Kansas Department of Social and Rehabilitation Services
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Integrated Service Delivery - Candy Shively, Deputy Secretary (785) 296-3271
Economic and Employment Support - Sandra Hazlett, Director (785) 296-3349

MEMORANDUM

To: EES Chiefs and Staff **Date:** August 29, 2000

From: Sandra Hazlett **RE:** Implementation Instructions for October 2000 KEESM Changes

This memo provides implementation instructions and information for the following October 1, 2000 KEESM changes:

GENERAL INFORMATION

1. **KEESM 2112(1) - Act in Own Behalf - Minors (SCL # 4)** - The definition of who may apply on behalf of a minor child is being expanded to allow individuals who currently meet the criteria to apply for prior medical for the child. This is applicable in situations where the adult was not able to apply on behalf of the child in the prior period. Eligibility determinations for these months shall be based on the child's circumstances during that particular month. This would include consideration of the needs and income of any legally responsible persons living with the child in the month for which coverage is being determined.

   This policy clarification was coordinated with Children and Family Policy staff and should be most beneficial to children for whom a Social Service plan has been developed and approved, but prior medical coverage is also needed. Although it can be applied in other situations, it may be necessary to obtain an application for the family the child was living with in order to accurately determine eligibility. It is appropriate to deny requests for prior coverage if sufficient information cannot be obtained from the current caretaker to determine eligibility.

   For example, an aunt requests prior and current medical coverage for her nephew who has recently moved in with her. Prior to this month, he was living with her sister, also the child's aunt. The only income the child has is $200/month in child support. In this situation, the child was not living with any legally responsible persons in the prior months so eligibility is determined based solely on the child's needs and income. It is also determined that other applicable general and non-financial eligibility have been met (such as citizenship and residency). In this situation, eligibility can be determined for the prior period.

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In contrast, that same child was living with his mother and siblings prior to moving in with his aunt. Additional information, including proof of the mother's income, is requested for the prior medical determination. The aunt indicates that she does not have her sister's income for the prior months. Therefore, eligibility is denied for the prior months because eligibility cannot be determined. The child's mother should be encouraged to reapply, as her income, etc will ultimately be needed in order to accurately determine eligibility.

At the recommendation of the Implementation Planning Team a new notice, the V046 - Prior Medical Information Request has been developed for use when requesting information specifically needed for prior medical determinations.

2. **KEESM 2210 - Child in Family (SCL #9)** - EES staff may verify that a home school is registered by contacting the Kansas Department of Education at (785) 296-1978. They maintain a database of registered home schools.

3. **KEESM 3310.23 - On-the-Job Training (SCL #58)** - The Workforce Investment Act (WIA) replaced the Job Training Partnership Act (JTPA) effective 7/1/00. For the Food Stamp Program, USDA has been contacted to determine if the income provisions applicable to JTPA now apply to WIA. A reply has not yet been received. The manual will be updated when this information is known. Until that time, staff shall assume that the income provisions applicable to JTPA as described in KEESM 6410 (32) are applicable to WIA.

4. **KEESM 11126.3 - Claims Discharged Through Bankruptcy (SCL # 97)** - The Central Office TOP Unit is Teri Alford. She can be reached on Groupwise and by phone at 785-296-2970. Mailing address is PO Box 2003, Topeka, KS 66601-2003.

5. **KEESM 11280 - Fraud Overpayment Recovery (SCL # 101)** - Effective with this revision, an FS repayment agreement must be sent even if the client has already signed a restitution agreement with the agency or with a court. A special notice has been developed that can be used in these situations that addresses the fact that an agreement has already been signed. This new notice is the F835, and it will be available for use in late September. As noted in the manual material, a repayment agreement (demand letter) is required by federal Food Stamp Regulations before the Treasury Offset Program can be used to collect a delinquent overpayment.

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HEALTHWAVE/MEDICAID

1. **General Information** - As noted in the SCL for KEESM Rev. 3, the new policies take effect on any application processed, or any children added, on or after October 1, 2000. For ongoing cases, the change to the family continuous eligibility period is effective with the next scheduled review. These new policies also apply to any prior medical determination connected with those applications or requests for coverage.

