

Case ID# \_\_\_\_\_

County Case # \_\_\_\_\_

Date \_\_\_\_\_

**Work First Family Assistance (WFFA) Application and Review Documentation Workbook**  
\_\_\_\_\_ County Department of Social Services

This is not an application. This is a workbook that will be used to collect the information needed to determine your eligibility for Work First Family Assistance.

*By applying for Work First Family Assistance (WFFA) you are also applying for Medicaid. Any information provided as a part of the application for WFFA will automatically be used as part of the Medicaid application, including citizenship status, immigration status, identity and social security numbers. Notify the caseworker if there are individuals in the household who only want to apply for Medicaid.*

Do you want to apply for WFFA which includes Medicaid? \_\_\_ Yes \_\_\_ No **OR**

Do you want to apply for Medicaid only? \_\_\_ Yes \_\_\_ No

**Do you have a disability you wish to report? (The reporting of a disability is strictly VOLUNTARY.)**

**DISABILITY:** "Disability means, with respect to an individual: (1) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (2) a record of such impairment; or (3) being regarded as having such an" impairment" (Americans with Disabilities Act of 1990)

\_\_\_ Yes \_\_\_ none/Prefer not to report

**Do you need help to complete the application or interview process?** \_\_\_ Yes \_\_\_ No

**PROGRAM SCREENING (ALL ANSWERS MUST BE YES TO BE POTENTIALLY ELIGIBLE.)**

Yes  No Is there a child in the home under age 18 or age 18 and will graduate from high school by age 19?

Yes  No Is the applicant an adult who lives with the child(ren) and who meets the kinship rule?

Yes  No Does the family reside in North Carolina and intend to remain permanently or for an indefinite period; or entered North Carolina seeking a job or with a job commitment?

Applicant: \_\_\_\_\_ Telephone No. \_\_\_\_\_

Address: \_\_\_\_\_

Mailing Address if Different: \_\_\_\_\_

Directions to home: \_\_\_\_\_

**Form DSS-8227 (Immigrant Access Notice) was provided and signed by the applicant.**

**DSS- 10001, LANGUAGE SERVICES AGREEMENT (For Limited English Proficiency (LEP) Customer) was provided and signed by applicant.**

*NON-APPLICANT HOUSEHOLD MEMBERS ARE NOT REQUIRED TO PROVIDE A SOCIAL SECURITY NUMBER, IMMIGRANT OR CITIZENSHIP STATUS. CONTINUE TO ASSESS THE NON APPLICANT BUDGET UNIT MEMBER FOR COUNTABLE RESOURCES SUCH AS INCOME AND ASSETS IN DETERMINING ELIGIBILITY.*

