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MEMORANDUM

To:	EES Chiefs and Staff	**Date:**	April 18, 2003
From:	Bobbi Mariani, Director Economic and Employment Support	**RE:**	Implementation Instructions KEESM Rev. 14 Effective May 1, 2003

This memo provides implementation instructions and information for the following May 1, 2003 KEESM changes:

Note the highlighted change in Item 7, page 5. This correction from the original instruction was transmitted to the filed on 5/1/03 in a Help Desk Message.

• Child Care Plan Termination - KEESM 1424, 1432, 7340, 7610, 7640 and 10610.

• Child Care Non-Cooperation with CSE - KEESM 2165.2.

• Extension of Time Limits for Domestic Violence Victims - KEESM 2244.

• Comparable Treatment for Disqualifications - KEESM 2550.

• Income Eligible Training-Employed (IE TC) Child Care - KEESM 2835.

• Work Program Assessment Process - KEESM 3130.

• Work Components - KEESM 3310.

• Work Experience - KEESM 3310.3.

• Job Skills Training/Post Secondary Education/Vocational Education Authorization Guidelines - KEESM 3322.

• Work Program Incorrect Payments - KEESM 11000.

• Medical Bona Fide Effort-Liquid Resources - KEESM 5200.

• Medical Temporary Care (Planned Brief Stay) - KEESM 8113.

• Dependent Care - KEESM 7224 and 7227.6

The May 1, 2003 KEESM is now available online on the KEESM home page. The hard copy is being issued to staff at this time. All changes will apply to cases processed May 1, 2003 and after.

1. **Child Care Plan Termination -** [See Summary of Changes, item IV, A.(2).] The

following examples help to illustrate this change in policy.

- Example 1 - Joan is employed and receiving EM child care for her child authorized at 215 hours per month. She loses her job effective 2/12/03. She found this out on 2/5/03. She reported this to her worker on 2/12/03. The worker takes action to terminate the plan and close the case effective 2/28/03. The February plan will stay at 215 hours. When the February time sheet comes in, if the actual hours billed are 215 hours or less, it will be paid and not considered a client or provider overpayment.

- Example 2 - Using Example #one, if Joan takes her child to child care after 2/12/03, it will be allowed and not considered an overpayment. Child care used between 2/12 and 2/28 will be considered authorized, whether the parent looks for work or not. Verification of a job search is not required.

- Example 3 - Using the previous examples, if Joan simply loses full-time employment and goes to part-time employment, she remains eligible for child care. This is a change which needs to be reported. The 215 hours authorized for 2/03 will remain authorized. The new hours needed and authorization will be effective 3/1/03.

2. **Child Care Non-cooperation with CSE -** [See Summary of Changes, item IV, A. (3).] The following examples help illustrate this change in policy.

   - Example - Kay has 3 children - Ben, Sean and Luke. All 3 children have different fathers. After child care plans have been set up for all 3 boys, Kay does not provide requested information to CSE on Luke's father. When the EES worker is notified by CSE of this non-cooperation, the child care plan for Luke will be terminated effective the end of the first month timely and adequate notice can be given. The child care plans for Ben and Sean will remain uninterrupted. Kay's total family share does not change. Luke will remain on the case without a child care plan. Any family share amount assigned to Luke's plan will need to be transferred to Ben or Sean's plan. If Kay cooperates with CSE, the reinstatement criteria listed in KEESM 1423 would apply. If cooperation occurs by the end of the month following the effective end date, child care plans are reinstated effective the closure date, if eligible. If cooperation occurs after that time period, plans will begin with the date of cooperation or request, if eligible. A new application is not required for reinstatement purposes unless the current review period has expired.

   The EES worker is usually notified of non-cooperation with CSE in two ways, a KsCares alert message and/or a Groupwise message. In cases with multiple children and multiple absent parents, workers will need to know which child is in question in order to terminate plans properly.

3. **Extension of Time Limits for Domestic Violence Victims -** [See Summary of Changes, item VII, A. (4).]

Screening for domestic violence issues needs to be completed up front in order to identify individuals who may be eligible for TAF assistance beyond 60 calendar months and also to avoid placing clients in components that may jeopardize safety. Suggested screening questions are in Appendix 102.