KEESM 2640 and subsections - Medicaid Poverty Level Eligibles (SCL # 17 - 26) and KEESM 2700 and subsections - Requirements Specific to the HealthWave Program (SCL # 32 - 43) -

1. **Family Continuous Eligibility Period** - Individuals determined eligible on or after 10-01-2000 for MP, MA-CM or TAF shall have a continuous eligibility through date consistent with the rest of the family unit. This concept, called a family continuous eligibility period, is being introduced to streamline the addition of new children into the plan and provide consistent coverage periods among family members. It also provides for the elimination of the formal review requirement when the request is made to add children to an existing family group.

2. **Establishing the Family Continuous Eligibility Period** - A family continuous eligibility period is initially established by the continuous eligibility period of the children and/or pregnant women in a household with an MP, MA-CM or TAF program. For most families, this period is the same for all of the children in the household and the implementation of this policy will not cause a significant change. The current policy of aligning the continuous eligibility periods for Medicaid children with that of the HealthWave children shall continue. However, Medicaid eligible pregnant women and newborn babies eligible under the provisions of KEESM 2646 shall have continuous eligibility periods determined independent of the family continuous eligibility period that may result in differing periods within a single family group. For purposes of determining the family continuous eligibility period, the following priority order shall be used to determine the family continuous eligibility period when this occurs:

    a. Non-pregnant, non-newborn children

    b. Pregnant children or women

    c. Newborn children

    If more than one child in either item above is present, the period farthest in the future establishes the family continuous eligibility period.

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3. **Adding Children to a Plan** - When children are added to an existing family group (including those where only a pregnant women is eligible) a formal review is no longer required to be completed. Instead, specific information on the child shall be obtained from the family to ensure general eligibility requirements have been met. The child's name, birthdate, Social Security number (if Medicaid eligible), citizenship status (including verification of alienage), parents names, income and insurance information are needed. If other general eligibility requirements are met (such as residency and act in own behalf) the child shall be added to the plan beginning the month the request is received.

    Please note, for purposes of this material, recipient children are individuals under the age of 19 currently eligible for HealthWave or Medicaid under the MP, TAF or

MA-CM programs on the day the request is made for continuing coverage or, if an application is required, the date the application is received.

4. **Adding Recipient Children** - If a request for ongoing coverage is made for a child who is a current recipient as defined above, the child's coverage will be protected and will continue as long as the new family is cooperating in adding the child. To further facilitate continuing coverage, all children shall remain on the initial plan through the month following the month the change is reported. This should give the new family sufficient time to report the change and request coverage for the child in the new household. This extension of benefits on the previous case is not necessary if the child is being added immediately to the new plan or if it is known that the child has moved and is no longer eligible (such as entrance into a jail or a move out of state), unless the child is HealthWave eligible in the new household and because he or she is being added to the new plan after the first medical card cutoff, a break in coverage results.

   If the child is being added to a plan with an open MP program, the child is added beginning the month following the month coverage terminates on the previous plan, in order to prevent duplicate coverage. Because the child is continuously eligible based on the previous determination it is not necessary to complete a comprehensive eligibility determination for the child in the new family. The child shall be added and eligibility determined based on the current income budgeted for the new household. It is not necessary to obtain additional income or household information (unless the family is a premium paying family described below). For simplicity, any legally responsible persons the child brings into the plan shall not be added until the next formal review. The type of coverage the child is eligible for (Medicaid or HealthWave) is determined by the circumstances of the new family. It is not necessary to protect the type of coverage as long as the child is eligible in the new household. However, if the child is NOT eligible in the new family, the child shall retain the type of coverage he had on the previous case. Because the new child is being added to a plan with currently eligible children, instances where coverage must be protected should be relatively rare In either situation, the child is eligible through the end of the new family's continuous eligibility period.

   For example, a Medicaid eligible child living with his grandmother returns home to live with his mother and HealthWave eligible half-brother. On 12-15-2000 the child is removed from his grandmother's case effective 12-31-2000 and added to his mother's case effective 01-01-2001. Because of his mother's income, the child now falls into the HealthWave income range. HealthWave coverage is effective for this child effective 01-01-2001 through the end of his brother's continuous eligibility period.

   If this same child had insurance coverage that makes him ineligible for HealthWave, the type of coverage the child initially had, Medicaid, is provided through the end of the brother's continuous eligibility period.

