the time my TEA case is closed. I also understand that as a condition of eligibility for TEA, I must cooperate with the Office of Child Support Enforcement in establishing paternity and obtaining child support.

MEDICAID - As a condition of eligibility for Medicaid, each applicant or recipient must cooperate with the Office of Child Support Enforcement (OCSE) in establishing paternity and obtaining medical support for each child who has a parent absent from the home. All other OCSE services, including collection of child support payments from the absent parent, will be provided unless OCSE receives a written notice from me that I do not want these services.

ASSIGNMENT OF MEDICAL PAYMENTS

I authorize any holder of medical or other information about me to release information needed for a Medicaid claim to DHS. I further authorize release of any information to other parties who may be liable for my medical expenses. As an eligibility condition, I automatically assign my right to any settlement, judgment, or award which may be obtained against any third party to DHS to the full extent of any amount which is paid by DHS on my behalf. I authorize and request that funds, settlement or other payments made by or on behalf of third parties, including tortfeasors or insurers arising out of a Medicaid claim, be paid directly to DHS. My application for Medicaid benefits shall in itself constitute an assignment by operation of law and shall be considered a statutory lien of any settlement, judgment, or award received by me from a third party. A third party is any person, entity, institution, organization or other source which may be liable for injury, disease, disability or death sustained by me or others named herein, including estates of said individuals. I also assign all rights in any settlement made by me or on my behalf arising out of any claim to the extent of medical expenses paid by DHS, whether or not a portion of such settlement is designated for medical expenses. Any such funds received by me shall be paid to DHS. A copy of this authorization may be used in place of the original.

Personal Responsibility Agreement

I understand public assistance is temporary as I seek to become self-supportive and economically independent. I understand that it is my responsibility to find and keep a job and to secure all other potential sources of income for the support of myself and my dependent children.

In return for public assistance, I agree to be held responsible for:

1. Looking for employment or following up on job referrals required by my case worker before, during, and after approval of my application for assistance.

2. Cooperating with my case worker in developing and following my Employment Plan. DHS has informed me that the supportive services described in the attached information will be available to me as needed to comply with my Employment Plan.

3. Accepting full or part-time employment that may be offered.

4. Not voluntarily terminating employment.

5. Ensuring that my children receive their age appropriate childhood immunizations. (I understand that I will receive guidance form my caseworker on how to achieve this without cost to myself.)

6. Ensuring that my school age children attend school.

7. If I am an unmarried minor parent, I will reside in the household of a parent, legal guardian, other adult relative, or in an approved adult-supervised living arrangement unless my caseworker approves other living arrangements. I understand that I should tell my caseworker right away if circumstances occur that require an alternative living arrangement.

8. Cooperating with the Office of Child Support Enforcement in seeking child support payments and/or establishing paternity.

I understand that in some circumstances the agency may determine that I had good cause for not complying with the above requirements and in certain unique circumstances I may be granted an extension or exemption of a specific program requirement. **I also understand that I must sign this Agreement in order to apply for Transitional Employment Assistance.**

I declare under penalty of perjury that the information I have provided on this form is true and correct. If I receive benefits for which I am not eligible because I withheld information or provided inaccurate information, such assistance will be subject to recovery by DCO. Any assistance I receive in the future may be reduced to recover this overpayment, and I may be subject to prosecution for fraud and fined and/or imprisoned.

Parent/Caretaker Relative Signature	Date
Parent/Caretaker Relative Signature	Date
Minor Parent Signature (if appropriate)	Date
Case Worker's Signature	Date

INSTRUCTIONS
TO
DCO-180
Application for Transitional Employment Assistance

Purpose

The DCO-180 is used as the application form for TEA, TEA Medicaid, and other Medicaid categories. The form will also be completed to add persons to existing cases in these categories. Also, this form will be the input document for registration and denial purposes.

Completion

The DCO-180 should be completed by the applicant/recipient except in the areas designated "For Office Use Only". Only in cases of illiteracy or disability which prohibits completion by the applicant/recipient will the caseworker complete the form. The caseworker will sign as both the caseworker and the person helping complete the form in such cases. Any changes or additions made on this form should be completed by the applicant/recipient or the caseworker who originally completed the form.

Only one form will be completed for applications made on a given day. For example, TEA and TEA Medicaid applications made by the same application on the same day will require only one form. Once a signed DCO-180 is received and registered, it will not be released to the applicant to take home.

For Office Use Only

A. Registration

Once the DCO-180 is signed and received by the county, it must be registered. Only one application can be registered at a time. For applications with multiple categories, all data must be entered for each registration. The top section designated "For Office Use Only" will be completed as follows:

Field Name	Description
Register No	These fields will be completed by the terminal operator. Once all registration data has been keyed and accepted, the system will display a register number. If registering multiple applications, list the register numbers in the same order as the categories were registered.
Application Date	The date (MMDDYY) the signed DCO-180 is received by the county.

County	The three digit county number.
Category	The appropriate two digit category code. If registering multiple applications, enter the category code for each type of application.
	Refer to the DCO-Users Manual for valid category codes.
Adults	The number of adults included in the application.
Children	The number of children included in the application.
Worker #	The last four digits of the worker's Social Security number or the assigned worker number.
Worker Name	Name of the worker whose number is entered in field 8.
MRT	If an MRT decision is indicated, enter "Y", otherwise, leave blank as the system will automatically default no "N".
Key Date	Completed by the terminal operator. The date (MMDDYY) information is keyed and accepted by the system.
OP. IN	Initials of the terminal operator keying information into the system.