Following is an example that illustrates the policy intent:

- Example 1 - A TAF case is closed 5/31/03 because the client has received 60 months of cash assistance. In August 2003, the mother reapplies for TAF and indicates that she is a domestic violence/sexual assault (DV/SA) victim. The mother's statement and one piece of corroborating evidence meets the burden of proof requirement unless there is an independent, reasonable basis to doubt the statement. Evidence may include, but is not limited to, police or court records, protection from abuse (PFA) orders (filed for and/or obtained) or documentation from a shelter worker, attorney, clergy, medical or other professional from whom the client has sought assistance: or other corroborating evidence such as a statement from any other individual with knowledge of the circumstances which provides the basis for the claim, or physical evidence or domestic violence, or any other evidence which supports the statement.

Due to the presence of DV/SA, this closed TAF case can be reopened and assistance extended after the 60 month time limit has been reached. The client can continue to receive TAF for as long as the DV/SA barrier exists. This client needs to be participating in OARS or with a local DV agency in order to extend assistance. Six month progress reviews will help assess the status of this employment barrier and assistance can continue as long as domestic violence/sexual assault issues continue to negatively impact the client's ability to work.

This client should have an OR PRAP code and be in the OAR component on SESP during this extension period. This coding is important for federal work participation reporting and for identification of domestic violence situations if the state ever exceeds the 20% hardship provision. At the time that the client states that the domestic violence/sexual assault issues no longer negatively impact the client's ability to work, the TAF cash case would be closed.

3. **Comparable Treatment for CSE Disqualifications -** [See Summary of Changes, item V, A. (2).]

   The policy of not applying a comparable penalty to FS cases when the TAF participant fails to cooperate with CSE is to be implemented at the time of the next instance of non-cooperation that occurs on or after May 1, 2003. In addition, any failures to cooperate that are being processed on or after receipt of this Implementation Memo shall not be acted upon for the food stamp benefit month of May 2003.

   Persons currently being penalized on food stamp cases for failure to cooperate with CSE shall be re-added to the food stamp case at the time of the next review or case change involving household composition. A case file search to re-add persons disqualified for CSE non-cooperation is not required. Staff may, if they wish, identify

these persons and add them to FS cases prior to the next review or case change involving household composition.

The following notices are being end dated 4/30/03 as a result of this change: A281 (TAF/FS Denial-CSE Requirements Not Met), A483 (TAF/FS - 1st CSE Penalty), and A484 (TAF/FS - 2nd +CSE Penalty).

4. **Income Eligible Training - Employed (IE TC) Child Care -** [See Summary of Changes, item IV, A.(4).] The following examples help illustrate this change in policy.

   • Example 1 - Jose is limited in his English-speaking abilities. He is not in Work Programs. He needs to brush up on his English before he can start work. Child care for ESL classes may be authorized for a maximum of 6 months so he can pursue employment.

   • Example 2 - Sara is currently in college and will be finishing her teaching degree this semester. She is not on TAF. She will be starting her student teaching assignment this semester. Once she completes her student teaching she will graduate and be able to accept a teaching position. IE TC child care shall be authorized for her student teaching experience.

5. **Assessment Process -** [See Summary of Changes, item VII, A. (6).]

   The ES 4307, is being removed from the manual. The Self Assessment Form, Appendix 108, is the suggested format for areas to begin using in place of the 4307. This format is designed to engage the worker and the client using case management techniques and Beverly Ford concepts. Areas, however, have the flexibility to develop a tool that best meets their needs as long as the tool identifies the following : client's skills, prior work experience, employability, and motivation. Beginning May 2003, EES staff have 90 days to complete the work program assessment.

6. **Work Components –** [See Summary of Changes, item VII, A. (1).]

   Assignment to components should be based on individual client and family need and information gained during the assessment. For individuals with domestic violence and substance abuse issues, consideration should be given to prioritizing assignments in components that address those barriers (i.e., OAR or AOD).

   EES Management Areas will establish TAF and, if applicable, FS E &T work program progress review procedures to meet the area's unique situations. Progress reviews need to minimally occur every 6 months. The plan will include:

   • area's requirement for face-to-face progress reviews
   • area's requirement for frequency of progress reviews
   • area's requirement for use of 4309 in EAP progress reviews
   • area's requirement for job contact verification in job search components
   • area requirements for progress reviews may vary by county and those variations need to be addressed

   The Area Plan should be developed by June 30, 2003 and reviewed/updated as needed.