   If the child is being added to an open MA-CM or TAF plan, follow the guidelines of those programs to add the child. However, if the child is not eligible, coverage shall be provided under the MP program as described above.

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If the child is being added to a family group without an open MP program, a new application must be obtained from the family. The application is being used as a vehicle to gather necessary information on the child and caretaker (such as address) and to ensure basic eligibility requirements (such as residency and act in own behalf) are met. Although an application must be completed, it is NOT necessary to complete a formal review. A review may be completed if it is determined that it is in the best interest of the family to do so (see below).

If a formal review is completed and the child remains eligible, a new twelve month continuous eligibility period begins. The type of coverage is determined by the new family's circumstances and a coverage change may result. If a formal review is not completed or the family fails to cooperate with the review process or the child is ineligible based on the review, the child shall be added to the case and coverage provided, under the original coverage type (HealthWave or Medicaid), through the end of the original continuous eligibility period. Any LRP's for the child shall be added to the case as well. It may be necessary to override MERE in order to provide the correct type of coverage.

Note that a formal review will be necessary if coverage is requested for additional children. However, in the event the review is denied, coverage shall be protected as described above only for the recipient child.

The protection of continuous eligibility from a previous household only applies when the request or application is received if the child is a current recipient. If the request is made after coverage has already terminated on the initial case, no protection is provided for the child and he is added to the plan as described below and in KEESM 2783.2(1) (b) or 2648.2(1)(b).

5. **Adding Non-recipient Children** - A formal review is not required to add a non-recipient child to a current MP, MA-CM or TAF program. However, a full eligibility determination must be completed for the child. All general eligibility requirements (such as citizenship/alienage, residency, act in own behalf, age and SSN for Medicaid eligibles) must be met as well as financial and non-financial criteria. Coverage for this child is not protected as it is for a continuously eligible recipient child.

   To determine eligibility for MP, the child will be added beginning the month of request. Income currently budgeted on the case for any individual who will be part of the plan shall be used to determine the child's eligibility. It is not necessary to secure new income verification when the income has previously been verified. Income and state employee status of the child and any LRPs who have not previously been included in the determination must be obtained. Income of these individuals must be verified and converted for budgeting purposes. If the family does not cooperate in the process, the child is not eligible.

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6. **Prior Coverage** - Even though a formal review application will not be required, prior medical coverage is available for up to three months prior to the month of request. Income already budgeted and converted on an existing MP program shall be used to determine eligibility for prior coverage. It is not necessary to use actual income amounts if the income is currently budgeted. However, actual amounts shall be used to budget new income sources that the child and/or LRP's bring into the determination.

   For example, a request to add a child to an existing MP program consisting of the child's mother and two siblings is made on 02-05-01 and prior coverage is requested. The child has child support income that varies from month to month and the mother is employed. To determine eligibility, the mother's converted income already budgeted on the MP plan is used. The actual amount of the child's child support received in each month is used for the specific month.

7. **Newborn Children** - Newborn children not born to recipient mothers (as defined in KEESM 2646 and 2793) are added to an existing MP program in the same manner as older, non-recipient children. A formal review is no longer required and eligibility is determined based upon the current situation of the household. Income currently budgeted for existing household members shall be used to determine eligibility. New legally responsible persons not previously included in the plan shall be added in order to determine eligibility. If eligible, prior coverage may be provided if the birth is reported within three months following the month of birth. If the newborn is HealthWave eligible, a HealthWave Change Request Form shall be completed to add the child to HealthWave effective the month of birth. Children born to recipient mothers continue to qualify for automatic coverage, with the length of coverage determined by the type of coverage.

8. **Impact on Premiums** - If the family is a premium paying family and the addition of the child either reduces or eliminates the premium, the change is effective the month following the month of the request to add the child. If the addition of the child increases or initiates a premium, the change is effective the first month the new child is eligible. If the child being added is a newborn child, the premium change is effective the month following the month of birth. If the family reports a change in income that may reduce or eliminate the premium at the time a new child is being added, the new income amount shall be budgeted beginning the month following the month of the request to add the child is made. Either situation may require a HealthWave Change Request Form to ensure the family is properly billed.

   KEESM 2770 also includes clarification for treatment of cases with overdue premiums that were reviewed in error. This is described in greater detail in a separate memorandum addressing new premium reports.