**HOUSEHOLD MEMBERS APPLYING FOR WFFA**

<b>1</b>	Name (Last, First, MI)	Sex	Marital Status	D.O.B.	Place of Birth	Race/Ethnicity	Language Preference
Father's Name		Mother's Name		School (current enrollment) <input type="checkbox"/> YES , Where _____ <input type="checkbox"/> NO			Grade (current /highest completed)
Relationship to casehead/payee		Will household member be included in application? <input type="checkbox"/> YES <input type="checkbox"/> NO, explain				Individual ID. No.	
If household member is included in the application, complete the following: <input type="checkbox"/> U.S. CITIZEN <input type="checkbox"/> QUALIFIED IMMIGRANT						Social Security Number, if included in application	
<b>AGENCY USE ONLY</b>							
ID Verified <input type="checkbox"/> Yes <input type="checkbox"/> No Document viewed:			Citizenship/ Immigration Document(s) viewed:				
<b>2</b>	Name (Last, First, MI)	Sex	Marital Status	D.O.B.	Place of Birth	Race/Ethnicity	Language Preference
Father's Name		Mother's Name		School (current enrollment) <input type="checkbox"/> YES , Where _____ <input type="checkbox"/> NO			Grade (current /highest completed)
Relationship to case head/payee		Will household member be included in application? <input type="checkbox"/> YES <input type="checkbox"/> NO, explain				Individual ID. No.	
If household member is included in the application, complete the following: <input type="checkbox"/> U.S. CITIZEN <input type="checkbox"/> Qualified Immigrant						Social Security Number, if included in application	
<b>AGENCY USE ONLY</b>							
ID Verified <input type="checkbox"/> Yes <input type="checkbox"/> No Document viewed:			Citizenship/Immigration Document(s) viewed:				
<b>3</b>	Name (Last, First, MI)	Sex	Marital Status	D.O.B.	Place of Birth	Race/Ethnicity	Language Preference
Father's Name		Mother's Name		School (current enrollment) <input type="checkbox"/> YES , Where _____ <input type="checkbox"/> NO			Grade (current /highest completed)
Relationship to casehead/payee		Will household member be included in application? <input type="checkbox"/> YES <input type="checkbox"/> NO, explain				Individual ID. No.	
If household member is included in the application, complete the following: <input type="checkbox"/> U.S. CITIZEN <input type="checkbox"/> QUALIFIED IMMIGRANT						Social Security Number, if included in application	
<b>AGENCY USE ONLY</b>							
ID Verified <input type="checkbox"/> Yes <input type="checkbox"/> No Document viewed:			Citizenship/ Immigration Document(s) viewed:				
<b>4</b>	Name (Last, First, MI)	Sex	Marital Status	D.O.B.	Place of Birth	Race/Ethnicity	Language Preference
Father's Name		Mother's Name		School (current enrollment) <input type="checkbox"/> YES , Where _____ <input type="checkbox"/> NO			Grade (current /highest completed)
Relationship to casehead/payee		Will household member be included in application? <input type="checkbox"/> YES <input type="checkbox"/> NO, explain				Individual ID. No.	
If household member is included in the application, complete the following: <input type="checkbox"/> U.S. CITIZEN <input type="checkbox"/> QUALIFIED IMMIGRANT						Social Security Number, if included in application	
<b>AGENCY USE ONLY</b>							
ID Verified <input type="checkbox"/> Yes <input type="checkbox"/> No Document viewed:			Citizenship/ Immigration Document(s) viewed:				

5	Name (Last, First, MI)	Sex	Marital Status	D.O.B.	Place of Birth	Race/Ethnicity	Language Preference
Father's Name		Mother's Name		School (current enrollment) <input type="checkbox"/> YES , Where _____ <input type="checkbox"/> NO			Grade (current /highest completed)
Relationship to casehead/payee		Will household member be included in application? <input type="checkbox"/> YES <input type="checkbox"/> NO, explain					Individual ID. No.
If household member is included in the application, complete the following: <input type="checkbox"/> U.S. CITIZEN <input type="checkbox"/> QUALIFIED IMMIGRANT						Social Security Number, if included in application	
<b>AGENCY USE ONLY</b>							
ID Verified <input type="checkbox"/> Yes <input type="checkbox"/> No			Citizenship/ Immigration Document(s) viewed: Document viewed:				
6	Name (Last, First, MI)	Sex	Marital Status	D.O.B.	Place of Birth	Race/Ethnicity	Language Preference
Father's Name		Mother's Name		School (current enrollment) <input type="checkbox"/> YES , Where _____ <input type="checkbox"/> NO			Grade (current /highest completed)
Relationship to casehead/payee		Will household member be included in application? <input type="checkbox"/> YES <input type="checkbox"/> NO, explain					Individual ID. No.
If household member is included in the application, complete the following: <input type="checkbox"/> U.S. CITIZEN <input type="checkbox"/> QUALIFIED IMMIGRANT						Social Security Number, if included in application	
<b>AGENCY USE ONLY</b>							
ID Verified <input type="checkbox"/> Yes <input type="checkbox"/> No			Citizenship/ Immigration Document(s) viewed: Document viewed:				
7	Name (Last, First, MI)	Sex	Marital Status	D.O.B.	Place of Birth	Race/Ethnicity	Language Preference
Father's Name		Mother's Name		School (current enrollment) <input type="checkbox"/> YES , Where _____ <input type="checkbox"/> NO			Grade (current /highest completed)
Relationship to casehead/payee		Will household member be included in application? <input type="checkbox"/> YES <input type="checkbox"/> NO, explain					Individual ID. No.
If household member is included in the application, complete the following: <input type="checkbox"/> U.S. CITIZEN <input type="checkbox"/> QUALIFIED IMMIGRANT						Social Security Number, if included in application	
<b>AGENCY USE ONLY</b>							
ID Verified <input type="checkbox"/> Yes <input type="checkbox"/> No			Citizenship/ Immigration Document(s) viewed: Document viewed:				
8	Name (Last, First, MI)	Sex	Marital Status	D.O.B.	Place of Birth	Race/Ethnicity	Language Preference
Father's Name		Mother's Name		School (current enrollment) <input type="checkbox"/> YES , Where _____ <input type="checkbox"/> NO			Grade (current /highest completed)
Relationship to casehead/payee		Will household member be included in application? <input type="checkbox"/> YES <input type="checkbox"/> NO, explain					Individual ID. No.
If household member is included in the application, complete the following: <input type="checkbox"/> U.S. CITIZEN <input type="checkbox"/> QUALIFIED IMMIGRANT						Social Security Number, if included in application	
<b>AGENCY USE ONLY</b>							
ID Verified <input type="checkbox"/> Yes <input type="checkbox"/> No			Citizenship/ Immigration Document(s) viewed: Document viewed:				

