

Operation Manual Volume 1 – General Administration
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MS 0001 – R. 6/5/23 – OMTL-626

Family Support Manuals and Program Instructions

The Division of Family Support (DFS) is responsible for developing, writing, and publishing operations manuals, forms, and memorandums for eligibility programs administered by the Department for Community Based Services. Information and procedures in the manuals conform to federal and state laws and regulations and must be applied in a like manner in all counties.

A. The following manual material, cover letters, and forms are located online and available to staff from the [Family Support Knowledge Base](#).

1. Operation Manual that includes volumes devoted to:

- a. General administration of all programs and claims;
- b. Supplemental Nutrition Assistance Program (SNAP);
- c. SNAP work provisions;
- d. [Cash assistance programs (Kentucky Transitional Assistance Program (KTAP), Kinship Care (KC), Family Assistance Short Term (FAST), Work Incentive (WIN));]
- e. Kentucky Works Program (KWP);
- f. Family Related Medicaid programs (only used for claims). For current Family Related Medicaid policy, access Modified Adjusted Gross Income (MAGI) Medicaid;
- g. Adult Medicaid programs and State Supplementation;
- h. MAGI Medicaid, Advance Premium Tax Credit (APTC), Cost Sharing Reduction (CSR), and Qualified Health Plan (QHP);
- [i. Child Care Assistance Program (CCAP);]
- j. Clarifications; and
- [k. Operational Manual Transmittal Letters.

2. Forms Library that includes forms and procedural instructions that are manually generated. Procedural instructions for some system-generated forms are also included on this site;]

3. Family Support Memorandums (FSM);

4. Tip Sheets; and

5. User Guides

- B. The general public can access the Operation Manual from the [DFS webpage](#). Other material is not accessible at this site. The local office makes material available for review at the request of a client or any interested party. To avoid copying an entire volume of information for manuals appearing in PDF format, use the file function for printing and enter the desired range of pages.
- C. Field staff is alerted on Worker Portal when new or revised material is added to the intranet site. Review all newly issued or revised material. Staff can locally print information.

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MS 0010 – R. 11/1/09 – OMTL-343
Cabinet Structure

The Cabinet for Health and Family Services (CHFS) consists of several agencies with various functions that include the provision of direct services to individuals, families and businesses. The list of CHFS agencies and a brief description of each is located on the [CHFS Agencies webpage](#).

- A. The Department for Community Based Services (DCBS) is an agency within CHFS that administers adult and child protection/permanency and family support programs. There are DCBS offices in every county that provide direct services to individuals and families. DCBS consists of the following Divisions:
 - 1. Service Regions;
 - 2. Child Care;
 - 3. Violence Prevention Resources;
 - 4. Protection and Permanency;
 - 5. Administration and Financial Management;
 - 6. Program Performance; and
 - 7. Family Support.
- B. Field staff located in the counties is attached to the Division of Service Regions and managed by a Service Region Administrator. Information regarding the counties in each Service Region is located on the [CHFS Service Regions webpage](#).
- C. The Division of Family Support (DFS), located in Frankfort, is responsible for developing policies and procedures relating to the administration of income support programs and providing technical support to field staff. Additional information about the Division is located on the [DFS webpage](#).

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*MS 0015 – 3/9/15 – OMTL-483

Ethics Policy for Family Support Employees

The Department for Community Based Services (DCBS) and its employees must recognize the vulnerability of their clients and the serious responsibilities associated with the provision of public assistance. The behavior of human service professionals shall reflect an emphasis on integrity, professional trustworthiness, and on the values of respect for persons, competence, loyalty, diligence, honesty, and confidentiality.

DCBS professionals have a duty to be familiar with their responsibilities under this manual section and to consider which ethical principles apply in a particular situation. If there is a conflict between two or more ethical principles and/or responsibilities in a particular case, staff should consult with his or her supervisor in choosing a proper course of action.

Family Support employees:

- A. Adhere to standards of ethics, confidentiality, and security agreements;
- B. Execute their responsibilities on behalf of the citizens of the Commonwealth. As such, they do not use their positions for personal gain or influence;
- C. Strive to improve the quality and efficiency of services rendered by Kentucky state government;
- D. Are honest, objective, and diligent in the performance of their duties and responsibilities;
- E. Avoid leading or coaching program applicants or recipients into making statements or taking any other action in order to gain benefits to which the individual or household is not entitled;
- F. Avoid participation in any activity they know to be illegal or improper;
- G. Are continually aware of the public trust they hold and their obligation to maintain a high standard of integrity, competence, and dignity in the performance of their duties;
- H. Do not enter into any activity which may be in conflict with the interest of the citizens of Kentucky;
- I. Refrain from entering into any activity which may prejudice (or give the appearance of such) their ability to objectively perform their duties and responsibilities;
- J. Do not solicit or accept directly or indirectly, any gift, gratuity, favor, or other economic consideration from any person, group, private business or public agency, or from members of their immediate families, which may affect the impartial performance of the employee's duties;

- K. Are prudent in the disclosure or use of information acquired in the course of their duties;
- L. Shall not disclose information that may infringe upon another's right to privacy;
- M. Shall not use confidential information for any personal gain or in a manner which may be detrimental to the welfare of the citizens of the Commonwealth;
- N. Do not use state resources, including time, facilities, equipment, supplies, or uniforms for private benefit or advantage;
- O. Shall secure prior approval of their Cabinet's management before using state time, facilities, equipment, supplies, or uniforms for community projects;
- P. Strive for improvement in the proficiency and effectiveness of the service and products they deliver;
- Q. Extend respect, honesty, fairness, and cooperation to citizens, colleagues, and members of other agencies;
- R. Document their professional work accurately, truthfully, and according to agency policy and/or legal requirements in order to ensure proper accountability;
- S. Act in the best interest, promote the welfare, and avoid harming those they serve.

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MS 0020 – 6/5/23 – OMTL-626
General Case Processing

- A. [Eligibility determinations for the Kentucky Transitional Assistance Program (KTAP), Family Assistance Short Term (FAST), Kinship Care (KC), Supplemental Nutrition Assistance Program (SNAP), Modified Adjusted Gross income (MAGI) Medicaid, and Adult Medicaid (AMA) determinations are completed on Worker Portal.
- B. All individuals contacting the toll-free number or the local office requesting assistance are entered on Worker Portal by designated staff.
- C. Applications, recertifications and case changes can be processed by any worker statewide regardless of the county of residence. When a worker processes a case, the worker documents on Worker Portal comments any and all actions taken within the case at the time of processing.
- D. Workers cannot take or process an application of an individual who is a relative or close personal relationship. For procedural instructions on employee-related case processing, refer to [MS 0025](#).
- E. Supervisors or designated persons accept and process applications filed by Department for Community Based Services (DCBS) employees.
- F. All applications or reapplications must be acted on promptly. No longer than 30 days should elapse between the application date and authorization for action date, with the exception of unusual case situations. If the time frames required by the specific program are not met, document the reason for the delay on Worker Portal comments.
- G. To ensure authorizations are completed promptly, cases processed by workers without case decision must be reviewed immediately.
- H. Ongoing eligibility is reviewed periodically as required by specific program guidelines.
- I. Deny an application for assistance or discontinue benefits if:
 - 1. An individual withdraws the application or requests discontinuance;
 - 2. It is established a technical or financial factor is not met; or
 - 3. An individual fails to verify eligibility factors.
- J. All requested verification should be returned to the Centralized Mail Center. Staff in the Centralized Mail Center scans the verification into the Electronic Case File (ECF), which creates a task on the Worker Portal dashboard.

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MS 0025* - 10/1/19 – OMTL-553
Employee Related Case Processing

Confidential cases, such as those involving Department for Community Based Services (DCBS) employees, an employee's relative, any individual in which a conflict of interest may arise, any individual that resides at same physical residence as a DCBS employee and/or any other individuals with whom an employee has a close personal relationship are required to be processed and maintained by a supervisor or designated staff member. This is done to avoid any conflicts of interest and to ensure privacy.

- A. A relative is defined as “a parent, foster parent, parent-in-law, child, spouse, brother, foster brother, sister, foster sister, grandparent, grandchild, son-in-law, brother-in-law, daughter-in-law, sister-in-law, cousin (up to first cousin), or other family member who resides in the same household.”
- B. A conflict of interest exists whenever employees are placed in a position where, for some advantage gained or to be gained personally, they find it difficult, if not impossible, to devote themselves with complete energy, loyalty, and singleness of purpose to the general public interest as represented by their employment with the department.
- C. Close personal relationships may include, but are not limited to:
 - 1. Dating or co-habiting relationships;
 - 2. Relationships in which business transactions are regularly conducted;
 - 3. Personal friendships that transcend a casual acquaintance, such as: a person whose home is frequently visited by the employee, or vice-versa, or a person with whom the employee socializes “one-on-one” on a regular basis;
 - 4. Individuals who reside at the same physical residence of the employee;
or
 - 5. Relatives as defined in item A.

Any DCBS employee should remove themselves from acting on any official matter which involves a relative, close personal relationship, or their own records. When potential conflicts arise, the DCBS employee must immediately alert his/her supervisor or appropriate manager to the conflict of interest.

- D. Workers cannot take or process an application of an individual who is a relative as defined in item A, or close personal relationship as defined in item C. The worker is responsible for advising supervisory staff if an applicant is a relative or close personal relationship. The worker cannot provide case status information or inquire about the case for a relative. In addition, Family Support employees may not act on behalf of a payee by

receiving, cashing, or co-signing checks. Please reference [MS 0015](#) Ethics Policy for Family Support Employees.

- E. All cases that include a DCBS employee should have the question on the Application Information screen in Worker Portal, "Is there a DCBS employee living in the home?" answered as "YES". Supervisors and designated individuals are responsible for disposing all cases for DCBS employees.
- F. Report "DCBS Weekly Personnel File Match" is available in Worker Portal as an On-Demand report. Staff should be utilizing this report to assist in the integrity of staff self-reporting.

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MS 0030 – R. 3/1/23 – OMTL-616
Case Record

[The case record is the official document (electronic through Worker Portal or hardcopy) of the Department that establishes accountability for the expenditure of state and federal funds. Local management staff is responsible for ensuring case records are properly maintained, purged of obsolete material, and accessible to staff. This includes hard copy case records if the overpayment is pending or is established if the overpayment occurred prior to the implementation of the electronic case file (ECF).

For purging of hardcopy records, refer to [MS 0040](#), and for archiving, refer to [MS 0045](#).

- A. Each hard copy file or Worker Portal/ECF contains pertinent information about each applicant and recipient and supporting documentation for every decision made regarding eligibility. At a minimum, this includes:]
1. Date of application;
 2. Date and type of action (approval, denial, interim, special circumstances, restoration, etc.);
 3. Documentation sufficient to support the eligibility determination;
 4. Verification used in the determination of initial and continuing eligibility;
 5. The basis for denial or discontinuance of assistance;
 6. The condition that prompts a need for special accommodation to ensure access to benefits and services by individuals or families with a physical or mental condition;
 7. Accommodation offered and accepted by an individual or family;
 8. Signed applications;
 9. [Copies of notices manually prepared and provided to the household;
 10. Forms completed and/or provided by the household;]
 11. Maintaining a single archival case file folder per case;
 12. Annotating in red on the hard copy case record if an overpayment is identified, regardless if the overpayment is pending or is established if the overpayment occurred prior to the implementation of ECF.
 13. The Kentucky Works Program (KWP) material is scanned into the ECF into the appropriate category for the specific verification or form received.

The KWP material retained in the case file includes:

- a. Participation verification records;
 - b. Payment vouchers and verification of expenses;
 - c. Forms WIN-1 and WIN-2, if appropriate; and
 - d. All manually sent notices, such as form PA-105, Notice of Ineligibility.
- B. Case records are readily accessible to staff at all times. Each region has a plan for maintaining archived inactive hard copy cases, which includes:
1. The location of inactive case record files;
 2. A designated individual responsible for maintaining archived inactive case record files;
 3. A method for tracking case records that are removed from files; and
 4. Procedures for sending and maintaining records in off-site storage, if applicable, to ensure they can be easily located and retrieved.
- C. Hard copy case records contain confidential material. To ensure information is not lost or misused, records are:
1. Opened one at a time except for comparative study;
 2. Purged of obsolete material that is disposed of by shredding or burning. For additional information on purging, refer to MS 0040;
 3. Never stored in desks;
 4. Returned to the case record storage area on a timely basis; and
 5. [Never removed from the local office except to transfer to another county, the Office of Administrative Hearings, Quality Control, Central or Regional Office, or offsite storage or archives.]
- D. Discontinued case records are retained as a record of the expenditure of funds for audit purposes.

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MS 0040 – R. 6/1/18 – OMTL-529
Purging Obsolete Material

Hardcopy case records are required to be retained for a length of time specified by each program. With the implementation of the Electronic Case File (ECF), existing hardcopy case records are retained following normal purging procedures. Any form or verification scanned into ECF will become a permanent record.

To ensure records contain only relevant material, case records are purged of all outdated material. Material not directly related to eligibility or benefit authorization is not retained. Purged material is shredded or burned prior to disposal.

Any claim established after the implementation of ECF must have the corresponding documentation noted as part of the claim case record in ECF.

- A. DO NOT PURGE a case record involved in an audit until the audit is completed, a response to the audit has been filed, and the audit is closed.
- B. For benefit programs except the Supplemental Nutrition Assistance Program (SNAP), material retained permanently in an active case is:
 - 1. Case history sheets, PAFS-116;
 - 2. Application and need determination forms;
 - 3. All forms used to establish technical eligibility;
 - 4. All forms relating to Long Term Care (LTC);
 - 5. Hearing decisions on which eligibility is based; and
 - 6. All forms and material related to fraud or overpayment claims.

Kentucky Works Program (KWP) material is not purged from case records. It is retained indefinitely or until the Kentucky Transitional Assistance Program (KTAP) is inactive for five consecutive years.

Form PAFS-706, Voter Registration Rights and Declination, is retained as part of the case record for three years from the date of completion.

All other material, including the PA-10 series, MA-105 or PA-105, not required to substantiate a period of eligibility, is purged from active KTAP or Medicaid cases after five years.

- C. For SNAP cases, maintain all local office records related to certification and issuance such as monthly reports, application registers, and issuance listings, for a period of three years from the month of origin.

Hard copy files that are marked "DO NOT PURGE" prior to ECF are maintained as a hard copy case record. Scan into ECF any part of a hard copy case record that

applies to a newly discovered claim. Before a hard copy case record is purged, inquire Worker Portal to determine the status of the case, and to determine if there is a pending or established claim. DO NOT PURGE a claim case unless the claim is paid-in-full for three years. Intentional Program Violation (IPV) claims should never be purged.

Purge the following from the case record by burning or shredding:

1. Material which is older than three years, except claims-related material.
 - a. DO NOT PURGE IPV claims records or any case file records which substantiate either pending disqualifications or disqualifications which are being or have been served.
 - b. This includes documents such as signed disqualification consent agreements, court determinations, signed statements waiving the right to an administrative disqualification hearing, a hearing decision, and the notification of disqualification.
 - c. [Retain IPV claims records indefinitely as long as the records can be used (i.e., the records are accurate, relevant, up to date, and complete) to respond to requests from another State which is participating in the Electronic Disqualified Recipient Subsystem (eDRS). Refer to [MS 1210](#).]
 2. Irrelevant material.
- D. All purged material must be shredded or burned. Local offices may place the purged material in lockable recycling containers. For assistance with disposal of records, contact the Cabinet Records Coordinator, Division of Facilities Management.

When purging the case records, remove all binder clips and spirals. It is not necessary to remove paper clips and staples.

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MS 0045 – R. 11/1/09 – OMTL-343
Archiving Case Records

Archiving is the act of sending case records for storage to the Department of Libraries and Archives (DLA) when the entire case record can be destroyed after a certain time period. Only **inactive** case records can be archived.

DO NOT archive cases involving pending or established claims. When the established claim has been paid in full for three years, the case can be archived.