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9. **Pregnant Minors** - Changes are also being implemented for individuals under the age of 19 eligible for Medicaid under the pregnant woman category. A formal review is no longer required at the end of a pregnant minor's postpartum period, unless it is otherwise scheduled to occur. Prior to the first medical card run in the final month of her postpartum coverage, a determination of ongoing eligibility will be made. The

PP/PW coding shall be removed and eligibility determined based upon the current information on the family. The determination shall include all members of the assistance plan (siblings, LRP's, newborn, etc). If eligibility exists, she shall be placed in the new category (Medicaid or HealthWave). If there is no eligibility coverage terminates on the last day of her postpartum period. However, coverage for her newborn continues through the month of his first birthday.

10. **HealthWave Eligible Children** - It is important that action be taken as quickly as possible to add children to the new plan. If, in the new household, the child is HealthWave eligible, a break in coverage may result if the case is not authorized by first medical card run in the month coverage terminates. Although a break in coverage results, the continuous eligibility period of the child shall remain in tact if the family is cooperating in the process. If a situation is encountered that provides for an optional MP review, the potential of a delay in coverage shall be considered in making the decision to complete the review.

    For example, a mother reports her son moved out of her household on 11-20-00 and the child is removed effective 01-01-01. On 12-27-00 a request is made to add the child onto his father's open MP case. Action is taken to add the child effective 01-01-01 and the child is HealthWave eligible. Because the request was made after first medical card run, a break in coverage results. Although the child is HW eligible through the end of the family continuous eligibility period of the new household, there is no coverage for January. HealthWave Change Request Forms are not appropriate to provide coverage when a gap month results in these instances.

11. **Optional MP Reviews** - Although no significant policy changes have been made, additional procedural guidance for completing formal MP reviews prior to the scheduled review is being included in this revision. This includes situations involving applications for other program involvements as well as applications for other medical programs, including MP. Additionally, it has been clarified that optional reviews shall not be completed if a family has overdue premiums.

    In general, an MP review that can be completed prior to the scheduled review shall be completed if it is the family's best interest to do so. Many factors are used in making this determination, including the child's current coverage, the stability of the family's current arrangement and the administrative effort to track any potential coverage changes. All of these factors shall be considered when determining if an optional review is to be completed. Because the majority of medical recipients are eligible under the Medicaid category, and will remain eligible under the Medicaid category, it is generally considered to be in the best interest of the family to complete optional reviews.

    Example 1: An MS application is received in 02-01 for the father in a family with three Medicaid eligible children. Except for the Social Security COLA increase, the income the family has remains consistent with what is currently budgeted. No change in coverage will result when the new income amounts are budgeted. In this case, the reviews can easily be matched up and no additional administrative action will be necessary. It is determined that it is in the family's best interest to

complete the review. The review date is set and the continuous eligibility through dates on PLGD are extended.

Example 2: A child care application is received for a family consisting of a father, mother and their two children, one Medicaid eligible and the other HealthWave eligible, in 11-00 because mother has taken a temporary job for the holidays. She states that she may decide to stay on if it works out for her. The family income has increased significantly with a second income source and would cause both children to fall into the HealthWave premium paying range. In this situation it would not be in the family's best interest to complete the review. It is not known if the income source will change and you must monitor both a coverage change and the establishment of a premium. The MP review through date remains as initially established and the Child Care review through date may be set to match that of the MP program or it can be set at twelve months.

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Example 3: An application for cash and food stamps is received in 02-01 for a mother and her two HealthWave eligible, premium paying children. The mother reports she lost her job several months ago and her unemployment has run out. However, they have moved in with her mother and both children receive child support. Cash assistance is denied (excess income) and food stamps are approved. The new income is budgeted on the MP case and the premium amount is eliminated effective 03-01. Both children will now fall into the Medicaid income range. In this case, it is determined that it is in the family's best interest to complete the review, as additional changes are not anticipated and we have opportunity to extend coverage for the family. HW coverage remains in effect until the end of the initial continuous eligibility period and coverage changes to Medicaid effective the next month. The MP review through date is extended to match that of the food stamp review.

With the implementation of the family continuous eligibility period and the elimination of the review requirement when certain household changes occur, an additional situation bears noting. When a current recipient child moves into a new, non-active household a review application is required. However, a formal review is not required to be completed as long as the child is living with a caretaker-relative and meets age and residency requirements. The situation shall be evaluated to determine if a formal review is in the client's best interest.