7. **Work Experience -** [See Summary of Changes, item VII, A. (5).]

   Background

   Prior to July 1998, EES allowed work experience assignments with private for-profit employers.

   EES made several policy modifications to the work experience component in July 1998 in order to address the U.S. Department of Labor guidance, "How Workplace Laws Apply to Welfare Recipients." These modifications include: Limiting the work experience component to nonprofit work sites; calculating the maximum number of monthly assigned hours based on the total cash assistance benefit and the food stamp allotment divided by the federal minimum wage; generally limiting participation in the work site assignment to 6 months.

   What are the May 2003 KEESM Work Experience changes?

   - Expanding policy to allow for work experience placements with private for-profit employers

   - Allowing a work experience reimbursement allowance to offset expenses associated with the work experience assignment. This reimbursement would be paid from the area TAF allocation

   - Adding procedural work experience information to the KEESM Appendix.

   These changes will be available in May 2003 and areas may utilize the work experience assignment with the private for-profit employers and the work experience reimbursement allowance.

   As areas plan for implementing these changes, consideration should be given to the following current existing policies related to Work Experience:

- Assignments to the work experience component should not exceed a six-month period unless a clearly documented reason substantiates a longer assignment (KEESM 3310.3 (2) (c))

- Grievance Procedures for Regular Employees of Businesses for Regular Employees of Businesses with OJT and/or Worksite Agreements (KEESM 1640)

   Why would an area want to implement the work experience changes?

   TANF Reauthorization Proposals will likely require Kansas to modify current component assignments in order to meet the federal work participation requirements. Enhancing and increasing utilization of work experience assignments may be needed to meet the federal participation requirements. In addition to the TANF Reauthorization provisions that will limit the activities currently counted for participation, other changes will negatively impact the state's ability to meet federal work participation requirements: increase in assignments to 40 hours per week;

increase the participation requirement from the current 50% to 70%; Kansas is scheduled to lose the waiver that currently allows counting job search and job readiness activities without the 6-week federal limit (October 2003).

When the July 1998 changes were implemented, some areas had successfully developed work site agreements and assignments with private for-profit employers. Areas may wish to develop these partnerships with for-profit employers and enhance employment possibilities for our clients.

Use of the work experience reimbursement allowance will allow areas to make work site assignments for more weekly hours than an assignment based on the cash and food stamp benefit amounts. This would promote assignments similar to actual employment and would also provide more hours of work participation.

Why would an area not want to implement these changes?

Areas may feel that they already have resources available to accomplish the goals of these work experience policy changes. Some areas may be working closely with WtW and/or WIA and our mutual clients may be utilizing paid work experience assignments and/or OJT's through WtW and/or WIA.

Areas may be reluctant to devote staff time to work site development with private for-profit employers. Areas may already be working with Vocational Rehabilitation partners and piggybacking on VR fee for service agreements that provide services that are similar to a paid work experience. Examples may include working with KETCH or providers that are developing actual job placements for a fee for service. A particular area may wish to utilize the TAF allocation for job development rather than a paid work experience. OJT is another option that is currently available to areas.

Areas may have already developed strategies that combine work experience with another component (i.e., job skills training) that would meet the increased federal work participation requirements proposed under TANF Reauthorization.

Areas may already be working with a contracted employment service provider (i.e., Job Readiness Training) that is providing an activity that is similar to a paid work experience. Areas may feel that this arrangement is meeting the needs of their clients at this time.

Work Experience Reimbursement Allowance:

Areas have the flexibility to issue TAF clients participating in work experience (profit and nonprofit) a Work Experience Reimbursement Allowance for additional costs associated with participation in work experience. The worker will use the W808 Work Experience Reimbursement Allowance Notice, to notify the client when the Work Experience Reimbursement Allowance has been authorized.

Note: TAF clients participating in work experience could be eligible for other support services (i.e., transportation, special services allowance, etc.) in addition to the Work Experience Reimbursement Allowance if there is a documented need.

The Work Experience Reimbursement Allowance is considered exempt income in the determination of cash and food stamp benefit amounts.