### Non-Applicant Household Members

<b>1</b>	Name (Last, First, MI)			Relationship to applicant:	Sex	Date of Birth	Place of Birth
Race/Ethnicity	Language Preference	Marital Status	School(current enrollment)	Grade	Father's Name	Mother's Name	
<b>2</b>	Name (Last, First, MI)			Relationship to applicant:	Sex	Date of Birth	Place of Birth
Race/Ethnicity	Language Preference	Marital Status	School(current enrollment)	Grade	Father's Name	Mother's Name	
<b>3</b>	Name (Last, First, MI)			Relationship to applicant:	Sex	Date of Birth	Place of Birth
Race/Ethnicity	Language Preference	Marital Status	School(current enrollment)	Grade	Father's Name	Mother's Name	
<b>4</b>	Name (Last, First, MI)			Relationship to applicant:	Sex	Date of Birth	Place of Birth
Race/Ethnicity	Language Preference	Marital Status	School(current enrollment)	Grade	Father's Name	Mother's Name	

Check here:  if more people are in the household

<b>BENEFITS FROM OTHER STATES</b>
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**Has anyone on the application lived outside of North Carolina?**     Yes     No

If yes, who? \_\_\_\_\_ When? \_\_\_\_\_ City/County/State: \_\_\_\_\_

**Did he/she receive any assistance in the other state?** (Check all that apply.)

TANF (Federal)     Food & Nutrition Services     Medicaid

(Verify months of TANF assistance received.)

Agency Name and telephone number: \_\_\_\_\_

<b>TEMPORARY ABSENCE</b>
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**Is anyone temporarily absent from the home?**    \_\_\_ Yes (Complete the questions below.)    \_\_\_ No

Who?	When Did He/She Leave?	Why?	When Will He/She Return?

If the family member is expected to be absent for **fewer than 90** consecutive days, **include** him/her in the application, unless he/she is receiving WFFA or TANF assistance in another case. If absent for more than 90 days, see Section 112.

**INDIVIDUAL CRIMINAL VIOLATIONS**

Is anyone in your home:

Yes  No Trying to avoid a felony prosecution? Name: \_\_\_\_\_

Yes  No Fleeing from law enforcement? Name: \_\_\_\_\_

Yes  No Trying to avoid jail after conviction of a felony? Name: \_\_\_\_\_

Yes  No In violation of the conditions of probation or parole? Name: \_\_\_\_\_

Yes  No Convicted of a drug-related felony committed on or after August 23, 1996?

Name: \_\_\_\_\_

If **yes**, was the conviction in North Carolina?  Yes  No

If convicted in North Carolina, what was the classification of the felony? Class: \_\_\_\_\_\*

**[\*classification of felony must be verified by the Agency]**

These individuals may not be eligible for WFFA. (See Work First Manual Section 104, A.)