DO NOT archive cases involved in an audit until the audit is completed and the response to the audit is filed.

Because local offices utilizing off-site storage facilities must provide case record material within 48 hours of the request by a Quality Control analyst, do not select cases to be archived that have been inactive for less than one year.

When sending cases to be archived, indicate on each box the date the case records can be destroyed.

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MS 0050 – R. 6/1/18 – OMTL-529

[Case Responsibility

An application/reapplication for assistance, recertification, change report, or any information provided by or on behalf of a client is accepted by staff without regard to the county of residence of the client. Scan the documents into the Electronic Case File (ECF) for the specific case. Enter the application/reapplication, recertification, or change on Worker Portal.

Cases do not have one specific county or worker that has ongoing responsibility, with three exceptions.

- A. Kentucky Transitional Assistance Program (KTAP) cases that involve participation in the Kentucky Works Program (KWP). Ongoing responsibility for KTAP/KWP activities belongs to the county where the client lives. Recertifications and changes can be completed by any staff regardless of county;
- B. Cases handled by a Department of Juvenile Justice (DJJ) worker are processed by Central Office; and
- C. Simplified Assistance for the Elderly (SAFE) cases are processed in Central Office.]

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MS 0055 – R. 6/1/18 – OMTL-529
[Kentucky Online Gateway (KOG)]

The Kentucky Online Gateway (KOG) provides for a single sign-on to most systems used by staff and automates the request process management staff uses for system access.

A. KOG provides a single sign-on for the:

1. Department for Community Based Services (DCBS) Case Review;
2. Electronic Case Files;
3. E-Forms,
4. Kentucky Physicians Care;
5. Kentucky Health Benefit Exchange (KHBE) Worker Portal;
6. Kentucky Vital Events Tracking System (KVETS (Birth Index));
7. External Search and Exchange Portal (ESEP). This replaces KYNET and Kentucky Info Management System (KYIMS); and
8. Online Tracking Information System (OTIS).

Users can log in once using a single username and personal identification number (PIN) and access multiple systems.

- B. The KOG User Agreement must be accepted on the first use of KOG and may be required again if the User Agreement changes.
- C. KOG automates the process for requesting, approving, and granting access to the applications on KOG. Supervisors use KOG to request access for employees, modify access, and update employee information. KOG provides email notification regarding approval and other tasks in KOG.
- D. Employees may make some changes to their contact information in Account Management in KOG. Employees may also change their security questions.
- E. The KOG Help Desk in the Cabinet's Office of Administrative and Technology Services (OATS) assists with users' access to KOG and other applications. KOG provides automation of some Help Desk tasks previously done through manual processes.
- F. The Help Desk can be contacted by phone toll-free at 866-231-0003, locally at 502-564-0104, or by submitting an e-mail to the [Commonwealth Service Desk](#).
1. **The Security Help Desk** handles the following issues: access revoked on KOG, etc. The Security Help Desk is option two when calling.

2. **The Network Help Desk** handles the following issues: logging onto the workstation, KOG issues related to a user's account, server issues, anything network-related for personal computer (PC) users, email issues, printer issues, etc. The Network Help Desk is option five when calling.]

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MS 0090 – R. 3/1/16 – OMTL-506
Returned Mail

[When mail is returned to the centralized mail center, use the following procedures.

- A. The mail center staff scans the envelope and contents into the Electronic Case File (ECF) and creates a task for the returned mail.
- B. The worker assigned to the task checks the address on Worker Portal.
 - 1. If the address is different, the worker determines if the mail needs to be resent to the new address listed on Worker Portal.
 - 2. If the address listed on Worker Portal matches the returned mail, the worker calls the household in an attempt to obtain the correct mailing address.
 - 3. If able to contact the household by phone, correct the address on Worker Portal to ensure written correspondence is delivered.
 - 4. If unable to contact the household by phone, generate a Request for Information (RFI) requesting that verification of residency be provided within 10 days. If the household does not respond to the RFI, the case will discontinue.
 - 5. If the household provides verification of the correct address, change address on Worker Portal.
- C. If the household does not respond to the request, take action on Worker Portal to discontinue the case.

If the contents are notices originating from the Department for Community Based Services (DCBS), shred the envelope and the contents. If the returned mail contains sensitive material such as original birth certificates or check stubs, store in the hard copy file (if one exists) until the client is due to return to the office.

- D. Document in case comments regarding action taken.]

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Returned Checks

Individuals must return any check for which they are not eligible. Individuals, their Authorized Representative (AR), or any other interested party may return checks to a Department for Community Based Services (DCBS) office. Checks may also be returned to Central Office.

[A. For checks, including Kentucky Transitional Assistance Program (KTAP), Kinship Care (KC), Supplemental Nutrition Assistance Program (SNAP) Employment and Training Program (E&T), Kentucky Works Program (KWP) supportive services, State Supplementation, Family Assistance Short Term (FAST), which have been returned to Central Office, the Program Specialist will receive notification via email about the check and respond via email within five workdays. The response authorizes the appropriate action to:]

1. Cancel a check if:

- a. The recipient of the check died prior to the first day of the month for which the check was issued;
- b. The recipient has moved and cannot be located, and mail sent to the recipient by the local or Central Office has been returned to the local office. A check is not cancelled until procedures for returned mail in [MS 0090](#) are completed and the recipient cannot be located. If, after the check has been cancelled but prior to the last day of the month covered by the cancelled check, the location of the recipient becomes known, the check must be made available to the recipient;
- c. The recipient voluntarily returned a check to avoid an overpayment;
- d. A supportive services provider returns a duplicate payment;
- e. A supportive services payment is returned due to an incorrect amount or provider on the check. In this instance, the correct payment is issued on Online Tracking Information System (OTIS);
- f. The individual is discharged from a Personal Care Home (PCH), unless the individual is going to another PCH or is receiving Community Integration Supplementation (CIS);
- g. The individual is discharged from a Family Care Home (FCH), unless the individual is going to another FCH;
- h. The individual is no longer receiving Caretaker Services or Community Integration Supplementation (CIS); or
- i. The payment was issued in error.

[Note: Once the cancelled KTAP, KC, FAST, or State Supplementation check has been redeposited, the Family Self-Sufficiency Branch (FSSB) will

update the status on the Update Benefit Status screen to Cancelled.
For a KWP supportive services check, OTIS is updated.]

2. Re-mail a check if return was due to an incorrect address and the current mailing address is established. Take action to correct the address on Worker Portal to ensure delivery of subsequent checks.
3. Reissue a KTAP or KC check for the original amount if there has been a change in payee and the new payee is eligible for the original amount.

[Do **NOT** change the payee for FAST or supportive services. Cancel the erroneous payment on Worker Portal or OTIS and issue a new payment to the correct individual/provider.]

4. Reissue the check, if a recipient of KTAP or State Supplementation dies on or after the first day of the month for which the check was issued, to:
 - a. The widow, parent, or guardian; or
 - b. The executor or administrator of the estate. If the check is reissued to an executor or administrator, obtain a copy of the executor or administrator appointment order as verification.
- B. For mutilated checks, request the payee bring the remains of the check to a DCBS office. Mail the check along with a completed form PAFS-61, Disposition of Returned Check, to:

Division of Family Support
Family Self-Sufficiency Branch
KTAP Section
275 E. Main St., 3E-I
Frankfort, KY 40621

Once FSSB receives the form and mutilated check, FSSB will contact Treasury regarding a replacement. Once the check is replaced by Treasury, FSSB will mail the check to the DCBS office for the individual to pick up. At the time the individual picks up the check, form PAFS-62, Local Office Check Log must be completed and form PAFS-62 Sup. A, Affidavit of Check Receipt, must be signed.

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MS 0110 – R. 5/1/24 – OMTL-647

Report of Nonreceipt of Benefits Issued by Check

[If a payee reports non-receipt of a check or that a check has been lost or stolen, the payee may request a replacement of a check (Kentucky Transitional Assistance Program (KTAP), Kinship Care (KC), Supplemental Nutrition Assistance Program (SNAP) Employment and Training Program (E&T), Kentucky Works Program (KWP) supportive services, Family Assistance Short Term (FAST), Relocation Assistance Program (RAP), and State Supplementation).]

A payee must report non-receipt, loss, or theft of a check within 12 months of the intended receipt in order to receive a replacement check. Replacement checks are not issued for requests made after 12 months.

Example: The issuance date of the check is June 1, 2022. The individual may request replacement of the check until May 31, 2023. If the individual reports non-receipt, loss, or theft of the check on June 1, 2023 or after, the replacement request is denied.

A. When a payee reports non-receipt, loss, or theft of a check:

1. [Inquire the appropriate system to determine the date the check was issued.
 - a. For KTAP, KC, FAST, SNAP E&T, and State Supplementation, access Worker Portal for issuance information.
 - b. For RAP and KWP supportive services checks, access the Online Tracking Information System (OTIS) for check issuance information.]
2. The payee must wait 10 business days from the daily check issuance date before completing form PAFS-60, Affidavit, to request a replacement.
3. If the individual is reporting the non-receipt by phone, tell the individual that they have to go to the local Department for Community Based Services (DCBS) office to sign form PAFS-60.

[If a FAST or KWP check is issued to a provider, send form PA-64, Provider Appointment Letter, to document the appointment to discuss non-receipt, loss, or theft of a check. Form PA-64 also provides instruction for the provider to return form PAFS-60 signed and notarized to the office.]

4. Determine if:
 - a. The payee recently moved and failed to provide a forwarding address to the Post Office or a change of address was submitted too late to redirect mailing of the check;
 - b. The check was lost or stolen and if the check was signed before the loss or theft; or

- c. For a stolen check, the individual reported the theft to the police and obtained a copy of the police report.
5. Contact the Division of Family Support (DFS), KTAP Section at 502-564-3440 to determine if the check has been returned or cashed.
 - a. If the check has not been returned or cashed, verbally schedule an appointment with the individual within three days to complete form PAFS-60.
 - b. If returned, the check is re-mailed to the correct address.
 - c. If cashed, follow procedures in [MS 0115](#).
- B. At the time of the appointment to complete form PAFS-60:
 1. [In OTIS, navigate to Payments and select the payment that is reported stolen, lost, or not received. Then choose "Issue PAFS-60" and enter comments in the "Supportive Service Request to Stop Payment" comment box. Once the comments have been entered, follow the steps B.2.– 6.
 2. Complete the Update Benefit Status screen in Benefit Management in Worker Portal. This will create a task for the Family Self-Sufficiency Branch (FSSB).]
 3. Generate form PAFS-60 Part I on the Update Benefit Status screen for the individual to sign while in the office. For FAST payments or payments from OTIS issued to a vendor, form PA-64, Provider Appointment Letter, is used to notify the vendor of the need to sign the affidavit, form PAFS-60.
 - a. The form must be signed by the payee and Field Services Supervisor (FSS). If the FSS is unavailable, the form must be notarized.
 - b. If the payee is a vendor who is signing the form outside of the office, form PAFS-60 must be notarized.
 - c. Form PAFS-60 may also be signed by the Power of Attorney (POA) if verification of the POA is provided and scanned into the Electronic Case File (ECF).

Note: Do not use a version of form PAFS-60 other than the one generated from Worker Portal. The use of any other version will be rejected and will result in an unnecessary delay for the individual. In addition, if form PAFS-60 Part I is not system-generated, then form PAFS-60 Part II cannot be generated.

- 4. Explain the following to the payee:
 - a. The original check cannot be cashed once form PAFS-60 is signed and a stop payment has been placed on the check.
 - b. If the original check, which is issued in a self-sealed envelope known as thermo-bond, is received after form PAFS-60 is signed, it must be returned

to the DCBS office. The replacement check has a different check number and date of issuance.

5. Once the form is completed and signed, mail the original version to:

Division of Family Support
Family Self-Sufficiency Branch
KTAP Section
275 East Main St., 3E-1
Frankfort, KY 40621

Scan the form into ECF. Copy versions of the form cannot be used to request a replacement.

6. When form PAFS-60 is received by FSSB, the status on the Update Benefit Status screen will be changed to Stopped and a replacement will be requested from Treasury. Once Treasury has replaced the check, FSSB will update the status to Replaced and mail the check to the DCBS office for the individual to pick up. CHK-1, Notice of Replacement Check, will be system-generated, informing the individual that the replacement has been processed and can be picked up at the DCBS office. When the individual picks up the check, form PAFS-62, Local Office Check Log, must be completed and form PAFS-62, Sup. A, Affidavit of Check Receipt, must be signed.

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Replacement of a Check that is Cashed

If the original check is cashed before the stop payment is in place:

- A. The Division of Family Support (DFS) Central Office (CO) worker will update the Benefit Status on Worker Portal to "cashed". This generates a notice, CHK-1, Notice of Replacement Check, to the individual stating that the check was cashed and providing instructions on how to dispute that he/she cashed the check.
- The CO worker obtains a copy of the cashed check and emails a copy to the Program Specialist.
- B. [When the individual comes to the local office to dispute the cashed check, have them view the cashed check signature. If the payee is a Kentucky Works Program (KWP) supportive services provider, send form PA-64, Provider Appointment Letter, to the provider to complete form PAFS-60 Part II. Form PAFS-60, Part I and Part II, is evidence in the event legal action is initiated for false swearing or fraud. Advise the individual that the form may be used as evidence and extend to the payee the opportunity to consult legal counsel, if desired, before signing the form.]
1. If the individual states he/she signed the check, send an [e-mail to DFS](#) explaining that the individual no longer claims non-receipt of the check.
 2. [If the individual denies the endorsement is theirs, complete the Update Benefit Status screen. This will create a task to the Family Self-Sufficiency Branch (FSSB). Generate form PAFS-60, Part II on the Update Benefit Status screen and have the individual sign the form.
Note: Do not use any version of form PAFS-60 other than the one generated from Worker Portal. The use of any other version will be rejected and will result in an unnecessary delay for the individual. In addition, if form PAFS-60 Part I is not generated from Worker Portal, form PAFS-60 Part II cannot be generated from the system.]
Form PAFS-60 Part II **must** be signed by a Notary Public. The form cannot be signed by a staff person who is not a Notary Public. If a Notary Public does not sign the form, this will cause a delay in the replacement check. Treasury will return the form and require a new form PAFS-60 Part II be completed with all the necessary signatures.
 3. If the individual denies the endorsement is his/hers, request the individual to provide a police report for the forged endorsement.
 4. Scan the signed form PAFS-60 Part II and the police report into the Electronic Case File (ECF). Mail the **original** version of the form and police report to:

Family Self-Sufficiency Branch
KTAP Section
275 East Main Street, 3E-I
Frankfort, KY 40621

5. Once FSSB receives the form, it is forwarded to Treasury. Treasury has the final decision regarding the replacement of a check that has been cashed. Treasury may contact the individual for additional information regarding the endorsement of the check. There is no time frame in which Treasury must make the decision to issue the replacement. If Treasury replaces the check, FSSB will update the status to Reissued and mail the check to the DCBS office for the individual to pick up. When the individual picks up the check, form PAFS-62, Local Office Check Log, must be completed and form PAFS-62 Supp A, Affidavit of Check Receipt, must be signed.
 6. If the individual fails to view the endorsement, send an [e-mail to FSSB](#) explaining that the individual failed to view the endorsement.
Failure to view the endorsement or sign form PAFS-60 does **not** affect the eligibility of the case.
- C. The Program Specialist must respond to FSSB within 10 calendar days from receipt of the request to view the endorsement.
- D. If, within six months of the first replacement check, a second replacement check is requested by the individual, follow the procedures for replacement check requests.

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MS 0120 – R. 9/1/21 – OMTL-581
Checks Received by the Local Office

[Checks may be mailed by Central Office to the local office for the payee shown on the check to pick up. These include checks that have been replaced by Treasury due to being lost, stolen, and/or damaged, or a rejected direct deposit. In addition, the local office may receive checks from individuals, their Authorized Representative (AR), provider, or any other interested party who needs to return checks. If someone other than the payee on the check picks up the check, there must be an explanation in Case Notes as to who authorized the individual to receive the check.