Calculation of the Work Experience Reimbursement Allowance:

Work Experience clients would routinely be assigned 24 to 40 hours per week. At the end of each month of the work experience assignment, the total number of work experience hours worked in that month based on the work site monthly report are multiplied by the federal minimum wage. The gross amount of the TAF grant and gross amount of the food stamp benefit for the month, including any supplemental payments during the month, are added together. If the TAF/FS total is greater than the number of hours worked multiplied by the federal minimum wage, there will be no Reimbursement Allowance. If the hours worked total is greater, the TAF/FS total will be subtracted from the hours worked total and the difference is issued to the client as a Work Experience Reimbursement Allowance.

This Work Experience Reimbursement Allowance payment would be made monthly. Payment Type is SS WP (Special Services). A new WP Service for Payment Code, LR Labor Standard Work Experience Reimbursement Allowance, has been added to identify these payments. The W808, Work Experience Reimbursement Allowance Notice, is available to send when this payment has been authorized.

- EXAMPLE OF REIMBURSEMENT ALLOWANCE CALCULATION -
  The client has worked 160 hours in work experience in February. 160 X $5.15 = $824.00. Gross amount of February cash ($300.00) and food stamp benefit ($141.00) total is $441.00. Since the hours worked at minimum wage is greater than the gross amount of cash and food stamp benefits, the EES Specialist will issue the difference of $383.00 ($824.00 - $441.00 = $383.00) as a Work Experience Reimbursement Allowance and send the W808 to notify the client of the payment.

  A new Work Program Activity code, WXP Work Experience With For-Profit Employer, has been added to the KsCares tables and should be utilized when a client is assigned to a for-profit work site assignment.

The calculation of the Work Experience Reimbursement Allowance is based on the information known at the time of the calculation. A Work Experience Reimbursement Allowance would not be considered as an incorrect payment if information that would have resulted in a different payment amount is discovered after the calculation and issuance of the allowance. For example, in the situation above it is later determined in April that the correct benefits for February cash should have been ($350.00) and the correct food stamp benefits should have been ($175.00) for a total benefit of $525.00. The client is issued those additional cash and food stamp benefits for February in April. Based on those benefits, the client would have been eligible for a $299.00 ($824.00-$525.00 = $299.00) Work Experience Reimbursement Allowance rather than the $383.00 payment received. The $84.00 difference would not be considered an overpayment because the Allowance was based on the information known at the time of the calculation. The supplement issued in April for February cash and food benefits would be used in the calculation of the April Work Experience Reimbursement Allowance.

9. **Job Skills Training/Post Secondary Education/Vocational Education Authorization Guidelines -** [See Summary of Changes, item VII, A. (3).]

This section of the manual has been modified to add information about Workforce Investment Act (WIA) and Kansas Board of Regents (KBOR) Waiver and Loan Programs. Additional flexibility related to approval of correspondence courses has also been added. Plans approved by WIA and KBOR programs are approved and countable activities for work program participation. Clients participating in WIA activities should be coded in the WIA activity. Participants in the KBOR programs would be coded in the Job Skills Training (JST) component. WIA has an established 30 hours of participation but JST hours in KBOR programs depend on the number of actual hours the client is participating.

Students attending post secondary institutions through a WIA plan may meet the eligible student criteria to receive Food Stamps. (KEESM 2350) Students in KBOR plans would need to meet the established criteria in 2530 in order to be eligible.

Correspondence courses may be authorized on a case by case basis if the course meets the criteria for approved Job Skills Training (i.e., assessment indicates client could be successful in the course, employment is available in the training field, number of projected openings in the chosen occupation should be equal to or more than the number of persons currently in training, and client is willing to move). Examples of approvable correspondence courses could include:

- Example 1 - Client is wanting medical record training but has current health problems that would limit participation in the training. On-line training could be approved to help move the client forward while health issues are also being addressed.

- Example 2 - Client lives in a rural community and has transportation problems. It is determined that training is appropriate for this client and on-line training in an appropriate curriculum is available. The client indicates that she would be willing to move to secure employment when training has been completed.

The Education/Training Assistance Desk Aide has been updated to reflect the May 2003 policy changes and is being re-issued with this Implementation Memo.

10. **Incorrect Payments -** [See Summary of Changes, item VII, A. (2).]

    This section has been revised to indicate that work program payments are unconditional and unrestricted and are not considered overpayments if used by the client for purposes other than those intended. Prior to May 2003, an area may have considered a work program payment that was not used for the intended purpose as an incorrect payment and established an overpayment on KsCares.