Example 4: It is reported on 10-13-00 that a HealthWave child living with his mother has moved into his father's household. The mother's case is closed effective 11-30-00. The father applies on 11-15-2000 and reports income well in excess of HealthWave standards. In this situation a review would not be in the best interest of the family. It is apparent that a child will no longer meet income standards in the new household and awaiting additional income information may delay case processing past the first medical card run for December. It would be in the child's best interest to provide continuing HealthWave coverage through the end of the initial continuous eligibility period.

As in example 3, when the optional review is completed and a coverage change results, the continuous eligibility period is extended. However, the continuous eligibility date on PLGD shall be left in place until end of the initial continuous eligibility period. KAECSES edits prevent automatic coverage changes during this time. By leaving the initial date on PLGD additional mechanisms to track the change in coverage are not necessary. An alert will be generated prior to the expiration of the continuous eligibility date. PLID should be reauthorized for the month following the end of the continuous eligibility through date and the new coverage type will be established. When the initial continuous eligibility date expires, the category of eligibility (Medicaid or HealthWave) is determined based upon the current situation. However, coverage must continue until the end of the continuous eligibility period, as the child continues to be eligible.

Example 5: A family with HealthWave eligible children, ages five and eight, have a continuous eligibility through date of 07-01 and apply for FS in 11-00. An MP review is completed and a decrease in income puts the younger child in the Medicaid range. The continuous eligibility date for the older child is extended to 10-01 but the continuous eligibility date for the five year old is left in place. Following the receipt of the alert due to the expiration of the continuous eligibility date, the case is accessed again in 06-01 to rework eligibility for the younger child, who turned six in 04-01. Because of his birthday, the child falls into the HealthWave range when the program is reworked. It is not necessary to change coverage in this situation, as HealthWave coverage was previously provided. A continuous eligibility date of 10-01 is entered on PLGD for this child.

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12. **Health Insurance/Crowd Out** - Comprehensive health insurance that is not reasonably accessible to the child will not impact eligibility for HealthWave. Reasonable accessibility is determined by the distance involved in traveling to the plan's enrolled medical providers. If the closest providers are located more than 50 miles from the child's home, this exception may be considered. However, this shall not be granted automatically solely based on distance. The additional factor of where residents of the client's community typically seek care must be considered.

13. **Implementation Issues** - For cases containing children with different continuous eligibility periods, action taken to convert to the family continuous eligibility period shall be taken at the time of the next review. In the event a child is added to a case prior to conversion into the family continuous eligibility period, the new child shall be added through the end of the review period.

    Over 1000 cases were identified that contain individuals with different continuous eligibility periods. However, the vast majority of these cases contained pregnant women or children under the age of 1, where different continuous eligibility periods are appropriate and will continue. Only about 50 cases contain other children with different continuous eligibility periods, so additional instructions have not been developed. However, if implementation issues are discovered as cases are being converted to the family continuous eligibility period, questions and concerns can be routed to EES Policy.

TAF ONLY RELATED CHANGES

1. **KEESM 2240 - Time-Limited Assistance (SCL #10)** - A printout that contains all TAF adults who are coded as DI on open TAF cases will be generated in early September 2000. During September 2000, EES staff shall send the newly developed KAECSES Notice V835 to all TAF households that contain an DI adult. This notice will inform households that months on assistance will now count in the 60 month lifetime limit.

   After October 1, these households will receive the KAECSES system generated notices regarding months on assistance.

2. **KEESM 3310 - Work Components (SCL # 51-61)** - Several changes in the component section are directly related to the issuance of the EES Contracted Employment Services Handbook. Components have been added, deleted and re-defined. Specifically, Employment Counseling/Comprehensive Job Coaching has been changed to Job Readiness Case Management. The information that was previously contained in the Job Development and Placement section (old section 3310.18) has also been incorporated in Job Readiness Case Management. The retention information that had been in the Job Development and Placement/Retention section is now in the Job Retention Case Management section (3310.18).