**CHILD SUPPORT ENFORCEMENT**

**Discuss the Child Support Requirement, as stated in Attachment I. (Optional) Offer to complete the Affidavit of Parentage, if appropriate.**

Absent Parent Name:		Date of Birth	Child(ren):	
Address:		AP Phone Number:	AP SSN:	
		AP's Employer:		
Absent Parent Name:		Date of Birth	Child(ren):	
Address:		AP Phone Number:	AP SSN:	
		AP's Employer:		
Absent Parent Name:		Date of Birth	Child(ren):	
Address:		AP Phone Number:	AP SSN:	
		AP's Employer:		

**INCOME**

**Does anyone in your household have income from working?** (This includes work study, sick pay, severance pay, vacation pay, working for a temporary agency, sheltered workshop, WIA, or VISTA.)

**Yes**  **No** If yes, complete the following:

1. Name: \_\_\_\_\_ Date Started: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Hrs. per Week: \_\_\_\_\_  
 Employer Address: \_\_\_\_\_ Rate of Pay: \_\_\_\_\_

Pay Received This Month (month of app.)		Pay Received Last Month	
Date	Amount (gross)	Date	Amount (gross)

2. Name: \_\_\_\_\_ Date Started: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Hrs. per Week: \_\_\_\_\_  
 Employer Address: \_\_\_\_\_ Rate of Pay: \_\_\_\_\_

Pay Received This Month (month of app.)		Pay Received Last Month	
Date	Amount (gross)	Date	Amount (gross)

**List all jobs for the last 6 months for anyone in your household who currently is not working.**

Person Who Worked	Employer	Dates Worked	Date Of Final Pay

If anyone in your household has **self-employment income, rental income, roomer income, or boarder income**, complete the following:

Who? \_\_\_\_\_ Type of Business/income: \_\_\_\_\_

(Collect at least two months' information. Additional months may be needed to make a representative projection of expected income.)

Month	Income	Expenses*	Adjusted Gross
1.			
2.			
3.			

\* See Section 114 XV. for discussion of expenses.

<b>Unearned Income</b>
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**Does anyone in your household receive any of the following?**

	Source Of Income	Who Receives the Income?	Freq.	Date Received	Av. Mo. Amount
Yes <input type="checkbox"/> No <input type="checkbox"/>	Work First Family Assistance				
Yes <input type="checkbox"/> No <input type="checkbox"/>	Financial Contributions given on a regular basis. Contributor:				
Yes <input type="checkbox"/> No <input type="checkbox"/>	Child Support/Alimony/Work Release Direct - Clerk of Court - IV-D (County: _____)				
Yes <input type="checkbox"/> No <input type="checkbox"/>	Social Security Claim #				
Yes <input type="checkbox"/> No <input type="checkbox"/>	Supplemental Security Income (SSI) Claim #				
Yes <input type="checkbox"/> No <input type="checkbox"/>	Military Allotment				
Yes <input type="checkbox"/> No <input type="checkbox"/>	Veteran's Benefits: Compensation/Pension/ A & A Portion VA File #				
Yes <input type="checkbox"/> No <input type="checkbox"/>	Unemployment Compensation				
Yes <input type="checkbox"/> No <input type="checkbox"/>	Worker's Compensation				
Yes <input type="checkbox"/> No <input type="checkbox"/>	Pension/Retirement/Civil Service Annuity				
Yes <input type="checkbox"/> No <input type="checkbox"/>	Railroad Retirement				
Yes <input type="checkbox"/> No <input type="checkbox"/>	Private Disability (May be earned. See 114, III.)				
Yes <input type="checkbox"/> No <input type="checkbox"/>	Interest/Dividends				
Yes <input type="checkbox"/> No <input type="checkbox"/>	Educational Grants, Scholarships				
Yes <input type="checkbox"/> No <input type="checkbox"/>	Income From Trust Fund/Promissory Note				
Yes <input type="checkbox"/> No <input type="checkbox"/>	Foster Care Payment/County Supplement				
Yes <input type="checkbox"/> No <input type="checkbox"/>	Other				