Any time a check is received in the local office, the worker must enter the check status information in Worker Portal under Benefit Management on the Update Benefit Status screen. This screen is also updated at the disposition of the check, whether picked up by the individual or returned to Central Office.

- A. Form PAFS-62, Local Office Check Log, is a mandatory form and must be completed and maintained for all checks received in the local office. Every check received in the local office must be entered on form PAFS-62 upon receipt, and the disposition of the check must be entered as well. It is extremely important that this form is updated appropriately with accurate information needed to track the checks received.]
- B. Form PAFS-62, Supp A, Affidavit of Check Receipt, is a mandatory form and must be completed and signed by the recipient and worker when the check is picked up. The form should be scanned into the Electronic Case File (ECF).
- C. If in 30 days, the individual has not picked up the replacement check:
 - 1. Complete form PAFS-61, Disposition of Returned Check, to cancel the check. Scan the form into ECF.
 - 2. Mail form PAFS-61 and the check to:

Division of Family Support
Family Self-Sufficiency Branch
K-TAP Section
275 E. Main Street, 3E-I
Frankfort, KY 40621

Annotate the envelope: **Do Not Forward**

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Documentation

If verification in the case record does not conflict with system entries, further comment is not required. However, if verification in the case record conflicts with system entries, an explanation must be provided in comments on Worker Portal. Comments also need to address any unusual circumstances regarding the individual's situation.

The following is a list of items that should be addressed in case comments.

A. Documentation for all programs:

1. At application or recertification case comments **must** contain a statement that rights and responsibilities were explained and understood by the client and that all required forms were given to the client.

It is not appropriate to comment that rights and responsibilities were explained if an interview is not conducted.

2. Resolution of computer matches.
3. Unusual circumstances pertaining to:

- a. The reason a request for an out-of-office interview is granted or denied;
- b. Deviation in normal office operating procedures;

[Example: Individual applies on March 12, 2024, but Worker Portal is not accessible. A hard copy application is taken and the action is not entered until March 13, 2024.

- c. Technical eligibility, program type, household composition, or deviation from normal calculation procedures for income allocations;
- d. A statement explaining the status of non-household and ineligible members and the consideration of their income and resources;
- e. Reasons for any delays in case processing;
- f. The reason information is determined as questionable and how this was resolved;
- g. The household's voluntary request for a denial or discontinuance;
- h. The need for accommodation in the provision of services due to a mental or physical disability of a household member; or

- i. A statement that an eligible member does not have any out-of-pocket medical expenses or chooses not to provide verification of the expenses, when a medical deduction is not considered.
- B. Additional documentation requirements relevant to specific programs are found in the appropriate volume.
- C. For **all programs, do not** editorialize, offer personal opinions, or air disagreements in case comments. Case comments are a part of the official case record, which is subject to review by supervisory staff, Central Office, Quality Control (QC), Management Evaluation (ME), Office of Administrative Hearings (OAH), Department of Medicaid Services (DMS), benefit recipients, and their legal counsel.]

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MS 0131 – R. 5/1/23 – OMTL-623
Electronic Income Verification (EIV)

[Electronic Income Verification (EIV) is a method of obtaining verification of an individual's earned income online. An online service may be used to assist individuals when verification of earned income is not readily available, and the individual advises the worker that verification of the income is available by a free online service. Before EIV can be used, the individual must be contacted to confirm the information provided through EIV is current and correct. Comments must be entered in Worker Portal to explain the verification of the income. This also applies to information received from the Eligibility Advisor (EA).

Note: EA should be accessed before using any other online verification service.]

- A. It remains the individual's responsibility to provide verification of earned income if information provided on an online service is incorrect or incomplete.
- B. [It is the agency's responsibility to conduct thorough interviews to ensure that the employer's name, rate of pay, hours worked, and pay schedule are documented in comments when earned income is reported and can be verified through an approved EIV.]
- C. EIV online services may have hidden fees that workers may not be aware of without completing additional research. Therefore, the online services must meet all of the following criteria:
 - 1. The online service must be free.
 - 2. The online service must not lead to a charge of any kind.
 - 3. The information must be accessible to the caseworker directly.

[If the EIV online service meets the criteria above, forward the information to the appropriate program branch inbox through the region's Public Assistance Program Specialist (PAPS) for approval to use the service. Once approval has been received from Central Office (CO), the service can be used.]

If the EIV online service is not approved, follow normal verification procedures.

- D. **Do not** utilize or set up accounts for EIV online services that do not meet the criteria listed above. **Do not** use an individual's username and password to log on to the individual's online account to verify earned income **or** allow an individual to use state computer equipment to do so.

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 MS 0140 - R. 3/1/26 - OMTL- 688
 Acronyms

Following is a list of acronyms and the programs utilizing the term.

Initials	Meaning	Program
ABD	Aged, Blind, Disabled	MA, State Supp.
ABE	Adult Basic Education	KTAP
ABI	Acquired Brain Injury (Medicaid) Waiver Program	MA
ABAWD	Able-Bodied Adults Without Dependents	SNAP
ADA	Americans with Disabilities Act of 1990	All Programs
ADH	Administrative Disqualification Hearing	SNAP, Claims
AE	Agency Error	Claims
APTC	Advance Premium Tax Credit	MA
AR	Authorized Representative	All Programs
BENDEX	Beneficiary Data Exchange	All Programs
BOW	Birth Out-of-Wedlock	KTAP, MA
BR	Benefit Reduction	KTAP, KC, SNAP
BUA	Basic Utility Allowance	SNAP
CAA	Community Action Agency	KTAP, SNAP
CAN	Child Abuse/Neglect background checks	Kinship Care
CC	Collateral Contact	All Programs
CCAP	Child Care Assistance Program	All Programs
CCR&R	Child Care Resource and Referral Agencies, sometimes referred to as R&R	All Programs
CE	Categorical Eligibility	SNAP
CHFS	Cabinet for Health and Family Services	All Programs
CMS	Claims Management Section	All Programs
COB	Close of Business	All Programs
COLA	Cost of Living Adjustment	All Programs
COM	Community Service	KTAP
CS	Client Statement	All Programs
CSV	Cash Surrender Value	MA
DAA	Drug Addiction and Alcohol	SNAP, MA
DCBS	Department for Community Based Services	All Programs
[DCSS	Department of Child Support Services	All Programs]
DDS	Disability Determination Services	MA
DFS	Division of Family Support	All Programs
DMS	Department for Medicaid Services	MA
DPP	Division of Protection and Permanency	KTAP, Kinship Care, MA
DOB	Date of Birth	All Programs
DSNAP	Disaster Supplemental Nutrition Assistance Program	SNAP
DVO	Domestic Violence Order	KTAP
EA	Eligibility Advisor	All Programs
ECT	Excessive Card Task	SNAP

EDG	Eligibility Determination Group	MA
E&T	Employment & Training	SNAP
EBT	Electronic Benefit Transfer	SNAP, KTAP, Kinship Care
ECE	Expanded Categorical Eligibility	SNAP
ECF	Electronic Case File	All Programs
EEO	Equal Employment Opportunities	All Programs
EITC	Earned Income Tax Credit, also known as EIC	All Programs
EIV	Electronic Income Verification	All Programs
EPO	Emergency Protective Order	KTAP
EPSDT	Early and Periodic Screening, Diagnosis and Treatment	MA
ERT	Employment Readiness Training	SNAP
ESAP	Elderly Simplified Assistance Project	SNAP
ESI	Employer-Sponsored Insurance	MA
ESL	English as a Second Language	KTAP
EXSNAP	Expedited Supplemental Assistance Program	SNAP
FAD	Family Alternatives Diversion	KTAP
FAST	Family Assistance Short Term	FAST
FCH	Family Care Home	MA, State Supp.
FEIN	Federal Employer Identification Number	KTAP
FFY	Federal Fiscal Year	All Programs
FH	Fair Hearing	All Programs
FICA	Federal Insurance Contributions Act	All Programs
FIS	Fidelity Information Systems	SNAP, KTAP
FLSA	Fair Labor Standards Act	KTAP
FMV	Fair Market Value	MA
FNS	Food and Nutrition Service	SNAP
FO	Final Order	All Programs
FPL	Federal Poverty Level	All Programs
FRYSC	Family Resource and Youth Services Center	KTAP
FSSB	Family Self-Sufficiency Branch	All Programs
FTI	Federal Tax Information	All Programs
GED	General Equivalency Diploma	KTAP
HCBS	Home and Community Based Services	MA
HH	Household	All Programs
HOH	Head of Household	All Programs
HHS	Health and Human Services	KTAP, MA
HIPAA	Health Insurance Portability and Accountability Act of 1996	All Programs
HOO	Hearing Officer Order	All Programs
HUD	Department of Housing and Urban Development	All Programs
IAS	Integrity & Analysis Section	All Programs
ICF IID	Intermediate Care Facility for Individuals with an Intellectual Disability	MA

ICPC	Interstate Compact on the Placement of Children	KTAP, MA, Kinship Care
IDA	Individual Development Account	KTAP
IEES	Integrated Eligibility and Enrollment System	All Programs
IET	Integrated Education Training	SNAP
IEVS	Income and Eligibility Verification System	All Programs
IHE	Inadvertent Household Error	SNAP
IK	In Kind	SNAP
IMD	Institution for Mental Diseases	MA
IPV	Intentional Program Violation	SNAP
IRS	Internal Revenue Services	All Programs
IVR	Interactive Voice Response	All Programs
JRA	Job Readiness Training	KTAP
KAR	Kentucky Administrative Regulation	All Programs
KC	Kinship Care	KC, KTAP, SNAP
KCHIP	Kentucky Children's Health Insurance Program	MA
KCTCS	Kentucky Community and Technical College Systems	KTAP
KMA	Kentucky Medical Association	MA
KMP	Kentucky Medicaid Program	MA
KOG	Kentucky Online Gateway	All Programs
KPC	Kentucky Physicians Care Program	MA
KRS	Kentucky Revised Statutes	All Programs
KTAP	Kentucky Transitional Assistance Program	All Programs
KWP	Kentucky Works Program	KTAP
KYIMS	Kentucky Information Management System	MA
LEP	Limited English Proficiency	All Programs
LIHEAP	Low Income Home Energy Assistance Program	SNAP
LOC	Level of Care	MA
LTC	Long Term Care	MA
MA	Medicaid/Medical Assistance	All Programs
MAGI	Modified Adjusted Gross Income	MA
MAID	Medicaid Identification Card	MA
MCO	Managed Care Organization	MA
ME	Management Evaluation	All Programs
MHP	Mental Health Provider	MA
MRT	Medical Review Team	KTAP, MA, State Supp.
MMV	Missing Mandatory Verification	All Programs
MSBB	Medical Support and Benefits Branch	MA, State Supp.
NAB	Nutrition Assistance Branch	SNAP
NAC	National Accuracy Clearinghouse	SNAP
NCLEX	National Council Licensure Examination	KTAP
NCP	Non-custodial Parent	KTAP, MA
NEMT	Non-Emergency Medical Transportation	MA

NOH	Notice of Hearing	All Programs
NSLP	National School Lunch Program	SNAP
OAG	Office of Attorney General	All Programs
OAH	Office of Administrative Hearings	All programs
OATS	Office of Administrative and Technology Services	All Programs
OCR	Optical Character Recognition	All Programs
OIG	Office of Inspector General	All Programs
OTIS	Online Tracking Information System	KTAP
OVR	Office of Vocational Rehabilitation	KTAP
P&P	Protection & Permanency	SNAP, KTAP, MA, CCAP
PA	Public Assistance	All Programs
PAPS	Public Assistance Program Specialist	All Programs
PASS	Plan for Achieving Self-Support	MA
PCH	Personal Care Home	MA, State Supp.
PDB	Policy Development Branch	All Programs
PIB	Program Integrity Branch	All Programs
PL	Public Law	All Programs
POA	Power of Attorney	MA, State Supp.
PRO	Peer Review Organization	MA
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996	All Programs
PRTF	Psychiatric Residential Treatment Facility	MA
QA	Quality Assurance	All Programs
QC	Quality Control	All Programs
QDWI	Qualified Disabled Working Individuals	MA
QHP	Qualified Health Plan	MA
QIT	Qualifying Income Trust	MA
QMB	Qualified Medicare Beneficiaries	MA
R & R	Rights and Responsibilities	All Programs
RAP	Relocation Assistance Program	KTAP
RCO	Recommended Order	All Programs
RCW	Regional Claim Worker	All Programs
RDS	Report Distribution System	All Programs
[RFC	Request for Contact	SNAP]
RFI	Request for Information	All Programs
RIC	Revenue Intercept System	All Programs
RN	Registered Nurse	KTAP
RO	Related Observation	All Programs
RSDI	Retirement, Survivors, Disability Insurance	All Programs
RTW	Ready-to-Work Program	KTAP, SNAP
SAFE or SF	Simplified Assistance for the Elderly	SNAP
SAVE	Systematic Alien Verification for Entitlement	All Programs
SCL	Supports for Community Living Waiver Program	MA
SDX	State Data Exchange	All Programs
SEBT	Summer Electronic Benefit Transfer	SNAP

SVES	State Verification & Exchange System	All Programs
SFU	Standard Filing Unit	KTAP, MA (E&T only)
SI	System Inquiry	All Programs
SIPV	Suspected Intentional Program Violation	All Programs
SLMB	Specified Low Income Medicare Beneficiaries	MA
SNAP	Supplemental Nutrition Assistance Program	SNAP
SOLQ	State On-Line Query	All Programs
SP	Second Parent	KTAP
SR	Simplified Reporting	SNAP
SRA	Service Region Administrator	All Programs
SRAA	Service Region Administrator Associate	All Programs
SSA	Social Security Administration	All Programs
SSI	Supplemental Security Income	All Programs
SSN	Social Security Number	All Programs
SSP	Self-Service Portal	All Programs
SST	Short-term Training	KTAP
SUA	Standard Utility Allowance	SNAP
SWICA	State Wage Income Collection Agency	All Programs
SYETP	Summer Youth Employment and Training Program	All Programs
TAA	Transitional Assistance Agreement	KTAP
TANF	Temporary Assistance for Needy Families	KTAP
TAP	Targeted Assessment Program	KTAP
TDD/TTY	Telecommunications Device for the Deaf and Hard of Hearing	All Programs
TMA	Transitional Medical Assistance	KTAP, MA
TOA	Type of Assistance	MA, State Supp.
TOP	Treasury Offset Program	Claims
TPL	Third Party Liability	KTAP, MA
TPR	Termination of Parental Rights	KTAP, MA
UI	Unemployment Insurance	All Programs
UIB	Unemployment Insurance Benefits	All Programs
USC	United States Code	All Programs
USDA	United States Department of Agriculture	SNAP
VA	Veterans Administration	All Programs
VES	Vocational Education Skills	SNAP
VISTA	Volunteers In Service To America	All Programs
VP	Vendor Payment	All Programs
VR	Vocational Rehabilitation	KTAP
WEP	Work Experience Program	KTAP, SNAP
WIOA	Workforce Innovation and Opportunity Act	All Programs
WIC	Women, Infant, and Children	All Programs
WIN	Work Incentive Reimbursement	KTAP

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MS 0150 – R. 9/1/22 – OMTL-605
Confidentiality Requirements

Disclosure of information concerning applicants and recipients of assistance or services from the Department of Community Based Services (DCBS) is limited to purposes directly connected with the administration of the program. Such purposes include establishing eligibility, determining amount of assistance, and providing services.