B. TEA, TEA Medicaid Denials

If the application(s) is to be denied, then the denial section must be completed and forwarded to the terminal operation upon disposition. If denying more than one application with the same casehead, enter the appropriate two digit category code in the same order they were entered on the system as indicated in the category field. Each denial code should coincide with the appropriate category. Refer to the DCO Users Manual for a listing of the denial.

Field Name	Description
Worker #	The last four digits of the worker's Social Security number or the assigned worker number.
Denial Date	The effective date (MMDDYY) the application for assistance is being denied.
Reason	Two digit denial reason. Refer to the DCO-Users Manual for Denial Codes and Reasons.
Category	The two digit category code being denied.
CN	Client Notice. Y - System generated notice specific to Reason (Field 15) will be generated. N - System generated notice will not be generated. Worker will send notice.

Field Name	Description
Key Date	Completed by the terminal operator. The date (MMDDYY) information is keyed and accepted by the system.
OP INT	Initials of the terminal operator keying information into the system.

Routing and Retention

Form DCO-180 will be forwarded upon completion by the worker tothe terminal operator. If the transaction is accepted on line, the terminal operator will initial and date the form and return it to the worker. The form should then be filed in the case record and retained until the case record is destroyed.

ATTACHMENT 2

ARKANSAS DEPARTMENT OF HUMAN SERVICES
FOOD STAMP PROGRAM
REQUEST FOR INFORMATION

County_____ **Date**_____

Casehead's Name_____ **Casehead's SSN**_____

Worker_____

The Arkansas Department of Human Services, Division of County Operations, has been operating a Simplified Food Stamp Program for households where all members receive TEA benefits or a combination of TEA and SSI benefits. We will no longer be operating a Simplified Food Stamp Program in Arkansas. Effective March 1, 2000, we began converting all households from the Simplified Food Stamp Program to the regular Food Stamp Program.

Your household has been participating in the Simplified Food Stamp Program. In order to convert your food stamp case to the regular Food Stamp Program, we need some information. Please answer the following questions and return this form in the enclosed self-addressed, stamped envelope on or before _____.

1. Do you pay rent for your residence? **YES** ☐ **NO** ☐
   If yes, how much is your rent payment? $_____ each month.

2. Are you buying your home? **YES** ☐ **NO** ☐
   If yes, how much is your house payment? $_____ each month.

3. Do you pay utility costs for your residence? **YES** ☐ **NO** ☐
   If yes, enter your current monthly utility costs? (Do not include past-due costs.)
   $_____ Natural gas, butane gas or other heating fuel
   $_____ Water and Sewer
   $_____ Other (Explain _____)
   $_____ Electricity
   $_____ Telephone
   $_____ Garbage/Trash Pickup

   How do you heat your home? _____ What kind of fuel do you use? _____
   Do you use an air conditioner in the summer? **YES** ☐ **NO** ☐
   Do you live in a public housing project? **YES** ☐ **NO** ☐

4. Does _____ or _____ currently have medical expenses not covered by his or her Medicaid card? **YES** ☐ **NO** ☐
   If yes, please provide receipts, bills, or statements to verify his or her current medical expenses.

5. Do you or anyone in your household pay someone to care for a child or a disabled or elderly adult so that a household member can work, attend training or school, or look for work? **YES** ☐ **NO** ☐
   If yes, give name of person or daycare center._____
   Telephone number _____ Address _____
   Amount paid $_____ How often do you pay?_____

6. Does anyone help pay any of the costs listed on this form? **YES** ☐ **NO** ☐
   If yes, which costs? _____
   Who helps pay them? _____

Please sign here_____ **Enter the date here**_____

ATTACHMENT 3

tment of Human Services ... One ...
Program for ... us where ...

... changes in your circumstances

... when it goes up ...

ARKANSAS DEPARTMENT OF HUMAN SERVICES
FOOD STAMP PROGRAM
NOTICE OF CONVERSION

County_____ **Date**_____

Casehead's Name_____ **Casehead's SSN**_____

Manual Issuance Date 00

The Arkansas Department of Human Services, Division of County Operations, has been operating a Simplified Food Stamp Program for households where all members receive TEA benefits or a combination of TEA and SSI benefits. We will no longer be operating a Simplified Food Stamp Program in Arkansas. Effective March 1, 2000, we began converting all households from the Simplified Food Stamp Program to the regular Food Stamp Program.

1. Your food stamp case has been converted to the regular Food Stamp Program.
2. Your household is entitled to receive food stamp benefits until _____.
3. You were receiving $_____ in food stamp benefits.
4. Beginning _____ you will receive $_____ in food stamp benefits.

Use the attached *Change Report* to report changes in your circumstances.

For food stamp eligibility:

- You must report changes in your total household income when it goes up or down by more than $25 per month. (You do not have to report changes in your TEA check.)
- You must report new income from any source.
- You must report if income from any source stops.
- You must report if your household's liquid resources (cash, savings, stocks, bonds, etc.) increase to $2,000 or more.
- You must report the acquisition of any licensed vehicle.
- You must report changes in the number of people in your household.
- You must report any new address. If you move, you must also report your new rent or mortgage and utility costs.

For TEA eligibility:

- You must report any change in income regardless of the amount received or how often received.
- You must report if your household's liquid resources (cash, savings, stocks, bonds, etc.) increase to $3,000 or more.
- You must report the acquisition of any licensed vehicle.
- You must report your new address if you move.