**Key the above income into the automated budget in EIS.**

**RESOURCES**

**Does anyone you are applying for have any of the following?**

**Yes**  **No** If yes, check (✓) all that apply.

Yes✓	Resource	Who Owns the Resource? (List all owners.)	STATED VALUE				Access (Circle all that apply.)	Verified Value FOR AGENCY USE ONLY
			Retro 1	Retro 2	Retro 3	Mo. Of App.		
<input type="checkbox"/>	Cash/						A J RT I	
<input type="checkbox"/>	Checking Account #: _____ Bank: _____ #: _____ Bank: _____						A J RT I  A J RT I	
<input type="checkbox"/>	Savings Account/ Safe Deposit Box #: _____ Bank: _____ #: _____ Bank: _____						A J RT I  A J RT I	
<input type="checkbox"/>	IRA's, CD's, Money Market, Mutual Funds #: _____ Bank: _____ #: _____ Bank: _____						A J RT I  A J RT I	
<input type="checkbox"/>	Stocks Broker: _____ Stock Name: _____ # Shares: _____ Bonds Issuer: _____ U.S. Savings Bonds Face Value: _____ Series #: _____						A J RT I	
<input type="checkbox"/>	Other						A J RT I	

**A = Accessible to Owner**  
**J = Jointly Owned**  
**RT = Resulting Trust (List actual owner in 4<sup>th</sup> column.)**  
**I = Inaccessible (Document reason.)**

**TOTAL**

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**For AGENCY USE  
ONLY**

If the applicant has excess resources, you must inform the applicant, he/she can rebut/reduce the value of the resource. Does the applicant wish to rebut/reduce the value of a resource?

Yes  No

**Total Resources:** \_\_\_\_\_ (Limit: \$3,000)

**MEDICARE**

Is anyone you are applying for covered by **Medicare**?  Yes  No If yes, complete the data below.

Who?	RSDI Claim Number	Med. A	Med. B
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Verification of Medicare: (Agency Use Only)			

**PRIVATE HEALTH INSURANCE**

Is anyone covered by Private Health Insurance?  Yes  No **If yes, complete the following**

Insured	Type	Insurance Company Name and Address	Insurance Eff. Date	Policy /Group No. (If applicant or recipient)	Premium Amt. and Frequency	Who Pays?
Owner (Sponsor)						
<b>1.</b>						
<b>2.</b>						

(Agency Use Only)

Verification:

Complete a DMA-2041 for private health insurance.

**NOTE: If a Medicaid individual has private health insurance and a catastrophic illness, evaluate with DMA for coverage under the Health Insurance Premium Payment (HIPP) Program.**

1. Has anyone you are applying for been in an accident in the last 12 months?  Yes  No

(If yes, complete Form DMA-2043.)

2. Does everyone on your application receive Medicaid?  Yes  No

If no, have you already applied?  Yes  No If so, when? \_\_\_\_\_

3. Does anyone you are applying for owe any medical bills?  Yes  No

4. Does anyone you are applying for have any current or anticipated medical expenses?  Yes  No

Agency use only: If Question 3 or 4 is answered Yes or if there is a retroactive medical need, complete the chart below.

Family Member	Provider	Date Of Service	Date Of Last Payment	Amount Charged	Type	TPR/ Medicare Payment	Family Member Portion	Amt. Usable	Verification
	Phone #				Freq.				

**COLLATERAL CONTACT**

We need the name, address, and phone number of a person who does not live with you and is not related to you or anyone in your household. I need to contact this person to verify your household situation.

<p>Name: _____</p> <p>Address: _____</p> <p>Phone: _____</p>	<p><b>For Agency Use Only</b></p> <p>Did this collateral verify household size, composition, and residence?</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No - obtain second collateral.</p> <p>Discrepancies: _____</p>
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**ADDITIONAL INFORMATION**

- Do you pay rent?     Yes     No      If yes: Amount \_\_\_\_\_
- Do you receive any HUD/Section 8 assistance or a rent subsidy?     Yes     No  
If yes, how much are you responsible for each month? \$ \_\_\_\_\_
- Is anyone in your household pregnant?     Yes     No  
Name: \_\_\_\_\_      Due Date: \_\_\_\_\_
- Is anyone on your application a member of a federally recognized tribe?     Yes     No