- A. Applicants and recipients must be protected from harassment and exploitation for political or commercial purposes. Case records or listings of these individuals may not be open for public inspection or used in any manner so as to become a part of public record.
- B. Respect the applicant's/recipient's right to privacy.
 - 1. Do not conduct interviews with other individuals present unless the recipient consents.
 - 2. Do not discuss or disclose information about the applicant/recipient with a collateral contact.
 - 3. Do not discuss case situations informally or outside the office setting.
 - 4. Do not provide any information by e-mail to the applicant/recipient. If you receive an e-mail from an applicant/recipient, respond with the following message: "I am not allowed to respond to e-mails regarding confidential information. Please call 1-855-306-8959 or come into the local office to discuss your request for information". Before sending the e-mail, remove all confidential information, such as applicant's/recipient's name, social security number (SSN), or address, from the original e-mail, including the subject line.
 - [5. Do not provide any specific information in a voicemail message to a generic voice mailbox or to a contact number that does not belong to the applicant/recipient. When a generic voicemail greeting is received, it is appropriate to state, "Hello. This is DCBS. Please call us back at 855-306-8959". If calling another contact number, leave the same message.]
- C. All e-mail communication must be **encrypted before** it is sent outside of the state government e-mail system. Case information, including Personal Health Information (PHI), **cannot** be sent via unencrypted e-mail to agencies outside of the state government e-mail system. Encrypted communication is not sent to a recipient.
 - 1. All e-mail messages should include the following confidentiality notice:

"This electronic message is intended to be for the use only of the named recipient and may contain information that is confidential or privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or use of the contents of this message is strictly prohibited. If you have received this message in error or are not the

named recipient, please notify us immediately by contacting the sender at the electronic mail address noted above, delete, and destroy all copies of this message. Thank you.”

This notice can be added to the signature block of the e-mail if an automated signature is used.

2. Prior to the release of case information:

- a. The recipient must complete form DCBS-1A, Informed Consent and Release of Information and Records Supplement, before PHI can be released by DCBS.
- b. Before an outside agency can release PHI to DCBS, the outside agency must have the form DCBS-2, Informed Consent and Release of Information and Records, completed by the recipient.

3. Do not send PHI in the subject line of any e-mail message, whether encrypted or not. This includes the name or any corresponding record number.

4. Before attaching a document to the message, double-check the document to determine that it is the correct one.

5. Before sending the e-mail, check to ensure no unintended information is included.

- D. Forms and/or information utilized in the voter registration process are to remain confidential and be used only for voter registration purposes.
- E. Any person who violates requirements regarding confidentiality is subject to a fine of not less than \$50 and not more than \$200, or imprisonment for not more than six months, or both.

For additional information regarding the Health Insurance Portability and Accountability Act (HIPAA), refer to [MS 0160](#).

For additional requirements regarding safeguarding Internal Revenue Service (IRS) information, refer to [MS 0680](#).

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MS 0160 – R. 11/1/09 – OMTL-343

Health Insurance Portability and Accountability Act Compliance Requirements

The Department for Community Based Services (DCBS) must comply with provisions of the [Health Insurance Portability and Accountability Act \(HIPAA\)](#).

- A. The HIPAA component which impacts DCBS staff administering Family Support programs is the safeguarding of an individual's health information.
- B. The term "health information" relates to any information, whether oral or recorded in any form or medium, that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse. Health information relates to:
 - 1. The past, present, or future physical or mental health or condition of an individual;
 - 2. To the provision of health care to an individual; or
 - 3. To the past, present, or future payment for the provision of health care to an individual.
- C. Examples of safeguards that apply to covered entities and that are mentioned in the preamble to the HIPAA Privacy Rule are:
 - 1. Shredding documents prior to disposal.
 - 2. Locking doors or cabinets where medical records are kept.
 - 3. Limiting access to the keys or combinations of the locks for these doors or cabinets.
 - 4. Turning computer screens away from public view.
 - 5. Locking or logging off computer monitors when they are not being used.
 - 6. Never giving health information to a third party who is not an authorized representative.
 - 7. Monitoring the duplication and transmission of health records on fax machines, photocopiers, and printers.
 - 8. Keeping records containing health information face down on desks and tables.
 - 9. When sending a fax containing health information, first call the recipient so the fax will be picked up immediately; and
 - 10. Speaking softly so that others do not overhear health information.

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*MS 0175 – 1/15/25 – OMTL-664

Disclosure of Information

Case record information should never be shared with any individual or entity not authorized to obtain it. This also applies to testimony in court. However, through appropriate action, information may be requested to use in either legal action or personal business.

- A. Open Records Requests are requests for eligibility information for an individual(s). These can come from the individual themselves, law enforcement, or another individual or entity that would otherwise be unable to access these records. These requests are not generally completed by field staff. If documentation for an Open Records Request is received, the documentation should be forwarded through regional chain of command to the appropriate program inbox.

[Information regarding the submission of a request, including the information for media requests](#)

- B. Subpoenas may be used as a request for information by the judicial system. Guidance regarding what can or cannot be disclosed based on the type of subpoena may be obtained from the regional attorneys or, if the regional attorney is unavailable or cannot help, the Cabinet for Health and Family Services (CHFS) Office of Legal Services (OLS) in Central Office.

[List of regional attorneys that may be able to assist](#)

1. Contact the regional attorney or OLS at 502-564-7905 immediately upon receipt of a subpoena. If time permits, the regional attorney/OLS will assist. If time does not permit OLS assistance, take the following action:
 - a. If the subpoena requests a Family Support worker to appear in court, the worker must appear in court with the requested information as directed. In addition, the worker should take a copy of [KRS 205.175](#) and explain to the judge that all Family Support case records are confidential pursuant to KRS 205.175 and can only be released by court order. If the judge orders the release of the information, the worker must comply.
 - b. If the subpoena requests a Family Support worker to appear in a setting other than the courtroom or in the presence of a judge, the employee must appear as directed and advise that all CHFS case information is confidential pursuant to KRS 205.175 and can only be released to a judge by a court order. (See Volume 3 MS 2040 if the individual presents a court order).
 - c. If the subpoena requests release of information contained in the case file and the individual requesting information is acting on behalf of CHFS, such as a county attorney involved in child support activities, provide the requested information.
2. Grand jury subpoenas are not court orders and while a judge is not present at the proceeding, information may be released to the grand jury only if the

investigation involves alleged fraud in benefits programs administered by CHFS. Use the following information when a grand jury subpoena is received.

- a. The requested information can be provided to the prosecuting attorney or given during the grand jury appearance.
 - b. ALL information, requested by and provided to the grand jury, is confidential. **No aspect** of any case is to be discussed with anyone outside the grand jury proceedings.
 - c. If the investigation is for other criminal actions, contact OLS for guidance prior to the grand jury hearing.
 - d. Failure to follow these instructions will cause the individual named in the subpoena to be held in contempt.
- C. Warrants must be reviewed using program-specific information to determine if information may be released and what information may be released.

For specific information regarding the requirements relating to the general release of:

1. Supplemental Nutrition Assistance Program (SNAP) material, see Volume 2 MS 7200.
2. Kentucky Transitional Assistance Program (KTAP) and other Temporary Assistance for Needy Families (TANF) funded programs, see Volume 3 MS 2040.
3. Non-MAGI Medicaid, see Volume 4A MS 1235.
4. MAGI Medicaid, see Volume 4B MS 1040.
5. State Supplementation, see Volume 5 MS 1250.

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MS 0180 – R. 11/1/19 – OMTL-555

Viewing of Case Record Material by Recipients and Representatives

- A. The following portions of the case record may be viewed at any time by the client or a representative designated by the recipient on form DCBS-1, Informed Consent and Release of Information and Records, or the DCBS-1A, Informed Consent and Release of Information and Records Supplement:
1. Forms completed or provided by the client;
 2. Worksheets used in the eligibility determination;
 3. Correspondence to and from the client;
 4. Decisions from the Medical Review Team;
 5. Non-confidential medical records of the client;
- B. The following portions of the case record **cannot** be viewed unless the client obtains a court order:
1. Medical records marked as "confidential – not to be viewed or shared with the patient";
 2. Names of individuals who provided information regarding the client;
 3. The nature or status of criminal proceedings;
 4. Records subject to Health Insurance Portability and Accountability Act (HIPAA) procedures. For more information regarding HIPAA, see [MS 0160](#);
 5. Child support screens, which contain the absent parent's tax refund information.
- C. Case record inspection is conducted in any local office, with care taken that no part of the record is lost. Electronic Case File (ECF) documents must be printed for viewing. The client, Power of Attorney (POA), Authorized Representative (AR), or attorney **cannot** view the case material from the computer screen. If requested, copies of the record pertinent to the issue are prepared for and provided to the client or representative at any local office. Case material cannot be provided through e-mail or mail. The only exception to sending case material via mail is for a telephonic hearing.
- D. Information needed for the settlement of a deceased client's affairs may be released to a bona fide representative or administrator of an estate, but are still subject to HIPAA requirements. See [MS 0160](#).

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MS 0190 – R. 6/1/11 – OMTL-389
Agreement to Safeguard Information

An agency, organization, or school may obtain recipient information if a Memorandum of Understanding (MOU) Safeguarding Information in Public Assistance Programs and Business Associate Agreement has been completed with the Department for Community Based Services (DCBS). These are confidentiality agreements that are negotiated and maintained by staff in the Division of Family Support (DFS).

- [A. To qualify to enter into an MOU, a requesting agency must meet the following criteria:]
 - 1. The agency must be federally funded;
 - 2. The agency must provide needs-based services, where eligibility is based on an income test; and
 - 3. Staff of the agency must be subject to the same confidentiality requirements as Cabinet employees.
- B. Examples of agencies that meet the above criteria include public housing authorities and public Boards of Education.
- C. Organizations which do not meet the criteria include churches, associations sponsored by religious groups, civic clubs, United Way, the Red Cross, individuals such as temporary help in the local offices, custodians, guards, repairmen, summer workers, landlords, or students working on research papers. Case information can only be released to these groups/individuals if the recipient completes form DCBS-1, Informed Consent and Release of Information and Records, or DCBS-1A Supplement.
- [D. If an agency/organization/school meeting requirements in item A requests client information and does not have a current signed MOU agreement with DCBS, contact the [Policy Development Branch \(PDB\)](#).
- E. Staff in PDB:
 - 1. Will initiate completion of the MOU directly with the agency; and]
 - 2. Send out renewal agreements every two years to agencies that have an existing MOU.
- F. A listing of all currently active confidentiality agreements is maintained with DFS. To inquire about the status of a confidentiality agreement, [contact PDB](#).

Volume 1 – General Administration
MS 0200 – R. 6/1/26 – OMTL – 696
Complaint Module on Worker Portal

The Complaint Module is a method by which the Cabinet for Health and Family Services (CHFS) complies with a Food and Nutrition Administration (FNA) mandate to track client contacts and complaints. Entries are made on the module for all individuals who contact the cabinet for assistance concerning an issue with a case. All CHFS field staff with user access to Worker Portal can access the Complaint Module.

[All complaints reported by individuals should be logged in the Complaint Module, including Civil Rights complaints of discrimination.]

Access the Complaint Module by signing into Worker Portal and navigating to the Case Summary Screen. From Tools, select 'Complaints' from the drop-down. Options for a new Complaint entry or a Complaint Search are available.

[The complainant is defined as the person making contact. The complainant can be making a formal complaint or inquiring about their own or another individual's case. Before a complainant is entered into the Complaint Module, conduct a thorough search in the Complaint Module via the Complaint Search selection to determine if the same complaint has been previously entered.]

It is critical that all users strive to keep the data that is entered into the Complaint Module current at all times. There may be duplicate entries for a complainant if they have made different points of contact or called multiple times.

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MS 0210 – R. 6/1/26 – OMTL – 696
Civil Rights Overview

[In accordance with Federal law, United States Department of Agriculture (USDA) and United States Department of Health and Human Services (HHS) policies, the Department for Community Based Services (DCBS) and contracted vendors cannot discriminate against any person in the provision of services and benefits based on race, color, national origin, disability, age, sex, and religious and political beliefs.]

A. Policies and practices must conform to the following statutes:

1. [Title VI of the Civil Rights Act of 1964, which protects individuals from discrimination based on race, color, or national origin in any program or activity that receives federal funding. Specific discriminatory actions prohibited under Title VI include the following if the action is based on race, color, or national origin:]
 - a. Providing services that are more limited in scope or lower in quality; or
 - b. Limiting participation in a program.
2. [Section 504 of the Rehabilitation Act of 1973 protects qualified individuals with a disability from discrimination in the provision of any benefit or service provided under any program or activity that receives federal funding. Discriminatory actions prohibited under this authority may include the following if the action is based on disability:]
 - a. Denying a qualified individual with a disability any aid, benefit, or service that is provided to others.
 - b. Providing different or separate aid, benefits, or services to a qualified individual with a disability, unless such action is necessary to ensure that the aid, benefit, or service is equally effective as those provided to others.
3. [Title II of the Americans with Disabilities Act (ADA) of 1990 and the ADA Amendments Act of 2008 prohibit discrimination based on disability in programs and activities of all state and local governments. Specific discriminatory actions may include the following if the action is based on disability:]
 - a. Imposing eligibility criteria that screen out or tend to screen out an individual with a disability from fully or equally enjoying any program or activity unless such criteria are shown to be necessary.
 - b. Providing a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to gain the same result or reach the same level of achievement as that provided to others.
 - c. [Denying an individual with a disability an equal opportunity to obtain

the same result, to gain the same benefit, or to reach the same level of achievement, in the most integrated setting appropriate to the individual's needs.

4. The Age Discrimination Act of 1975 prohibits discrimination based on age in programs or activities receiving federal funding.
 5. Discrimination based on religion is prohibited by a number of Federal laws and regulations. including Section 11(c) of the Food and Nutrition Act of 2008, as amended.]
 6. Title IX of the Education Amendments of 1972 prohibits discrimination based on sex in any education program or activity that receives federal funding.
 7. Civil Rights Restoration Act of 1987 (Public Law 100-259) clarifies the intent of Congress as it relates to the scope of Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, to ensure nondiscrimination in all programs and activities of a recipient, whether those programs and activities are federally funded or not.
 8. The Food and Nutrition Act of 2008, as amended, Supplemental Nutrition Assistance Program (SNAP), formerly the Food Stamp Program, prohibits discrimination against any applicant or participant in any aspect of program administration for reasons of race, color, national origin, disability, age, sex, and religious and political beliefs.
 9. Title III of the ADA and ADAAA prohibits discrimination based on disability by public accommodations and commercial facilities.
 10. Section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. § 18116(a), 45 C.F.R. Part 92) [HHS]).]
- B. Ensure the following general requirements are met in the provision of all services and benefits to applicants and recipients:
1. [Do not discriminate against any individual for reasons of race, color, national origin, disability, age, sex, and religious and political beliefs in any aspect of program operation, including but not limited to the application process, benefit or claims determination, hearings, employability assessments, or work program components.
 2. Explain and provide the Civil Rights pamphlet in the language and format the applicant can understand at the application and any time the individuals question or do not understand their rights.]
- The pamphlet can be accessed at: [Cabinet for Health and Family Services Civil Rights Brochure](#).
3. [Provide assistance to any individual needing reasonable accommodation due to a disability they or another household member currently has or has

had in the past, an individual with a disability causing a physical or mental impairment that substantially limits one or more of the major life activities and has a record of such an impairment; or is regarded as having such an impairment. Definitions of common disabling conditions and suggested accommodation, as well as other information relating to Title II of the Americans with Disabilities Act, can be found at [Kentucky Personnel](#).

4. Document the need for and provision of any reasonable accommodation provided for a disabled individual to apply for benefits in Worker Portal.]
- C. Accommodation in the provision of benefits and services may include, but is not limited to:
1. Visiting an individual's home to conduct interviews.
 2. Scheduling interviews that do not conflict with disability related appointments of the applicant or a disabled member of the household.
 3. Rescheduling interviews if notified that a conflict exists with disability-related appointments.
 4. Making reminder calls regarding appointments or needed information. Document comments in Worker Portal when the call is made.
 5. [Reading and/or explaining letters and forms to an applicant or recipient.
 6. Providing a sign language interpreter or other auxiliary aids or services, including but not limited to Video Relay Services (VRS) for a deaf or hard-of-hearing applicant or recipient. See MS 0220.]
 7. Allowing flexibility in the required hours of participation and component placement in work activities.
 8. Providing extra space in the interview area to allow for medical equipment, such as a walker, oxygen tank, wheelchair, etc.
 9. [Providing other individualized assistance on a case-by-case basis to ensure the applicant or recipient is provided equal access to benefits and services.
- D. Assist applicants, recipients, or their representatives who feel discriminated against in filing a complaint. Refer to MS 0240.]