    A printout will be generated to help staff identify existing KsCares work program overpayments on closed cases. Work program overpayments caused by agency or client error on work program cases that have been closed for more than 3 years may be deleted and the paper file may be destroyed.

    Examples of situations that would not be considered overpayments with the May revision include:

    - Example 1 - Mandatory TAF client is working with VR. She finished her college

degree (VR plan) and was hired as a teacher in Oregon. Both EES and VR participated in the relocation plan by providing payments. The TAF cash case closed because the client was moving out of state.

After the client received the EES $1500 relocation payment and before she actually moved out of state, she found out that the job offer had fallen through because she did not have the correct credentials to teach in Oregon. She has spent the $1500 relocation payment. The $1500.00 is not considered an overpayment because it was made directly to the client and is considered unconditional and unrestricted. Note that these type of payments should be made directly to the provider whenever possible.

- Example 2 - A Special Services Allowance was issued to a TAF work program client to pay for car insurance because the insurance company would not accept a payment from SRS. It is discovered later that the client never paid for the car insurance. This payment would not be considered an overpayment because it was made directly to the client and is considered unconditional and unrestricted.

11. **Bona Fide Effort - Liquid Resources -** [See Summary of Changes, item VI, A. (1)]

For medical assistance, the countable value of some liquid resources is now reduced or eliminated when action is taken to ultimately convert the resource to an exempt burial plan. The reduced resource value is applied retroactively to the month the conversion process begins (or an application month in some instances) provided the time frames outlined are followed and the individual is fully cooperative in the process. For situations where cooperation is not received or the time frames are not met, the full value of the resource is countable until the month the conversion is complete. For implementation purposes, this is applicable to benefit months beginning 05-01-03. The full value of these resources is countable for benefit months prior to 05-03.

To demonstrate cooperation, the individual must follow through with any necessary action to complete the conversion process in a timely manner. Cooperation includes providing additional information to the company holding the resource, ensuring all necessary paperwork with the funeral home is in place (if applicable) and timely reporting to SRS when these actions are complete. In addition, the necessary actions must be completed by the time frames referenced in the KEESM. In general, verification that action to begin the conversion process must be obtained within 15 days of the application, or report of excess resources. However, for applicants, if the actual value of the resource involved is not discovered until a later date, the 15 days shall begin on the date of discovery. In addition, other delays may also cause a delay in the date the 15 day period actually begins, such as delayed requests for verification of a resource value. These situations should be documented to describe the course of events.

As long as the applicant is cooperating, the application shall continue to pend until the conversion process is complete. If this results in an untimely application, an untimely code of CV may be used. For recipients, the case shall be suspended until the conversion is complete. To suspend, an SU code is entered in the Benefit Issuance indicator on the KAECSES MSID screen, or the case may be deauthorized for the month. No record is recognized by the MMIS with either method, so eligibility

will not be set. It is important to realize that in either situation, failure to receive two continuous months of Medicaid eligibility records will result in the client falling of buy-in. It is also important that the recipient understand this may occur upon initiating this process.

The following examples illustrate application of this policy:

- Example 1: An MS AC application is received on 05-15 and a life insurance policy with a face value of $5000 and a cash surrender value of $5600 is reported (it is noted on the application that the policy is intended for burial). The life policy is a countable resource and, in combination with other resources (which total below $2000), the applicant has excess resources. Upon hearing about the burial plan exemption, the applicant's daughter decides to cash in the life insurance policy and prearranges a funeral. However, the plan cannot be funded until the proceeds from the life insurance policy are received. Verification that the request was sent to the insurance company on 05-25. The application will continue to pend until the life insurance monies are received, provided the applicant continues to cooperate with the process. On 07-05 the daughter reports that the life insurance check was received two days earlier. Verification of the exempt irrevocable burial plan and prepaid casket and vault are presented.

  The case is now processed. Because the agency received verification that the request to convert the resource was made within 15 days of the application and the conversion was ultimately completed within 90, the resource used to fund the burial plan (in this case the life insurance policy) is exempt beginning with the month of application. Without consideration of the burial plan, the individual is below the resource level and coverage is approved beginning in May.