**If yes, complete the following:**

Name of Tribal Member:	Tribe:	Have an enrollment card?
1.		<input type="checkbox"/> Yes <input type="checkbox"/> No
2.		<input type="checkbox"/> Yes <input type="checkbox"/> No
3.		<input type="checkbox"/> Yes <input type="checkbox"/> No
4.		<input type="checkbox"/> Yes <input type="checkbox"/> No

**ADDITIONAL SERVICES**

**Our agency also offers other services and referrals to other community programs. Please tell me if anyone you are applying for would be interested in the following.**

<u>Service Explained</u>	<u>Service Offered</u>	<u>Referred</u>	
		Yes	No
<input type="checkbox"/>	<b>Family Planning Services</b> - These services include counseling, education, and medical services for males and females regarding birth control. <b>Who?</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<b>Medical Transportation</b> - If approved for Medicaid, you may qualify for help from the county DSS in arranging and/or paying for medical transportation for visits to the doctor's office or hospital. <b>For whom?</b> _____ (Complete DMA-5046.)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<b>Health Check</b> - This program provides medical and dental health care screenings for <i>Work First Family Assistance</i> and Medicaid recipients from birth through age 21 and assistance in arranging transportation to appointments. <b>For whom?</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<b>Adult Health Screening</b> - This program provides for 1 annual health screening for adults over age 21 so that serious illnesses can be detected early and treated. <b>For Whom?</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<b>Carolina ACCESS</b> (for applicable counties)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<b>WIC</b> (Women's Infants and Children) - WIC is a program to help you buy food if you are pregnant or have a child under age 5 in the home. <input type="checkbox"/> <b>Currently receives WIC</b>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<b>Maternity Care Services</b> - The Baby Love Program will provide a maternal care coordinator (MCC) to assist pregnant women during their pregnancy. If you want this service, do you agree to let DSS give the MCC information about your eligibility? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<b>Child Care</b> - Assistance in arranging and/or paying for child care for children under age 13 or disabled children. <b>Do you need dependent care assistance?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<b>Life Line/Link Up</b> - Anyone in your home who gets Work First Family Assistance, Medicaid or SSI and has a phone bill in his name can get a deduction on his phone bill. <b>For whom?</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<b>Vocational Rehabilitation</b> - Assistance for individuals with minor disabilities for medical treatment, rehabilitation, training, education, and job placement. <b>For whom?</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<b>Voter Registration</b> - Are you registered to vote at your current address?	<input type="checkbox"/>	<input type="checkbox"/>

Yes  No **If no, would you like to register while you are here today?**  Yes  No

(If yes, complete Part A of NC Voter Registration Application/Update Form)

(If no and applicant does not wish to register, have applicant sign declination form)

**BENEFIT DIVERSION (AGENCY USE ONLY)**

**Is Benefit Diversion appropriate for this applicant?**

- Benefit Diversion is not appropriate.
- Benefit Diversion Offered  Approved amt. \$ \_\_\_\_\_ months covered \_\_\_\_\_
- Declined/Denied (Reason):** \_\_\_\_\_
- Benefit Diversion Agreement (Form DSS-8657) Completed

**REQUIRED FORMS AND NOTICES**

**Check (✓)**

- Rights and Responsibilities were explained. (Give applicant Attachment II)
- Audit/DAST screening was completed for each adult (DSS-8218)
- Form DMA 2188 (Notice of Privacy Practices) was given to the applicant.
- MRA Core Requirements (DSS-6963A) was signed by each adult.
- First Stop requirement was explained to each adult.
- Family Cap requirement explained to applicant
- Form DSS-6966 (Notification of the Family Violence Option) was given to the applicant.
- Form DSS-8221 (Work Requirements if Child Care Not Available) was given to the applicant.
- Notice of Requirement To Cooperate and Right To Claim Good Cause for Refusal To Cooperate In Child Support Enforcement was given to applicant

**CERTIFICATIONS**

- The following individuals *can not* be included in the Work First case:

**Name(s):**

**Reason:**


- It appears you are not eligible for Work First Family Assistance because:

\_\_\_\_\_

\_\_\_\_\_

Do you still want to apply?  Yes  No

If no, do you want to apply for Medicaid?  Yes  No (If no, complete DMA-5095 for Medicaid)

**By signing this form, I am saying that:**

- ✓ I understand the penalties for giving false information, and I have told the truth on this form.
- ✓ I know my rights and what I must do to get assistance.
- ✓ I agree to give information about what I have said.
- ✓ I agree to report changes to social services.
- ✓ I agree to let social services get proof of what I have said from any person or other agency.
- ✓ I know social services keeps private anything said about my situation.
- ✓ I know if I do not sign this form, I will not get assistance.

**Applicant's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Witness: (if signed with an "X")** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Interviewer's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Decisions on applications must be made within 45 days, unless pending for verification of citizenship/identity.

**AGENCY USE ONLY**

**On Line Verification Check Completed:**  YES  NO

**Summary Results Attached**  YES  NO

Is there a family cap child?  YES  NO \_\_\_\_\_

Is there a minor parent?  YES  NO \_\_\_\_\_

How many months have been used on time limits? \_\_\_\_\_ of 24 months \_\_\_\_\_ of 60 months

Approved

Retro Auth-from \_\_\_\_\_ thru \_\_\_\_\_

Ongoing Auth-from \_\_\_\_\_ thru \_\_\_\_\_

DB/ PML Auth- from \_\_\_\_\_ thru \_\_\_\_\_ Whom \_\_\_\_\_

Pending/Reason \_\_\_\_\_

Denied  Withdrawn REASON: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Processor's Signature

\_\_\_\_\_  
Date

**ADDITIONAL NOTES**

## NOTICE OF REQUIREMENT TO COOPERATE AND RIGHT TO CLAIM GOOD CAUSE FOR REFUSAL TO COOPERATE IN CHILD SUPPORT ENFORCEMENT

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### BENEFITS OF CHILD SUPPORT ENFORCEMENT

Your cooperation in the child support enforcement process may be of value to you and your child because it might result in the following benefits.

- Finding the non custodial parent;
- Legally establishing your child's paternity;
- The possibility that support payments might be secured and might be higher than your welfare grant; **and**
- The possibility that you and your children may obtain rights to future social security, veteran's, or other government benefits.

### WHAT IS MEANT BY COOPERATION?

The law requires you to cooperate with the social services and child support agencies to get any support owed to you and any of the children for whom you want *Work First Family Assistance*, unless you have good cause for not cooperating.

In cooperating with the social services or child support agency, you may be asked to do one or more of the following things.

- Name the parent of any child applying for or receiving *Work First Family Assistance* and give information you have to help find the parent;
  - Help determine legally who the father is, if your child was born out-of-wedlock;
  - Give help to obtain money owed to you or the children receiving *Work First Family Assistance*; **and**
  - Report to the State any money which is given directly to you by the absent parent and/or absent spouse.
- You may be required to come to the social services office, child support office, or court to sign papers or give necessary information.

### ASSIGNMENT OF RIGHTS

- Any child support paid or owed to you due to a court order must be paid to Child Support Enforcement.
- The child support paid to Child Support Enforcement will be used to repay the *Work First Family Assistance* benefits you have received.

### WHAT IS MEANT BY GOOD CAUSE?

You may have good cause not to cooperate in the State's efforts to collect child support. You may be excused from cooperating if you believe that cooperation would not be in the best interest of your child and if you can provide evidence to support this claim.

### IF YOU DO NOT COOPERATE AND YOU DO NOT HAVE GOOD CAUSE

- You will not be eligible for Medicaid through the Work First program. If you are pregnant, you will be evaluated for eligibility in the Medicaid for Pregnant Women (MPW) program. (Your children will still receive Medicaid, if eligible.)
- Your family's Work First Family Assistance will be terminated for at least one month or until you cooperate, whichever is longer.

### HOW AND WHEN YOU MAY CLAIM GOOD CAUSE

- If you want to claim good cause, you must tell a worker that you think you have good cause. You can do this at any time you believe you have good cause not to cooperate.
- If you claim "good cause," you must be given another notice. This second notice will explain the circumstances under which social services may find good cause and the type of evidence or other information social services needs to decide your claim. You may ask for this second notice to help you decide whether or not to claim good cause.