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MS 0220 – R. 6/1/26 – OMTL – 696

Interpreter Services for Deaf and Hard-of-Hearing Individuals.

- A. [All staff shall take appropriate steps to ensure that communications with applicants, participants, members of the public, and their representatives are as effective as communications with others.

Staff shall furnish appropriate auxiliary aids and services where necessary to afford individuals with disabilities, including applicants, participants, members of the public, and their representatives, an equal opportunity to participate in and enjoy the benefits of a service, program, or activity of the agency.

The type of auxiliary aid or service necessary to ensure effective communication will vary in accordance with the method of communication used by the individual; the nature, length, and complexity of the communication involved; and the context in which the communication is taking place. In determining which type of auxiliary aids and services are necessary, a public entity shall give primary consideration to the requests of individuals with disabilities. To be effective, auxiliary aids and services must be provided in accessible formats, in a timely manner, and in such a way as to protect the privacy and independence of the individual with a disability.]

When interpreter services are needed for a deaf or hard-of-hearing individual, do the following:

1. Document the case that the individual requires interpreter services and indicate how these services were provided. Answer **Yes** within Worker Portal to “Are Special Interviews Required?” and make the appropriate entry.
2. [At application, reapplication, and recertification, provide the individual with form [CHFS-OHRM-EEO-2, Your Right to Effective Communication](#). Document in the case that the form was provided to the individual either by mail or in person. If Worker Portal is unavailable, the individual must complete the [CHFS-OHRM-EEO-3, Waiver of Interpreter Services](#) – form to be scanned to the Electronic Case File (ECF).]
3. If available, use qualified on-site personnel. A qualified interpreter is an interpreter who can interpret effectively, accurately, and impartially both receptively and expressively, using any necessary specialized vocabulary. There are three types of qualified interpreters:
 - a. Certified Deaf Interpreter (CDI) – used for a deaf or hard-of-hearing individual, who can assist in providing an accurate interpretation using sign language. This includes Video Relay Services (VRS);
 - b. Deaf/Blind Interpreter – used for a deaf and blind individual who places their hands over the hands of the interpreter to read signs through touch and movement; or

- c. Oral Interpreter – used for a deaf or hard-of-hearing individual who can lip read.
- 4. When a worker becomes aware that a sign language interpreter is needed, they should contact their supervisor, and the supervisor should get approval for the request from their Service Region Administrator Associate (SRAA).
- 5. [Request services from the Kentucky Commission for the Deaf and Hard of Hearing (KCDHH) Access Center. The Access Center is a language interpreter referral service for state agencies. Information about services available from the Access Center is located at the [Kentucky Commission on the Deaf and Hard of Hearing](#).
 - a. The individual may have the telephone equipment to use VRS. VRS is a qualified interpreter service.
 - b. To request an interpreter, go to the [Kentucky Commission on the Deaf and Hard of Hearing](#) and click on “Interpreting/CART”. Complete the KCDHH Inter-Agency Access Center request form. When completing the form, the SRAA’s contact information must be entered into the billing information sections. The requester fields should have information about a supervisor from the local office where the request was made, and the consumer is the individual who requires interpreter services. Notification is sent once the Access Center has received the request. Another notice is sent within a few days to confirm that an interpreter has been scheduled. Because it may take up to two weeks to schedule an interpreter, the worker should request the interpreter when scheduling appointments.

When requesting an interpreter from KCDHH, provide the following information:

- 1) Local office supervisor name, address, and phone number;
 - 2) The date services are needed;
 - 3) The time (beginning and estimated end time);
 - 4) The location of the assignment;
 - 5) Type of assignment (application, meeting, etc.)
 - 6) Name of the individual needing services;
 - 7) Individual’s preferred mode of communication, if known; and
 - 8) Billing information (SRAA name, address, and phone number).
- c. The interpreter who provides services must complete the Annual Required Affidavit for Bidders, Offerors, and Contractors. This form must be completed by the interpreter and uploaded to the Kentucky Information Technology Standards (KITS) system with the billing invoice.

- d. After interpretation services are provided, the local office will receive a billing invoice. This invoice must be signed off on by an SRAA and uploaded to the KITS system with the Annual Affidavit for Bidders, Offerors, and Contractors. These forms may be uploaded by whoever has access to KITS. If the request form is signed off by someone other than a branch manager or SRAA, it will be rejected by the Accounts Payable Branch.
6. At application, reapplication, and recertification, or at any time an interpreter service is used, have the individual performing the interpreter service complete the confidentiality form, Business Associate Agreement. Scan a copy into ECF.
7. [Staff must not rely on an individual's companion for sign language interpretation. Companions may be used only in the following situations:
 - a. In an emergency involving an imminent threat to the safety or welfare of an individual or the public, an adult or minor child accompanying a person who uses sign language may be relied upon to interpret or facilitate communication only when a qualified interpreter is not available.
 - b. In situations **not** involving an imminent threat, an adult accompanying someone who uses sign language may be relied upon to interpret or facilitate communication when a) the individual requests this, b) the accompanying adult agrees, and c) reliance on the accompanying adult is appropriate under the circumstances. This exception does not apply to minor children.
- B. In situations when a service is performed by an approved interpreter and a fee is charged, each interpreter has their own billing statement. State employees and unlicensed interpreters provided by the individual (e.g., family members, friends, etc.) are not paid for their interpretation services.]
 1. Obtain a signed billing statement from the licensed interpreter, which includes:
 - a. Name of interpreter;
 - b. Social Security number or federal identification number;
 - c. Address, telephone, and email, if available;
 - d. Purpose of the assignment;
 - e. Date the service was provided; and
 - f. Amount of fee. The fee includes:
 - 1) The hourly rate includes time spent travelling, time spent interpreting, and mealtime. Mealtime cannot exceed one hour. Interpreters shall also be paid for at least two hours of service, which can include waiting time due to delays in appointments and when an individual does not appear for the appointment.

- 2) The number of miles traveled to and from the assignment and the mileage rate. Mileage is paid at the state rate.
 - 3) The cost for lodging, if appropriate.
 - g. The total;
 - h. Contact information of the worker to verify the service was provided; and
 - i. Signature of the interpreter.
2. There is no set rate for interpreting services. The agency must contact the individual interpreter directly regarding their billing fees. Rates are individually set by considering the following:
- a. Certification Level;
 - b. Nature of assignment;
 - c. Level of interpreter's education; and
 - d. Experience.
3. After service is rendered, scan the signed billing statement and email it to the [Accounts Payable Branch](#).

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MS 0230 – R. 6/1/26– OMTL – 696
Limited English Proficiency (LEP)

[The Cabinet must ensure all individuals with LEP have meaningful access to all programs and services administered by the Cabinet. LEP individuals are those who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English. Each local office must post notices in multiple languages in the local offices and program websites to inform the public of the availability of free interpreter services.]

Use the following policy and procedures to identify LEP individuals and to provide LEP services to those individuals.

A. When an individual comes into the local office to apply:

1. [Ask the individual for their primary language. Based on the individual's statement, enter the language on Worker Portal. Do not assume an individual does not speak or understand English or assume the individual's primary language based on appearance. If the individual does not speak or understand English, use the "I Speak" language identification posters to determine the primary language. If still unable to identify the language spoken, contact the Language Access Section for assistance;]
2. Inform the LEP individual that interpreter services are available at no cost to the individual using the "I Speak" posters; and
3. [If the individual indicates a primary language other than English and they do not want to use the approved interpreter service provided by the Cabinet, answer the corresponding waiver questions within Worker Portal to document the individual's request. If Worker Portal is **unavailable**, the individual must complete the [CHFS-OHRM-EEO-3, Waiver of Interpreter Services](#) Form, and scan it into the Electronic Case File (ECF). If, during the interview, the worker cannot clearly understand the individual, a Cabinet approved interpreter must be contacted to stay on the line in the background to ensure the quality and accuracy of the interview.

B. If an individual cannot understand verbal or written English, use one of the following options to access interpreter services:

1. Language Services Associates, Inc. (LSA/Interpretalk). The instructions for the LSA may be accessed at: [Language Access Section Interpretalk Instructions](#).
2. Affordable Language Interpreter Video Relay Calling. Instructions for video relay calling can be accessed at: [Affordable Language Interpreter Video Relay Calling](#). Video Relay Calling or a Virtual Face-to-Face interpreter should not be used for routine Supplemental Nutrition Assistance Program (SNAP) or Medicaid applications, even if the applicant is in the office.
3. Cabinet for Health and Family Services (CHFS) Qualified Interpreter Service. If LAS staff are not available, choose an interpreter from the CHFS

approved list of Cabinet employees who are qualified to provide interpreter services. The list can be accessed at:

[Office of Human Resource Management Interpretation Resources.](#)

Note: If you work in the same local office with CHFS Approved Cabinet Employees who are qualified to provide interpreter services, you may contact them if they are available to interpret.

4. CHFS Qualified Community-Based Partner Interpreters. If there is a need to contact a qualified non-CHFS interpreter, the following resource can provide interpreter services for a variety of languages, including Spanish. The list can be accessed at: [Office of Human Resource Management Interpretation Resources.](#)
- C. If the individual wants to use another individual to interpret for them, contact a Cabinet approved interpreter through CHFS LAS Interpreters, LSA/Interpretalk, or Video Relay Calling as needed, and explain to the individual that an approved interpreter is used even though they have another interpreter to ensure all the information, questions, and responses are interpreted correctly and without bias. Staff is encouraged not to allow minor children as interpreters unless all other options are exhausted.]
- D. If a form is identified as needing translation into another language, forward the form to the [Language Access Section](#) by email. Forms and notices generated by Worker Portal are available in English and other languages.
- E. If verification provided by the individual needs to be translated, send the material needing to be translated to the [Language Access Section](#) by email. Please include the date the information is needed and, if expedited translation is required due to time constraints, specify that in the request.
- F. Document in Worker Portal and on the Online Tracking Information System (OTIS) when interpreter services are needed and used for all programs. Documentation should include:
 1. When Special interviews are required;
 2. The date services are requested and provided;
 3. Which option is used; and
 4. The reasons for the service, such as application or recertification interview, interim communications, or translation of forms or other written material.
- G. [Make copies of “Know Your Rights” and have them available in the local waiting area. This brochure is available in ten languages and can be found at: [Know Your Rights/English](#). The brochure must be downloaded from the website, with copies made for distribution.]

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MS 0240 – R. 6/1/26– OMTL – 696
Civil Rights Complaints

Any individual who feels they have been discriminated against may file a complaint. Assist the individual in filing a complaint with any or all of the entities listed below. Retaliation against an individual who submits a complaint, assists in the investigation of a complaint, or interferes in the investigation of a complaint is prohibited by law. An employee who is determined to be in violation is subject to disciplinary action, up to and including dismissal.

- A. [Use the Fair Hearing process if the individual alleges denial of eligibility because of agency policy.
- B. Use the [AD-3027, USDA Program Discrimination Complaint Form](#), if the individual alleges discrimination in the manner in which services are provided or refusal of access to services.

- C. If form AD-3027 is submitted to the local office, forward it through the regional chain of command to the Cabinet for Health and Family Services, Office of Human Resource Management (OHRM), Equal Employment Opportunity Commission (EEOC) Compliance Branch at:

EEO/Civil Rights Compliance Branch
275 East Main Street, 5C-D
Frankfort, Kentucky 40621
Telephone: (502) 564-7770 EXT. 4107

- D. In addition to or in place of filing a complaint with the Cabinet, when discrimination is alleged in the provision of Supplemental Nutrition Assistance Program (SNAP) benefits, the individual may file a complaint with the U. S. Department of Agriculture (USDA) by writing or calling:

USDA, Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, S.W.
STOP 9410
Washington, D.C. 20250-9410
(800) 795-3272 (voice) or (202) 720-6382 (TTD)
Fax: (833) 256-1665 or (202) 690-7442
Email: programintake@usda.gov]

The complaint should be filed within 180 days of the alleged discriminatory action. Only the U.S. Secretary of Agriculture can extend the timeframe under special circumstances.

- E. [In addition to or in place of filing a complaint with the Cabinet, when discrimination is alleged in the provision of Temporary Assistance for Needy Families (TANF)-funded programs (Kentucky Transitional Assistance Payment (KTAP), Family Assistance Short Term (FAST), Work Incentive Reimbursement (WIN), Relocation Assistance Program (RAP), Kinship Care, Kentucky Works Program (KWP)) or Medicaid, the individual may file a complaint by writing or calling:

U.S. Department of Health and Human Services
Region IV Office for Civil Rights
200 Independence Ave., S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

- F. Civil Rights complaints may also be filed by writing or calling the:

Kentucky Commission on Human Rights
312 Whittington Parkway
Suite 020
Louisville, Kentucky 40222
(502) 595-4024 (voice) or (502) 696-5230 (Fax)]

- G. When the individual chooses to file a complaint with entities other than the Cabinet, recommend that the following information be included in the complaint to help with the investigation:

1. The name, address, and phone number of the person alleging discrimination.
2. The name and location of the office or contractor where the discrimination took place.
3. The nature of the incident, action, or aspect of program administration that led to the complaint.
4. The reason for the alleged discrimination, i.e., age, race, sex, disability, religious beliefs, national origin, or political beliefs.
5. The names, titles, and addresses of witnesses or people who have knowledge of the alleged discriminatory acts.
6. The date(s) when alleged discriminatory actions occurred.

- H. Advise the EEO/Civil Rights Compliance Branch, referenced in item C, of any discrimination complaints filed with agencies outside the Cabinet.

- I. [Complaints are investigated and resolved by the agency where the complaint is filed if the agency has jurisdiction to investigate the complaint.]

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MS 0260 – R. 6/1/26 – OMTL- 696
Overview of Electronic Benefit Transfer (EBT)

[The method used by the Department for Community Based Services (DCBS) to make benefits and payments available to eligible households is the EBT card.

A. The EBT card is used to access the following:

1. Supplemental Nutrition Assistance Program (SNAP) benefits;
2. Kentucky Transitional Assistance Program (KTAP) benefits;
3. Kinship Care benefits;
4. Kentucky Works Program (KWP) transportation payments; and
5. Work Incentive Reimbursement (WIN) reimbursement payments.

B. Acronyms used in relation to the EBT system are:

1. ATM - Automated Teller Machine
2. CSR - Customer Service Representative
3. EBT - Electronic Benefit Transfer
4. FNA - Food and Nutrition Administration
5. IVR - Interactive Voice Response
6. PIN - Personal Identification Number
7. POS - Point of Sale]

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MS 0270 – R. 6/1/26 – OMTL – 696

Required Explanations of Electronic Benefit Transfer (EBT)

During the certification interview, provide the household with the following explanations about EBT and the use of the EBT card and Personal Identification Number (PIN) in the language and format the Supplemental Nutrition Assistance Program (SNAP) applicant can understand:

- A. [EBT is the system used to deliver SNAP, Kentucky Transitional Assistance Program (KTAP), Kinship Care, Kentucky Works Program (KWP), transportation, and Work Incentive Reimbursement (WIN) payments in Kentucky. EBT provides a safer, more secure method for recipients to receive benefits. EBT also eliminates the need to mail or have the recipients pick up benefits each month. Benefits are simply added to the recipient's EBT account when an issuance is processed and are automatically available on the EBT card.]
- B. EBT cards are the size and shape of typical bank credit cards. The card is red, white, and blue with an American flag design. The EBT card contains the recipient's name and the EBT card number.
- C. [All EBT cards are mailed with an inactive status. The card should be received by the recipient in approximately 7-10 business days. When the recipient receives the EBT card, a sticker is attached to the card advising them to call the Customer Service Representative (CSR) to activate the card. The EBT card will **not work** until it is activated.]
- D. Only one EBT card is issued per individual, regardless of the number of cases in the individual's name and Social Security Number (SSN). Individuals who have an active EBT account for one type of benefit will not have a separate EBT account or be issued a separate EBT card for other types of benefits. The same EBT card is used to access SNAP, KTAP, Kinship Care, KWP transportation, and WIN payments.