   Current clients who are in components that have been eliminated should be changed to the new appropriate component at the time of the next progress review. A printout listing individuals in the Employment Counseling (EMC), Job Development Placement (JDP), or Job Coaching (COA) components will be generated early in September. Although these current components will remain on the KsCares Table until June 30, 2000, staff should not place clients in these components after October 1, 2000. The Table will be updated to indicate that these codes should not be used after October 1, 2001. In June 2001, another printout of clients in components that are no longer appropriate will be issued before the codes are removed from the KsCares Table.

   A printout will also be generated listing all current clients in the On-the-Job (OJT) component. KEESM Revision No. 3 removes OJT's established by contracted EES Employment Service providers. At the next progress review, a determination should be made of the status of the OJT agreement.

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3. **KEESM 3310.3 - Applicant Job Search (SCL #52) and 3310.9 - Employment Assessment Process (SCL #55)-** The ES-3100, Application for Cash, Health Care, ChildCare and Food Stamp Benefits, currently does a good job of instructing clients of their responsibility to seek work as soon as an application is made. When the 3100 is next revised, it will be modified to further emphasize these responsibilities to seek employment and work on barriers to seeking and retaining employment from the date of the application for assistance.

   In implementing the policy change to begin the assignment of AJS and EAP activities with the date of application for assistance, Areas should review their

current procedures related to initial applications. Interviews on the same date as the application are the ideal. In situations where this is not possible, Areas are encouraged to explore options to enhance the notification to applicants of the expectation of immediately seeking employment and working on removing any barriers to seeking and/or retaining employment. Some options that Areas may consider adopting include: modification of notices given to applicants about their initial interview which emphasize the expectation; requesting applicants to answer questions on the ES 4307-Assessment Guide, and return to EES staff at the initial interview; add a sheet to the application that explains the expectation; add a sheet to the application that indicates the applicant should visit the local Career Development Center; and/or provide training to the front desk staff that this expectation of immediately seeking employment should be emphasized in the discussion with applicants when applications are left at the front desk.

4. **KEESM 3310.5 - Community Service (SCL # 53)** - Forced community service for TAF individuals who are on parole or probation is now an approvable work program activity. Actual scheduled service hours per week should be listed on SESP. These TAF individuals may be assigned additional weekly work program activities if the additional assignment addresses the individual's barriers.

5. **KEESM 3310.25 - Pilot Projects (SCL #59) -** In order to assure accurate information on the number of pilot projects that are being operated and report the correct work program participation for Federal reporting purposes, **PPR** should be entered on SESP for "0" hours in addition to the actual component and actual scheduled hours that are being piloted.

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6. **KEESM 3310.31 - Welfare-to-Work (SCL # 61)** - The WtW printout (SAR report ID number SWMC383C-R02) should be utilized to determine which TAF clients meet the new eligibility criteria (30 months of TAF) and have not yet been referred to WtW. These individuals should be referred to WtW within 90 days of the effective date of KEESM Revision No. 3 (i.e. December 31, 2000).

   Local Workforce Investment Boards (LWIB) are in the process of meeting and establishing significant barriers to self-sufficiency that meet the new 30% eligibility criteria. Areas should establish local plans for the implementation of referrals that meet this criteria.

   The WtW Referral Form (suggested format) is being modified to incorporate the 10/00 changes. This suggested format will be incorporated into the KEESM when it has been finalized with KDHR.

   Also attached is a Fact Sheet/Desk Aid that identifies the 10/00 WtW changes for TAF recipients.

   The procedural change to show an established 30 scheduled hours of component assignment for WWP, WWC, or WWG rather than recording the scheduled hours for the actual component assignments should be made on

cases at the next progress review or the next case change. The KsCares table will be updated effective October 1 so that the 30 hours of participation in these components will count toward the TANF Work Participation requirement.

Note: The WtW code establishes the referral to WtW and should not be deleted from SESP.

7. **KEESM 3530 - Good Cause (SCL #63)** - See separate Implementation Memo regarding domestic violence issues.

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TAF AND FS REPORTING CHANGE

KEESM 9310 - Responsibility After Approval for Non-Monthly Reporting Households (SCL #89) - The policy change to require non-monthly reporting households to report when the amount of earned income being counted decreases or increases by more than $100 per month shall be applied to all affected applications processed on or after 10/1/00. A new notice has been developed that staff can send to non-monthly reporting approvals with earned income. This notice, the V040 - Reporting Requirements, notifies the household of the reporting requirements for a non-monthly reporting household, and specifically notifies the household of the fact that they have to report when the gross amount of earned income increases or decreases by more than $100 per month. The notice also has a space for entering the amount of earned income currently being counted to assist the household in accurate reporting. This notice was developed at the suggestion of field staff.