- Example two: A MS application is received on 05-26 and the applicant reports a bank account. On 06-03 verification is received the account has a countable balance of $3000. A phone conversation with the applicant on this date indicates the client is saving for his burial. The burial policy is explained and he indicates he intends to establish a burial fund of $1,000 in a separate bank account. On 06-10, a bank statement reflecting a new burial account, as well as a statement of the ongoing account balance a re provided. Because the burial fund is an exempt resource, and the value in the ongoing account has been reduced to below $2000, resource requirements are met.

Because the 15-/90 time frames were met, the case is processed without consideration of the funds ultimately used to purchase the burial plan beginning in the month of application. The case is approved for the months of May forward.

12. **Temporary Care (Planned Brief Stay) -** [See Summary of Changes, item VI, A.(6)]

    The definition of temporary care (also called planned brief stay) has changed. Persons entering a facility or other medical institution for a stay not expected to exceed the month of entrance and two following months shall be processed using independent living budgeting methodologies (HCBS or Working Healthy also apply). Previously, a temporary stay was limited to the month of entrance and following month.

This change is applicable to all cases in which a member of the assistance plan is residing in a Medicaid approved institution on or after 05-01-03. The change does not impact those cases in which a member of the plan has left the facility prior to this date, regardless of processing dates involved.

All cases in temporary care on 05-01-03 which were initially processed under the old provisions must be reviewed to determine if the temporary care budgeting period is extended. To assist with this process, the monthly TC printout should be reviewed. This is a printout of all cases with an active TC living arrangement code on the KAECSES LOTC screen. It is sent to staff the first week of the month. In some situations, independent living budgeting may continue to be applicable. Note that cases processed prior to receipt of this memo in which LTC budgeting methodologies were applied, will remain in LTC budgeting unless other changes occur. It is not necessary to evaluate these cases and switch budgeting based on this change.

As indicated in the Summary of Changes, any stay initially processed, using the temporary stay time frames which actually exceed the specified time limit, must be switched to LTC budgeting no later than the third month following the month of entrance. Adequate notice is required when taking this action.

For example, Clara enters the Pleasant Hill NF on 06-07-03 from the hospital, which she was admitted on 06-02-03 following a fall. Clara's daughter tells you that she is expected to be return home by 08-31-03 and this is supported by the ES-2161. A level of care score is also obtained that verifies the need for NF care, since the stay is expected to exceed 30 days. The case is processed using independent living budgeting and a six month base is established. On 08-15-03, the NF is contacted to double check on Clara's status. The NF reports that Clara will be leaving soon, but they don't know when she will be released. The doctor is coming next week and they can provide additional information after that date. A second contact is made with the NF on 08-24-03, and you discover that she will be staying for at least another week. Because the NF stay will now exceed the prescribed time frames, the case is adjusted and LTC budgeting begins. LOTC is also updated with the appropriate living arrangement/level of care codes and the patient liability is updated (if applicable).

13. **Dependent Care -** [See Summary of Changes, item I, A. (1).]

    The new policy for the treatment of dependent care expenses is to be applied to all applications received or processed on or after May 1, 2003. For ongoing cases, the new policy shall be applied at the time of the next review or case change involving dependent care expenses.

    As stated in the Summary of Changes, the fact that a family share has been determined is adequate verification of the obligation to pay dependent care expenses. Changes in the family share is information known to the agency and these changes must be acted upon providing timely and adequate notice as required.

    For households without a Child Care case, verification of the amount obligated is required to initially establish the deduction. (Refer to 1322.2(4).)

For households not subject to monthly reporting, changes in the amount obligated are not required to be reported. If, however, a change is reported, the verification rules of 9311.2 are applicable; i.e. if an increase in benefits will result, the expense must be verified. If a decrease will result, the expense must be verified at the time of the next review.

For households subject to monthly reporting, dependent care expenses are still required to be reported monthly on the monthly report form. Even though the form states to "attach proof", verification of a reported change is not required unless questionable. See 9211. *

The following notices are being end-dated as a result of this change: F705 (Chg in Benefits/Inc Chg No Dep. Care Verification) and V705 (Notice-Dependent Care Verification).

*** Note:** An error has been identified in Section 9211.2 of the May revision. Reference to mandatory verification of dependent care was inadvertently not removed from this section. A pen-and-ink errata will be issued after the hard copies of the May revision are issued to the field. The on-line version of the May revision has already been corrected

BM:PG:jmm

Attachment (1): Education/Training Assistance Desk Aide