For KWP transportation and WIN payments, if two individuals in the KTAP case are receiving either payment, each individual will have their own EBT card account.

Example 1: Mom has a KTAP, SNAP, and Kinship Care case. All three cases are in her name and SSN. Mom is issued one EBT card for all benefits.

Example 2: Mom and Dad have a KTAP and SNAP case in Dad's name and SSN. Mom has a Kinship Care case in her name and SSN. Dad is issued an EBT card for the KTAP and SNAP benefits. Mom is issued an EBT card for Kinship Care benefits.

Example 3: Mom and Dad have a KTAP and SNAP case. The cases are in Mom's name and SSN. Both Mom and Dad are working and receive transportation payments. Mom's payments are posted to the EBT account along with the KTAP and SNAP benefits. Dad has his own EBT account and card for his transportation payments.]

- E. The EBT card is mailed in a card carrier, which is a two-sided heavy paper folder with slots cut to hold the card in place during mailing. Supplemental EBT educational information is printed on the card carrier covering such subjects as:
 - 1. How and where to use the card;
 - 2. How and when to use the CSR;
 - 3. How to protect the card;
 - 4. The need for Personal Identification Number (PIN) security; and
 - 5. A non-discrimination statement.
- F. SNAP households may designate a representative to receive and use the EBT card on their behalf. Naming an EBT representative allows that person to contact the Customer Service Representative (CSR) on the recipient's behalf. If the household designates two representatives, one to apply for benefits and the other to use the EBT card, the household must specify which representative is to use the EBT card. Authorized representatives are not issued their own EBT card.
- G. The EBT system distributes benefits to recipients through Point of Sale (POS) terminals located in authorized retailers. EBT system problems are handled by customer service support 24 hours a day, 7 days a week for recipients and retailers.

Cash benefits on the EBT system can be accessed as follows:

- 1. The EBT card cannot be used for any cash benefit transactions or withdrawals from Automatic Teller Machines (ATM) in liquor stores, adult-oriented entertainment establishments, or any casino, gambling casino, or gaming establishment.
 - 2. The individual can withdraw cash at an ATM that displays the Quest logo. The individual gets one free withdrawal per month. The individual is charged a fee of 85 cents per withdrawal for subsequent withdrawals. The individual will also be assessed normal bank charges if the ATM charges a processing fee. The fee is deducted from the EBT account.
 - 3. The individual can withdraw cash at a retailer's POS terminal at authorized retailers with no charge at the time of a retail purchase. Individuals cannot request cash back from the SNAP benefits portion of the EBT account.
- H. Give all households authorized to receive benefits the toll-free telephone number when problems arise with their card and/or PIN. The Customer Service telephone number is 1-888-979-9949. The number is printed on the back of the EBT card and on the training material the recipient receives in the mail.

- I. [The CSR is operational 24 hours a day, 7 days a week, and is voice automated.]
- J. All certified retailers are provided with a toll-free telephone number for use when problems arise with their equipment or when completing a transaction. These numbers are:

Retailer HELP DESK 1-800-230-0179
EBT only Integrated-Call your Third-Party Processor
Manual Voucher Approval 1-866-340-9520
Retailer General Questions 1-800-350-8533

These numbers are printed on the training material the retailers receive.

- K. Recipients contact the CSR to:
 - 1. Report their EBT card lost, stolen, or damaged and request a new EBT card;
 - 2. Activate their EBT card. To activate the EBT card, the individual must provide the 16-digit EBT card number and the individual's date of birth MM/DD/YY;
 - 3. Check their benefit balance;
 - 4. Review their last 10 transactions; and
 - 5. Select and/or change a PIN.
- L. [Explain the use of SNAP benefits in a language and format the individual understands as follows:]
 - 1. SNAP benefits may be saved from month to month, but the account must be used at least once within a 12-month period.
 - 2. [The household has the right to designate an authorized representative to use its SNAP benefits on its behalf.]
 - 3. SNAP benefits can be used ONLY to purchase eligible food for their household, including seeds and plants to grow fruits and vegetables.
 - 4. SNAP benefits **cannot** be used to pay on any kind of credit account, even if it is for eligible food.
 - 5. [SNAP benefits **cannot** be used to purchase items such as alcoholic drinks, soap, tobacco products, firearms, ammunition, explosives, or a controlled substance as defined by 21 U.S.C., 802.
 - 6. SNAP benefits should not be used for anyone outside of your benefit group or use someone else's SNAP benefits for your household.

7. The EBT card, card number, or PIN should not be given to anyone outside the SNAP household or their authorized representative.
 8. SNAP benefits and food purchased with SNAP benefits should **not** be sold or traded.]
- M. Explain that the Kentucky EBT card can be used in all states.

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MS 0280 – R. 6/1/26 – OMTL – 696
Local Office Responsibilities

[Each local office is responsible for providing all households with an explanation of the Electronic Benefit Transfer (EBT) issuance process in a language and format the recipient can understand. The Family Support Supervisor (FSSV) is responsible for ensuring that these procedures are followed in the local office.]

- A. Maintaining security and control of EBT cards, which are sent to the local office for pickup.
- B. Retaining all issuance records for audit purposes for at least five years from the month of origin or for a longer period of time if requested in writing by the Food and Nutrition Administration (FNA) or for five years if Kentucky Transitional Assistance Program (KTAP) or Kinship Care benefits are included on the card.
- C. Ensuring that case information is accurately entered on Worker Portal.
- D. Worker Portal transmits the information required to issue EBT cards, and/or authorize benefits to the EBT system during nightly batch processing.
- E. [Reviewing the monthly report to confirm the EBT cards remaining in the local office at the end of each month.
- F. Annotating the report and emailing the report to the [Nutrition Assistance Branch \(NAB\) inbox](#).
- G. Contacting the Community Support Section at [Policy Development Branch \(PDB\) inbox](#) with questions concerning issuance of EBT cards, the selection of the four-digit Personal Identification Number, or benefits on the account.]

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MS 0290 – R. 6/1/24 – OMTL-649
Security of EBT Cards

Worker Portal tracks Electronic Benefits Transfer (EBT) cards from the initial request through the final process, eliminating the need for hardcopy logs that were previously used. The system has security measures in place to ensure separation of duties.

EBT cards are sent to the household's mailing address entered on Worker Portal. However, if the household has issues receiving mail, the EBT card can be mailed to the local office.

[When a new card is requested, the worker selects the office location where the household wants to pick up the new card. When received in the mail, the receiving worker or administrative specialist updates the system to show the card as received in the local office. The same worker that made the EBT card request is not allowed to log the card as received in the local office.

Additionally, when the individual comes in to pick up the EBT card, neither the worker that made the card request, nor the worker that logged the card as received by the local office, are allowed to give the card to household. The system requires the card to be updated as given to the household by a third, separate worker or administrative specialist. This individual verifies the identity of person picking up the card and enters case comments accordingly. In the event Worker Portal is unavailable, the worker should obtain a signed form EBT-29, Affidavit of EBT Card Receipt, give the card to the household and scan form EBT-29 into the electronic case file.

The individual has 30 days from the date the card was received by the local office to pick up the EBT card. If the individual fails to pick up the EBT card by close of business on the 30th day, a task is generated to the supervisor to destroy the card the following business day. If the individual comes into the local office to pick up the card and the EBT card has been destroyed, request another card.

When EBT cards are received in the local office and the envelope has been opened or a card is found and returned to the local office, update Worker Portal to show the card as received in that office. The supervisor and another employee destroys and/or witnesses the destruction of the EBT card if the card is returned to the local office, received damaged or not picked up within 30 days, and updates Worker Portal at the time of destruction.]

To maintain the security of EBT cards in the local office:

A. The Field Services Supervisor:

1. Maintains overall responsibility for secure storage of EBT cards and logging each card into Worker Portal;
2. Ensures EBT cards are NEVER left unsecured;
3. Routinely inspects the secure storage area;

4. Destroys or witnesses the destruction of EBT cards as the cards are returned to the local office, received damaged, or not picked up by close of business on the 30th day;
5. Updates information on Worker Portal at the time of destruction;
6. Creates and reviews an ad hoc report at the end of each month to reconcile the number of EBT cards remaining in the local office; and
7. Annotates the report and emails it to the [Nutrition Assistance Branch \(NAB\)](#).

Regional Staff (Service Region Administrative Associate (SRAA) and/or Public Assistance Program Specialist (PAPS)) will ensure the EBT cards are being stored securely with limited access. They may also run ad hoc reports to check the count of on-hand cards at any point in time.

EBT cards are not to be mailed between local offices.

[Management Evaluation (ME) will continue to check the status on how and where the EBT Cards are secured when they complete local office reviews.

Disciplinary action is initiated with the supervisor and/or the employee, if procedures to secure and distribute cards are not followed which results in a loss of cards.]

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MS 0300 – R. 10/1/14 – OMTL-476
Central Office Responsibilities

[The Division of Family Support (DFS) has responsibility for all Central Office issuance activities. DFS is responsible for the following:]

- A. Ensuring that Electronic Benefit Transfer (EBT) cards are mailed to all eligible households in a timely and accurate manner.
- B. Reconciling all benefit issuances; and
- C. Retaining all issuance records for audit purposes for a period of three years from the month of origin or for a longer period at the written request of the Food and Nutrition Service (FNS) or the Department of Health Services (DHS).

Volume 1 – General Administration
MS 0310 – R. 5/4/22 – OMTL-595
Time Limit for Using EBT Benefits

- A. [An Electronic Benefit Transfer (EBT) account must be debited by the recipient at least once every nine months for the Supplemental Nutrition Assistance Program (SNAP) or benefits will be removed. If the recipient fails to debit their EBT account at least once every nine months, the SNAP benefits in the account are expunged. When the benefits are expunged, they are deducted from the recipient's EBT account and are no longer available to the recipient. The recipient **cannot**, under any circumstances, get expunged benefits back.
1. When the oldest SNAP benefit in the EBT account has not been used within nine months, the EBT system checks each benefit in the account to determine if it should be expunged. For a benefit to be expunged, the "Available Date" for that benefit must be at least nine months in the past.
 2. The EBT system sends Worker Portal a file of all SNAP EBT accounts that have not had any debit activity for nine months. To ensure that the recipient is aware that they have had benefits removed from their EBT account, Worker Portal sends the household an expungement notice. This notice advises the recipients that they have not used their SNAP EBT account in the last nine months, the benefits listed on the notice have been expunged from their EBT account, and they cannot get these benefits back. If the recipient has a claim, these expunged benefits will be applied to that claim.]
- Note:** If the case is inactive due to the only household member deceased, a notice will not be issued.
3. When benefits are expunged, Worker Portal updates the benefit segments with the amount expunged and the date. This information is available on the benefit inquiry screen.
- B. [The discontinuance of the case has no impact on the EBT account. As long as there are SNAP benefits in the account and the recipient is debiting the account at least once every nine months, the recipient has access to the EBT account.
- C. An EBT account must be debited every 12 months for Kentucky Transitional Assistance Program (KTAP) and Kinship Care (KC) benefits, or the above benefit expungement process will take place.]
- D. Access the EBT system at each reapplication to determine the status of an individual's EBT card.
- E. If the EBT card status is anything other than active or inactive or if the EBT card number is blank, do the following:
1. Answer yes to the question "Does the household need a new EBT card?"
 2. Tell the recipient their old EBT card will not work.

- F. The worker needs to check the EBT system to verify EBT card status at every reapplication. This will prevent confusion when the applicant tries to access current benefits with a card that has been deactivated and allows recipients access to their benefits in a timely manner. Workers cannot assume that a card from an earlier eligibility period is still a valid card. If the worker cannot determine the status of a card, email the [Nutrition Assistance Branch \(NAB\)](#).

The EBT account will always remain active on the EBT system. The EBT card will remain active unless reported as lost, stolen, or damaged, or has otherwise been deactivated.

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MS 0320 – R. 7/1/16 – OMTL-504
Reconciliation of Issuances

The Division of Family Support (DFS) verifies and reconciles all Electronic Benefit Transfer (EBT) issuances.

[Retailers have the right to request a debit to a recipient's EBT account when it is discovered that the EBT transaction did not debit the recipient's account correctly.

When this occurs, Worker Portal will generate a notice to the recipient advising the recipient that the EBT account will be adjusted to pay the retailer for the purchase.

If the recipient contacts a worker and requests that the funds not be debited from their account and to request a fair hearing, take the following action: send, by e-mail, the recipient's name, Social Security Number (SSN), EBT account number, amount being debited, and the date the notice was sent to the recipient, to the [Nutrition Assistance Branch \(NAB\)](#).]

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MS 0330 – R. 7/1/16 – OMTL-504
EBT Inquiry

[A. Information concerning the Electronic Benefit Transfer (EBT) account, client, and card information is maintained on the Fidelity Information Systems (FIS) EBT system. To obtain access to the Kentucky FIS Security System, staff must complete a Kentucky User ID Form. E-mail or scan a copy of the signed form to the e-mail address on the bottom of the form. To complete the application, follow these steps:

1. Download the PDF format Kentucky User ID form.
2. Open the PDF format Kentucky User ID Form using Adobe Acrobat Reader.
3. Complete all fields on the form electronically (do not handwrite entries). Once all fields are completed, print the form.
4. Sign the form and obtain any other necessary local signature.
5. Supervisor will email a scanned copy of the signed form to the Commonwealth Security Desk (CSD) at the email address on the bottom of the form.

CSD will process your request and you will receive an email from the FIS Security System when the request has been processed.

B. To review EBT account information, visit [FIS EBT Edge](#). After selecting the appropriate option, you will be asked to log on. Enter your '7-digit HR user ID' and password.

1. The EBT System is used to:
 - a. Determine if an EBT card has been issued.
 - b. Determine if a personal identification number (PIN) has been selected.
 - c. Determine if there is a discrepancy between demographic data on Worker Portal and the EBT system; and
 - d. Review benefits information in order to assist the client in resolving any problems that could not be handled by the Customer Service Representative (CSR).
2. To view the above information:
 - a. Enter the client's Social Security Number (SSN).
 - b. Enter the EBT card number.
 - c. Enter the EBT case number; or

- d. Enter the client's name.

For problems signing on to the EBT system, [email the Commonwealth Service Desk](#) or contact by phone at 502-564-7576 or toll-free at 800-372-7434.

- C. In addition to having access to the EBT system for inquiry, staff also has a Benefit inquiry screen on Worker Portal. This screen displays when the "Benefit Management" tab is selected.

The information displayed on this screen is:

- 1. Worker Portal Case and EDG Number;
 - 2. Client/Vendor Name;
 - 3. Benefit Program, Benefit Month, and Benefit Type;
 - 4. Allotted Amount, Issued Amount, Recoupment Amount;
 - 5. Benefit Number
 - 6. EBT Availability Date; and
 - 7. Issuance Status
- D. In addition to having inquiry capability, designated staff at the Central Office level perform the following activities:
 - 1. Debit the EBT account as the result of a claims repayment or returned Kentucky Transitional Assistance Program (KTAP) or Kinship Care (KC) benefits;
 - 2. Add/update client's EBT account; and
 - 3. Issue an EBT card.]

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MS 0340 – R. 7/1/16 – OMTL-504
Replacing EBT Card

[All Electronic Benefit Transfer (EBT) cards are mailed with "Card Status" of "not activated". When the recipient receives the card, the recipient calls the Customer Service Representative (CSR) to activate the card. Once this is done, the "Card Status" changes to "01" (active card). In most instances, when a recipient needs a replacement EBT card, he/she should call a CSR at 1-888-979-9949.

If an EBT card is returned by the Post Office, the card status is changed by the EBT contractor to "undelivered". If the client calls the CSR to request a replacement card, the CSR can replace the card **only** if the address that the client gives the CSR matches the address that is on Fidelity Information Service (FIS). If the address does not match, the client must contact the Department of Community Based Services (DCBS) office to request a replacement card.]