## YOUR RIGHTS

### You have the right to:

- Apply for help and, if denied, reapply at any time.
- Get help, if you are eligible.
- Have up to 3 people with you in your interview.
- Have anything you tell us kept private.
- Withdraw from any assistance you get at any time.
- Apply to have another person added to your case.
- Get a written notice of any information we need to complete your application.
- Be protected by federal law against discrimination on the basis of race, color, national origin, sex, religion, age, disability, or political beliefs.
- Get a notice telling you why your application is denied.
- Apply for retroactive Medicaid for up to 3 months prior to your date of application.
- To have your Medicaid considered under all categories.
- Not have a permanent address as long as you plan to stay in North Carolina.
- Use your check however you want, as long as it is in the best interest of your family. If you do not use your check correctly, another person may be appointed to get your check and use it for you and your family.
- Ask for a hearing from the department of social services and the Division of Social Services if:
  - You are denied your right to apply for Work First Family Assistance.
  - Your application was not acted upon timely (within 45 calendar days).
  - Your application was denied, and you think the decision was wrong.
  - You believe your assistance is wrong based on the county's use of State regulations.
  - Your assistance is changed or stopped.
  - You asked for a review of your circumstances, and it has taken longer than 30 days or was not done.

### SOCIAL SECURITY NUMBERS

- You must tell the department of social services all of the social security numbers used by all individuals applying for assistance and/or receiving assistance. Non applicant household members are not required to provide a social security number, immigrant or citizenship status.
- The social security numbers will be matched with the Social Security Administration, the Internal Revenue Service, the Employment Security Commission (ESC), Office of Child Support Enforcement, Department of Transportation (DOT), out-of-state welfare and ESC agencies, and any other agency that is necessary. Information obtained by computer matching will be used to determine initial and ongoing eligibility.
- You have the right to withdraw your application(s) if you do not want this done.

## YOUR RESPONSIBILITIES

- You must let your caseworker know of any changes in your situation within 10 days.
- You must let your caseworker know about any changes in your address, employment, property, resources, expenses or needs, or who lives in your home. If you are not sure if you should report a change, the best thing to do is to report it, and let your caseworker decide if it is needed.
- Remember -- you may have more than 1 caseworker, and you must report your changes to each one.
- If you expect a child to be away from home for longer than 90 consecutive days, you must report the child's absence within 5 days of knowing this change. If you do not, your check will be reduced or terminated. This child is no longer eligible for cash assistance unless he has good cause for being absent from the home.
- You must let your caseworker know immediately if you get more Work First Family Assistance than you are supposed to.
- You must tell the truth. It is against the law to make false statements or to willfully withhold information. If you do not tell the truth, you can be taken to court and charged with fraud. Everything you tell the department of social services will be checked by them and, perhaps, by a State or federal reviewer. If anyone in your home is convicted of giving false information about where he lives in order to receive Work First Family Assistance, Medicaid, or SSI benefits in more than one place, he will be ineligible to receive cash assistance for 10 years from the conviction.
- If anyone in my home is found guilty of an intentional program violation by giving false information, he will :
  - Not get Work First for 12 months the first time he is found guilty;
  - Not get Work First for 24 months the second time found guilty; &
  - Not get Work First for the rest of his life the third time.
- The information you give may be stored in a computer data bank.
- By signing an application for Medicaid, you agree to allow the State to bill any medical insurance anyone included in the application has for any bills Medicaid pays. You also agree that, if you get a payment from an insurance company for a bill that Medicaid paid, you will repay the State for the Medicaid you used. You also agree to report to the department of social services if anyone in your Medicaid case is in an accident.

### WORK FIRST FAMILY ASSISTANCE REPORTING

If you get *Work First Family Assistance*, you may have to fill out a report of your family's income and your household situation every 3 months. If you get a *Work First Family Assistance* report, you must fill it out and return it to the department of social services by the deadline date printed on the form. If you get a report and do not turn it in, your *Work First Family Assistance* will stop.