For ongoing non-monthly reporting households, the policy change shall be applied to affected households at the time of the next review or case change involving reported earned income. Households should be sent notice V041 - Change in Earned Income Reporting Requirements. Non-monthly reporting households that report a change on the ES-1512, Change Report Form shall be sent a revised Change Report Form when supplies of the 10-00 revision are available from the warehouse. The system Change Report Form, F846, has also been revised to reflect the increased reporting amount and can also be sent to affected households.

FOOD STAMP ONLY RELATED CHANGES

KEESM 7226 - Shelter Costs and Increases in the Food Stamp maximum benefits, gross and net income limit (SCL #79) - The following increases in Food Stamp Program budget amounts will be implemented effective 10/1/00:

- Increase in the Maximum Excess Shelter Deduction from $275 to $300
- Increase in the Standard Telephone Allowance from $22 to $31
- Increase in the Maximum benefit amounts
- Increase in the Net Income Limit
- Increase in the Gross Income Limit

These changes will be processed automatically for all appropriate cases when rollover runs on the weekend of 8/26 and creates the month of October 2000. All cases affected by these changes will be identified on the Mass Change Reports available on SAR the following

Monday. Mass change notices will be automatically sent to all affected households on the 28th of August.

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CHILD CARE ONLY RELATED CHANGES

SRS Child Care Provider Agreement, ES-1641 (Rev. 10-00) (SCL- Forms, item f.) - Effective 10/1/00, this form should be used for all providers wishing to establish a Provider Agreement with SRS to provide child care services. The new form incorporates language to allow the provider to give consent for SRS and SRS contractors to publicly release information about the child care facility. The provider may also indicate that they do not wish to have information about their facility released publicly. The Provider Agreement shall not be delayed and/or denied if the provider indicates that they do not give consent for public release. Providers who do not give consent shall not have their information released to the public.

The Provider Agreement has also been revised to contain wording which would allow KDHE/Child Care Surveyors access to Registered providers for the purpose of determining whether the provider is in compliance with all laws for Registered Family Day Care Homes. All current and any new Registered providers will need to complete enrollment using the ES-1641 rev. 10-00 form. A report of all current Registered providers by area will be produced to assist in identifying these providers. All Registered providers should be enrolled using the new form before January 1, 2001.

In accordance with the Memorandum of Agreement between KDHE and SRS, KDHE will conduct annual unannounced visits to 25% of Registered Home providers who participate in the SRS Child Care Subsidy Program. The 25% sample will be pulled by SRS Central Office randomly and will be provided to KDHE Central Office for distribution to surveyors. By law, KDHE only can only make a visit to a Registered provider when there has been a complaint. Therefore, if a Registered provider who is part of the 25% sample does not allow admittance by the surveyor, KDHE cannot take any enforcement action. At that point the surveyor will contact the local SRS staff with the information. This can then be seen as a Provider Agreement violation and appropriate action can be taken by SRS. If the Registered provider does allow admittance by KDHE and violations are found, normal enforcement action will follow.

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RECAP OF NOTICES AND PRINTOUTS

NOTICES - The following is a listing of new/revised notices as a result of this revision:

F835 - Repayment Agreement (new)
F846 - Change Report Form (revised)
V040 - Reporting Requirements (revised)
V041 - Change in Earned Income Reporting Requirements (revised)
V046 - Prior Medical Info Request (new)
V835 - 60 Months for DI Persons (new)

PRINTOUTS - The following printouts will be generated to aid staff with implementation:

Early September - Printout listing all adults who are coded DI on open TAF cases. Staff should send the V835 to the TAF households containing these DI adults during September.

Early September - Printout listing individuals in EMC, JDP or COA work components. Staff should change to appropriate component at the time of the next progress review.

Early September - Printout listing individuals in OJT component. At the time of next progress review staff should make a determination of the status of the OJT agreement.

ATTACHMENTS

Fact Sheet/Desk Aid for 10/00 WtW Changes

SCH:PJ:jmm