A. Customer Service Responsibility

Customer Service is responsible for issuing replacement cards except in the following situations:

1. Current card status is not "active" or "inactive".
2. [Recipient advises Customer Service that his/her address is different than the most recent address on the EBT system. If the recipient uses a mailing address, the mailing address **must** be given to the CSR when calling (not his/her home address).
3. Recipient advises Customer Service that his/her name is different than the name on the EBT system.
4. Recipient wants his/her replacement card sent to his/her local office. These replacements must be issued by a DCBS office.]

B. Local Office Responsibility

[In the above situations, the CSR refers the recipient to a DCBS office. Replacement cards are requested through the Benefit Management on Worker Portal.]

1. If the current card status on the EBT system is "11", determine why the card was returned. If the current card status is "09", that card has been deactivated and a new card must be issued.
 - a. [If the case is active or pending:]
 - (1) If there is a new address for the case, update the address through the address change function or update the pending case before requesting the card.

- (2) Enter the case number and select "Option 1" on "Case Change Menu".
- (3) Enter a 'Y' for the question "Issue EBT Card", enter 'C' or 'O' for the question "Do you want EBT card mailed to the client or local office?", and press enter. (The case address will be uploaded and cannot be changed on this screen.); and
- (4) When the message 'REQUEST PROCESSED' is received, PF3 to return to the 'Case Change Menu'.

[If the case is active, the card will be sent to the recipient's mailing address if a 'C' was entered for the 'mailed to client or local office' question. If an 'O' was entered, the card will be sent to the client's DCBS office.]

- b. If there is no active or pending case in the head of household's Social Security Number:

- (1) Enter the case number and select "Option 1" on the "Case Change Menu".
- (2) Enter a "Y" for the question "Issue EBT Card?"
- (3) Enter the mailing address and press enter.
- (4) When the message "REQUEST PROCESSED" is received, PF3 to return to the "Case Change Menu".

[If the case is inactive, the card will be sent to the mailing address. If the card should be mailed to his/her local DCBS office, enter the office address as the mailing address.]

2. If the recipient's address has changed and their EBT card has been lost, stolen or damaged, follow steps as outlined in item 1.
3. For name changes, determine if the recipient wants to have a new card issued immediately. Explain to the recipient that if a new card is requested through the Kentucky Automated Management and Eligibility System (KAMES), the current card becomes invalid that evening. Benefits will be inaccessible until the new card is received. Advise the recipient that, if requested, the card replacement can wait until the current month's benefits have been used or until access to benefits is not needed for several days. The recipient could call CSR to have the card replaced at a more convenient time. The advantage to waiting is the worker can make the name change on KAMES and KAMES can update the EBT system. This enables the CSR to authorize the replacement once the recipient calls.

- a. Procedures for Delayed Card Replacement

- (1) If the case is active:

- (a) Make the name change on KAMES and end session. The name change will be sent to EBT that night.
 - (b) Advise the recipient to call the CSR when they do not need to use their card for several days and request a new card. Advise the recipient that once a request for a replacement card is made, the old card becomes inactive and cannot be used.
 - (2) If the case is inactive, the Nutrition Assistance Branch (NAB) will make the name change on the JP Morgan website and issue a replacement card.
- b. Procedures for Immediate Card Replacement
 - (1) If the case is active:
 - (a) Make the name change on KAMES.
 - (b) Request a replacement request through KAMES.
 - (2) If the case is inactive, NAB will make the name change on the JP Morgan website and issue a replacement card.
- 4. [If the recipient requests the replacement card be sent to his/her local Office, do the following:
 - a. If the case is active, request a replacement card through KAMES by entering 'O' for the question, "Do you want EBT card mailed to client or local office?"
 - b. If the case is inactive, enter the office address as the mailing address;
- 5. If the recipient contacts a local office to report a lost or stolen card, encourage the recipient to call the CSR at 1-888-979-9949 and request immediate deactivation of the card.]

[The state is federally required to provide a system of quality control (QC) to assure Supplemental Nutrition Assistance Program (SNAP) and Medicaid benefits are issued correctly. Penalties are imposed on any state that does not substantially reduce the error rate as determined by the QC process. The reviews are conducted by QC analyst staff within the Division of Program Performance with some re-reviews conducted by federal personnel. QC staff also review Child Care Assistance Program (CCAP) and Kentucky Transitional Assistance Program (KTAP) cases to determine if benefits were issued correctly.]

A. Sample cases are chosen monthly by means of systematic random sampling and are reviewed in depth to substantiate the worker's determination of eligibility and computation of the benefit allotment.

B. A QC review consists of:

1. Analysis of the case record including adequacy of each step taken by the agency in the process of determining eligibility and the benefit allotment;
2. [Interviews with staff and benefit recipients either in person or by phone;]
3. Other investigation, including any collateral contacts necessary to assure documentation of all eligibility factors and the accuracy of the benefit allotment; and
4. Preparation of QC-343, Review Findings Notifications, as appropriate to list errors and related observations, if any.
 - a. A positive QC error exists when the household receives an incorrect benefit allotment for any reason, resulting in either an over or under issuance of benefits. A positive QC error would also include households who were totally ineligible for benefits. These errors can be attributed to either the agency's action or failure to act, or an individual related action.

Example: The household received \$300 in benefits for the month of March. A QC review found that during the March SNAP application, the household failed to report wages being received and was not entitled to receive any benefits during the application month due to being over the income limits.

- b. A CAPER QC error would include when a case denied or discontinued incorrectly, incorrect notices issued to a household, agency took incorrect action during certification, denied the case for incorrect reasons, etc.

Example: The household applied for SNAP benefits on 5/2/2022 via Call Services. A Request for Information (RFI) form was issued on the same date requesting verification of household composition. On 5/5/2022, the household returns a written statement completed by the head of household

- to confirm household composition. This verification is deemed insufficient by the agency as completed by a member of the potential benefits group. Worker issues new RFI to return verification of household composition but does not specify why returned verification was insufficient. Household does not return additional verification and the application denies. CAPER errors exist as worker failed to follow second RFI procedure and notices generated to the household were unclear.
- C. Findings on individual cases are reported on the QC-343 by the QC analyst and sent for review and corrective action. When during the review the QC analyst discovers a change which occurred after the sample month, that information is transmitted to the county to which the review or error is attributed to.

[To ensure that the Division of Program Performance and local office staff meet time standards for responding to Quality Control (QC) reviews, form QC-343, Review Finding Notification, is uploaded to the QC SharePoint and a notification, with a link to the review, is sent to the appropriate DCBS Regional contacts and Central Office staff. The notification will either request form PAFS-343.1, Response to QC Errors, be completed or notify staff that no errors were found.

Note: It is the responsibility of the Public Assistance Program Specialist (PAPS) to forward to the appropriate Field Services Supervisor (FSSV) and to track the timeliness of form PAFS 343.1 when required. If form PAFS-343.1 is required, it should be completed for Supplemental Nutrition Assistance Program (SNAP) reviews. Form PAFS-343.1 is not completed for reviews for the Child Care Assistance Program (CCAP), Kentucky Transitional Assistance Program (KTAP), Long Term Care (LTC), Modified Adjusted Gross Income (MAGI), or Medicare Savings Program (MSP).

These procedures apply to all SNAP, KTAP, Kentucky Works Program (KWP), and Kinship Care (KC) reviews.]

Immediately upon receipt of the form QC-343, review the case record in relation to the findings reported on form QC-343 and take the following action:

A. If the case is cited in error:

1. If the reported case findings are correct, take action to correct the case within 10 calendar days from the date on form QC-343.
2. If necessary, schedule an interview with the recipient.
3. If the recipient disputes the information as reported on form QC-343, additional collateral contacts may be necessary to substantiate or refute the QC findings.
4. If an under issuance was identified on form QC-343, review and issue a supplement or restoration, if appropriate.
5. If an over issuance was identified on form QC-343, review and determine whether a potential claim exists. If so, submit a claim referral via the Benefit Recovery Module within 20 calendar days from the date on form QC-343.
6. Scan form QC-343 into the Electronic Case File (ECF).
7. Within 20 calendar days from the date on form QC-343 and after corrections have been made to the case, the FSSV completes form PAFS-343.1. This form identifies the error, what caused the error, and details what corrective action has been taken to prevent future occurrences. Once completed by the FSSV, the form is then submitted to the Program Specialist for review. Once reviewed and determined complete, the FSSV scans the form into ECF.

Note: The FSSV and PAPS should ensure that the findings are shared with all staff in efforts to prevent the same type of error in the future.

8. The PAPS must then go on the QC Share Point and select that the PAFS-343.1 is complete. This action will send notification to the appropriate Central Office and QC staff.
 9. [If an over or under issuance is identified on the QC-343, the PAPS should email the PAFS-343.1 to the DFS.IntegrityAnalysisSection@ky.gov inbox upon completion to advise what determination was made and what actions were taken.]
- B. If the case was cited as correct, review form QC-343 for "Related Observations" which may identify changes which occurred which were not reported to the agency resulting in a change in eligible benefit allotment. Take appropriate case action within 20 calendar days from the date on form QC-343.

Note: Form PAFS-343.1 must be completed for related observations on all SNAP reviews. If a response to a related observation is required for Medicaid, CCAP, KTAP, or KWP review, it will be noted on form QC-343. Otherwise, responses are not required for related observations.

- C. If form QC-343 indicates the recipient "refused" to cooperate with QC, take action to impose the disqualification. Please reference Volume I, MS 0390 to determine the appropriate action to take for each program.
- D. If, as a result of the investigation, it is clearly established that the findings reported on form QC-343 are erroneous as of the review date, take the following actions to dispute the QC decision:
1. Within 15 calendar days from the date on form QC-343, the FSSV provides the PAPS with the following information to take exception to the QC error as cited:
 - a. Case Name;
 - b. Case Number;
 - c. Region;
 - d. County;
 - e. Review Number;
 - f. Review Month; and
 - g. Explanation of why an exception to the error is taken and why the case is believed to be correct.
 2. [If the regional PAPS agrees with the exception, the PAPS forwards the request to the applicable program branch within the Division of Family Support. If the program branch agrees with the regional PAPS, then the

regional PAPS should forward the filed exception to QC within 20 calendar days from the date of form QC-343.

Note: Any requests forwarded after the 20-calendar day timeframe WILL NOT be reviewed by QC.]

- E. Comments should be entered into the case record regarding the QC-343 being received, summarizing the error that was cited, and explaining the actions that were taken to correct the case ongoing. Comments should also annotate whether or not an over or under issuance was identified, the determination made, and actions taken to resolve.
- F. Hearings Based on Findings: If the recipient requests a hearing and the hearing officer rules that, as of the review date, the QC finding was in error, take appropriate action as indicated based on the Final Order. HOWEVER, THE HEARING DECISION DOES NOT CHANGE THE QC DECISION. Follow procedures in item "D" when taking exception to the QC error.

MS 0390 REFUSAL TO COOPERATE WITH QC (1)

If form QC-343, Review Finding Notification, indicates the individual refused to cooperate with Quality Control (QC) take the following action:

- A. [For Medicaid (MA):
- B. The QC analyst sends the individual an appointment letter advising them that an analyst will call them at the time specified on the letter. While there are no sanctions or disqualifications placed against a recipient who refuses to cooperate with a Medicaid QC review, Quality Control can ask for the case to be discontinued for failure to complete their eligibility review. When notified by QC that a Medicaid recipient failed to comply, discontinue their case using the non-cooperation option in the Withdrawal module.
- C. If the Medicaid case discontinues due to not complying with QC, the Medicaid recipient may reapply at any time, following normal application policy, verification requirements and procedures. There is no time frame the recipient must wait before reapplying for Medicaid.]
- D. For KTAP and KWP:
- E. The QC analyst conducts a desk review of KTAP and/or KWP cases. No recipient interview is required; therefore, the cooperation of the recipient is not required, and no sanctions are imposed.
- F. Kinship Care:
- G. The QC analyst contacts the household to request certain verifications and acquires independent verifications. There are no sanctions placed against a recipient who refuses to cooperate with the Kinship Care QC review.
- H. For Supplemental Nutrition Assistance Program (SNAP):
 - 1. If a household **refuses** to cooperate with the QC analyst in completing the case review, disqualify the household from further participation until the household cooperates with QC and provides the necessary information to complete the review.
 - a. When notified by QC that a household has refused to cooperate, enter a disqualification on the individual who refused to comply with QC. QC will identify this person on form QC-343. If QC cannot determine which member refused to cooperate, apply the disqualification to the head of household. Document this in Case Notes.
 - b. Once the disqualification has been applied, Worker Portal discontinues the case and issues a notice to the household, indicating the household's refusal to cooperate as the reason for termination or denial of benefits and states the actions the household must take if it wishes to reapply and cooperate.

- c. If the household disbands and members reapply within the QC review period or within 125 days of the close of the annual review period (October 1 through September 30 of any given year), the penalty follows the person who refused to cooperate, and the new household will be disqualified. The new household, containing the disqualified person, must cooperate with the QC analyst, even if the household is otherwise eligible for expedited services. Follow the steps outlined in d1 and 2 below.
- d. If the household remains intact and reapplies within the QC review period or within 125 days of the close of the annual review period (October 1 through September 30 of any given year), the household must cooperate with the QC analyst, even if the household is otherwise eligible for expedited services. Enter the application on Worker Portal and take the following steps:
 - (1) If the household states that it is unwilling to cooperate with the QC analyst, the disqualification remains on the system and the reapplication will be denied for that reason.
 - (2) If the household states that it is willing to cooperate with the QC analyst, hold the reapplication pending and take the following action:
 - (a) Notify the original QC Analyst or QC Branch Manager by email or phone at (502) 564-1908 within 3 working days of the date of reapplication, of the household's intention to cooperate with the QC analyst. Provide current identifying case information with the QC review number and review date from form QC-343.
 - (b) Upon notification that the household intends to cooperate, the QC analyst schedules an appointment with the household. After the QC interview is conducted, the analyst forwards a memorandum advising the local office either of the household's decision to cooperate or of the household's refusal to cooperate.
 - i. If the QC notice indicates the household's refusal to cooperate, deny the reapplication.
 - ii. If the QC notice indicates the household's willingness to cooperate, delete the disqualification and process the reapplication.
 - iii. If the reapplication is approved, and QC later determines the household is no longer cooperating with the review process, follow steps in D. 1.a above.
- e. If the household reapplies more than 125 days after the end of the annual QC review period (September 30 of every year) cooperation with the state QC analyst for the prior review period is not required. However, the household must verify all eligibility requirements prior to being determined eligible.

- f. If the household is terminated for refusal to cooperate with a federal QC analyst and reapplies after 9 months from the end of the annual QC review period (September 30 of every year) cooperation with the federal QC analyst for the prior review period is not required. However, the household must verify all eligibility requirements prior to being determined eligible.
 - g. If an individual does not want to reapply for SNAP but states they will cooperate with the Quality Control review, refer them to the Quality Control Section to ensure the completion of the review so the disqualification can be deleted once the household has cooperated.
- 2. If the QC analyst did not have any contact with the household, (the household failed to respond to the appointment letters, did not contact the QC analyst personally or verbally, or contact DCBS concerning the appointment) it is considered as **failure** to cooperate, and no disqualification is applied.
 - a. [If a QC analyst specifically requests that the local office contact the recipient in an attempt to gain the recipient's cooperation, schedule an interview and notify the QC analyst of the interview date and time.
 - b. If the individual contacts the agency, instruct them to contact QC and explain to the individual that they must cooperate with the QC process as a requirement of receiving SNAP benefits.]

MS 0400*

AUDITS

The United States Department of Agriculture, Department of Health and Human Services, and the Government Accounting Offices periodically conduct audits to evaluate all phases of program operations. These evaluations emphasize financial accountability and compliance with federal laws and regulations.

The audit process includes the following procedures:

- A. The Division of Family Support (DFS) notifies the Service Region Administrator (SRA) and the appropriate local office supervisor of a scheduled audit.
- B. An exit conference is held at the conclusion of the audit to discuss deficiencies. The SRA and local office supervisor and/or designee will participate in the conference.
- C. The local office supervisor is responsible for ensuring that any deficiencies identified during the exit conference are corrected immediately.
- D. Official audit findings and corrective action recommendations are forwarded to the SRA and local office supervisor.
- E. The local office supervisor replies within 30 calendar days to the findings and recommendations, responding to each detail of the audit specifically. Submit responses, with any required claims information attached, to the Director of Family Support and the SRA.
- F. If the established timeframe cannot be met, an interim report on the progress is submitted to the Director of Family Support and the SRA.
- G. DFS notifies the SRA and local office supervisor when the audit is officially closed.

MS 0410 [QUALITY ASSURANCE CASE REVIEW (1)

All case reviews are completed on Worker Portal in the Quality Assurance (QA) Module. Reviews are completed to assess the accuracy of casework processing and to identify error trends and training needs to be addressed on a local, regional, or statewide basis.

A. The purpose of a case review is to ensure that:

1. A case is processed correctly;
2. Case decision is made according to Agency policy;
3. All information is obtained, reviewed, and evaluated to substantiate a case decision;
4. Impending changes are identified and processed appropriately;
5. Computer matches are acted upon timely and appropriately;
6. All required forms are scanned to the Electronic Case File (ECF) and all inconsistent information is clarified;
7. All areas of eligibility are documented;
8. All elements affected by an error are identified; and
9. All computations are correct.

B. Reviewer Functions

1. Reviewers follow the guidelines issued by the Service Region Administrator's (SRA) office, which establishes the required number of cases reviewed on a monthly basis.
2. Reviewers use the different levels of reviews available. Each level of case reviews contributes to the assessment of casework and identification of the need for coaching, mentoring, training, policy support, practice supports, and system changes.

C. Review Process

At each level of case review, these general procedures are appropriate:

1. Reviewers must read cases and review all elements.
2. When there are errors, the reviewer cites specific policy for the error identified.
3. If the case requires corrections, the reviewer indicates an error and that further action is necessary.

4. The worker is assigned a Case Review task and makes the necessary corrections within the allotted timeframe.
5. When the reviewed case is returned to the reviewer, the reviewer ensures that the necessary corrections are made. After all the necessary corrections are made, the reviewer updates the status to Complete.
6. If the worker disagrees with the error cited, a conference with the reviewer may be requested.
7. Reviewers may use the "Detailed Activity" report to track the status of case reviews.
8. The review outcomes are used in the performance evaluation of an employee to identify the caseworker's policy strengths and training needs.

D. Central Office Functions

1. Central Office staff will complete statewide 1st, 2nd, and 3rd level reviews.
2. When an error is identified, local staff must make corrections by the task due date. In some instances, other information may be needed by Central Office in order to complete the review. In the event that material is needed, the Program Specialist will be contacted to provide the information to Central Office within 5 work days from the date the information is requested if not already scanned into ECF.

E. Quality Assurance Reports

The information gathered by reports is used as a tool to monitor error rates by:

1. Identifying regional trends that suggest the need for targeted training;
2. Requesting additional statewide training when necessary;
3. Clarifying error prone policy;
4. Identifying needed changes in policy, procedures, or systems that could address errors;
5. Identifying areas for best practice tip sheets, checklists, Quick Reference Guides, and Worker Portal Announcements;
6. Supporting and measuring achievement at the regional level; and
7. Identifying errors and their root causes.

For more information on reports see [MS 0420](#).

F. Deleting QA Reviews

A reviewer can only delete a review that has not been started by a worker. For example, a reviewer has read the wrong case. As long as the review task has not been started by a worker, the reviewer can delete the review.]

MS 0420 [QUALITY ASSURANCE REPORTS (1)

Quality Assurance (QA) captures the results of case reviews and compiles various reports. The reports summarize the reviews completed by each worker, unit, county, and region.

A. Quality Assurance reports are used to:

1. Capture the results of case readings;
2. Provide summarized reports identifying trends in casework;
3. Determine error-prone areas and identify training needs;
4. Track case record actions to determine if policy and procedures for all programs are applied correctly;
5. Provide an orderly method for case reviews; and
6. Compile data identifying strengths and weaknesses of individual workers or counties.

B. The following is a list of Quality Assurance reports available on Worker Portal. Employees and management at all levels are to use the data found in the reports to improve accuracy and performance and to initiate corrective plans as needed.

1. QA Case Actions: This report compiles totals for all case decision actions taken on Worker Portal. It can be broken down by DCBS Region, County, and Program. The report breaks the reviews down by caseworker region, caseworker county, case action, review counts, reviews in error, and percentages of errors. The total number in error is divided by the total number of reviews and the result is the percentage in error. The report lists issuance errors which occur when an action taken on a case resulted in an incorrect benefit issuance.
2. QA Cases in Error: This report is used to identify the programs in which the most errors occur. It can be broken down by DCBS Region, County, and Program. It summarizes all of the cases in error. The report breaks the reviews down by worker, case number, review date, review level, review status, action due date, corrected timely, and error categories.
3. QA Detailed Activity: This report is used to look at cases read by a 1st or higher level reviewer. It can be broken down by DCBS Region, County, and Program. It provides the total number of reviews read. The report breaks the reviews down by case decision, caseworker, case number, review date, review level, review status, case action, corrected timely, and error categories.
4. QA Case Review Summary: This report break reviews down by the review elements. It gives an overall total for the review period specified on elements cited in error.]

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MS 0440 - R. 7/1/25 - OMTL-674

Administrative Hearing Overview

[Any applicant or recipient of any type of assistance from the Department for Community Based Services (DCBS) has the right to request a hearing before an impartial hearing officer, if dissatisfied with an action or inaction on the part of the Department that adversely affects their case.]

- A. At the time of application and at the time of any adverse action affecting their status with the Department, inform the individual in writing of the right to discuss the situation with a worker and/or to request a hearing. Such information is included on various Agency forms mailed or given to the individual. In addition, applicants are provided the pamphlet, PAM-PAFS-326, Division of Family Support Administrative Hearing Procedures.]
- B. The hearing process consists of:
 - 1. The request;
 - 2. Preparation for and scheduling of the hearing;
 - 3. The hearing itself;
 - 4. Review of the recommended order; and
 - 5. The final order.

Additional recourse for the recipient following an adverse hearing decision is available through appeal to the Cabinet Secretary/Secretary's Designee or Judicial review.

- C. For SNAP:
 - 1. [An Agency Conference is offered to households adversely affected by an agency action. The household is advised that an agency conference is optional and in no way delays or replaces the fair hearing process. The worker, supervisor, and the household member and/or representative attend the agency conference. An agency conference may lead to an informal resolution of the dispute. However, a Fair Hearing must still be held unless the household makes a written or verbal withdrawal. If a written withdrawal is received by DCBS, the Agency needs to scan this document into the Hearings Module as "Letter – Withdrawing". After this is complete, the Agency must also select the "Postponement/Withdrawal Request" button and complete the request. If the individual requests a withdrawal verbally, complete a withdrawal request via the Hearings Module by selecting the "Postponement/Withdrawal Request" button. Form PAFS-277, Hearing Withdrawal Confirmation Notice, will auto-populate and be mailed to the individual via the mail center. Form PAFS-277 is to be scanned into the Hearings Module as it is part of the official hearings record.]

An agency conference for households contesting a denial of expedited services is scheduled within two working days unless the household requests it be scheduled later or states no agency conference is wanted.]

2. The Agency must expedite hearing requests from households, such as migrant farm workers, who plan to move from the jurisdiction of the hearing official before the hearing decision would normally be reached. Hearing requests from these households are processed faster than others if necessary to enable them to receive a decision and a restoration of benefits, if the decision so indicates, before they leave the area.
3. Employment and Training Program (ETP) activity that may be appealed includes any denial, reduction, or termination of benefits due to a determination of nonexempt status or a determination of failure to comply with a work requirement. Individuals or households may appeal actions such as exemption status, the type of requirement imposed, or refusal to make a finding of good cause, if the individual or household believes that a finding of failure to comply has resulted from improper decisions on these matters.

When a fair hearing on these actions is scheduled, the caseworker must request ETP records from the ETP worker. The caseworker handles all local office activities prior to the hearing. The ETP worker and caseworker both attend the hearing.

- D. [The Office of Administrative Hearings (OAH), conducts hearings, upon request, for Kentucky Works participants. A participant is eligible for KWP supportive services while a hearing regarding a penalty is pending. Refer to Volume 3A, MS 4750 and MS 4770.
- E. Group Hearings. The Agency may respond to a series of individual requests for fair hearings by conducting a single group hearing if there is a single common issue in question. Hearing cases are consolidated only if the sole issue is related to a federal law, regulation or policy.

In all group hearings, the policies governing hearings must be followed. Each individual is permitted to present their own case or be represented by legal counsel or other spokesperson.]

Each individual has the opportunity to withdraw from the group if in the opinion of the hearing officer, the dissatisfaction results from actions in the individual's case.

- F. [Telephonic Hearings. Hearings conducted via special telephone equipment may be held at the discretion of OAH. During a telephonic hearing, the hearing officer is at one location and the agency representative, recipient, and representative are at different locations.

The recipient is notified by OAH that a hearing will be telephonic. If the recipient objects to a telephonic hearing, a face-to-face hearing is scheduled by contacting either OAH or the local office in writing prior to the scheduled hearing date.

Regarding evidence to be submitted for consideration at the hearing, the recipient may either bring the evidence with them to the local office where it will then be copied and sent to OAH, or they may mail copies directly to the hearing officer themselves.】

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MS 0450 - R. 7/1/25 - OMTL-674

The Hearing Process

The following procedures for administrative hearings are in accordance with the Kentucky Revised Statute KRS 13B, Administrative Hearings. If the hearing request involves a Medical Review Team (MRT) determination, refer to Volume 1 [MS 0465](#).

A. Upon receipt of a request for a hearing:

1. Complete a Request for Hearing through Worker Portal by accessing the Hearings tab at the top of the navigation page.
 - a. [When hearing requests are received by call services, the call services worker completes the request through the Hearings Module. This generates a task for the Office of Administrative Hearings (OAH) to schedule the hearing. Once the hearing is scheduled, a task will generate to the Hearings Public Assistance Program Specialist (PAPS) to review and assign the hearing to staff as appropriate.
 - b. Designated staff in the county of residence should try to resolve the issue before it goes to a hearing by offering the individual an opportunity to have an Agency Conference (see Volume 1 [MS 0440](#), C. 1.). In addition, OAH will conduct a telephonic prehearing conference with the individual and agency to explain the administrative hearing and ensure they are conducted in a fair manner prior to swearing in both parties during the scheduled hearing time. However, if a hearing is required, a staff member must attend the hearing (Refer to item A.1.c.).
 - c. A case decision worker, principal, or supervisor from the individual's county of residence should attend the telephonic prehearing conference and the hearing. Depending on the individual county, who attends may vary. **Do not** ask OAH to reschedule a hearing because the designated person cannot attend the hearing and/or due to travel to another county. Another worker will have to attend the hearing if the designated worker is unavailable.
 - d. The Regional Claims Worker (RCW) needs to thoroughly review the claim to be able to explain why the claim exists. If the issue is not resolved and a hearing is scheduled, the agency must submit the evidence to OAH via the Hearings Module and to the individual by mail at least eight days prior to the scheduled hearing.
 - e. Telephonic prehearing conferences on claims are held to determine the matter of the claim and to resolve any issue with the claim. The RCW has the ability to ask for a dismissal of a hearing during the telephonic pre-hearing conference due to an untimely request, if an issue relates to another agency, or if there is no issue found.
 - f. If Kentucky Claims Debt Management System (KCD) and Worker Portal Notices are a part of the evidence that is being presented, be sure to include the back of any notice included in the evidence to show the individual has been advised of their rights to request a fair hearing. Prior to uploading the evidence to the Hearings Module and mailing to the individual, **ALL** evidence must include a cover page labeled as: Exhibit 1, 2, 3 or Exhibit A, B, C, etc.

- g. During the hearing process if the agency is asked to waive the timeframes of hearing procedures, the agency's answer is always "NO". Additionally, if another worker had input in the case or gathered collateral information during the time of the claim, include that worker(s) as a witness. Attendance by a Department for Community Based Services (DCBS) worker is mandatory under these circumstances so evidence is not considered "hearsay". If investigative material is submitted into evidence that was gathered by the Office of Inspector General (OIG), then the OIG investigator must also be present, so the evidence is not considered "hearsay".]
- h. Attending staff should have a summary written (may use form PAFS-78.1, Administrative Hearing Summary) and be prepared to represent the agency.

Note: The DCBS representative should re-verify any collateral contact used as verification in the case to overcome the hearsay issue once the referral is received in the home county. If the contact is not willing to attend the hearing and testify, ask for a signed statement addressing the issue to be presented at the hearing.

- 2. [If the hearing issue involves a negative action, include a copy of the negative action notice (i.e., KIP-105 series, FS-105, MA-105, or PA-105), including the back page and forward to OAH. Limited KAMES-generated notices are maintained on the Report Distribution System (RDS) and may also be accessed through DocumentDirect. As RDS does not include the back page of a notice, it is advisable to have a current back page in the office and make a copy to include with the notice. The system-generated notices for Worker Portal are available in the Correspondence module. The back page is included with the notices in the Correspondence module. If the notice is not available at the time of the request, request the hearing through Worker Portal within 24 hours and forward the copy of the notice as it becomes available.
- 3. If the request is from an individual who has limited English proficiency and requires interpreter services or has a physical or mental condition which requires accommodation in order to participate in the hearing, annotate the hearing request with this information.
- 4. All requests must be sent to OAH, through the Hearings module in Worker Portal, within 24 hours of receipt, with exception of a hearing related to Medicaid payments or covered services.]
- 5. A request for a hearing related to Medicaid payments or covered services is heard by the Department for Medicaid Services (DMS).
 - a. Annotate a short description in Notes when requesting the hearing request through Worker Portal.
 - b. [Forward the hearing request within 24 hours to DMS via email to the [Department for Medicaid Services](#) or the following physical address:

Department for Medicaid Services
Administration & Financial Management

Administrative Service Branch
275 East Main Street, 6E-D
Frankfort, Kentucky 40621-0001]

- c. DO NOT send the case record to DMS.
 - d. The DCBS case worker does not attend the DMS hearing.
- 6. Individuals can also request DMS hearings by calling the Administrative Services Branch directly, at 502-564-9394.]
- B. Prepare for the hearing by reviewing the case record and writing a summary of the issue/action that prompted the request. If the hearing involves a claim issue, it may be necessary to contact the RCW for additional information about the case record and give a copy of the summary to the supervisor.
 - 1. [Include in the summary all information, documentation, notices, forms, comments, etc., that support the action taken by the agency. Be clear and concise; include pertinent information with an explanation in the event the worker is unable to attend the hearing and the supervisor or another worker must represent the agency's position.
 - 2. If the issue involves proper notification, include any manual or system-generated notices that are related to the issue to present at the hearing. Ensure that the back page of every notice is included.
 - 3. Include a copy of any manual section that relate to the issue/action. Include any pertinent policy clarifications that support the agency.]
 - 4. DO NOT include unprofessional language or comments in the summary.
- C. [Upon receipt of the hearing request, OAH schedules the hearing and may need to contact the individual for clarification of the reason for the hearing. OAH notifies the individual and appropriate Regional Contact of the issue to be heard, along with the date, time and place of the hearing. The Hearings PAPS is responsible for notifying field staff of the hearing.]

The worker and supervisor notify any witnesses of the scheduled date of the hearing. The worker, supervisor, or designated individual **MUST** prepare, attend, and actively participate in the hearing. A thorough review of the case record must be completed to determine if a worker verified information by collateral contact. If the case record reflects that this occurred, the worker who made the collateral contact **MUST** attend the hearing in order to avoid any "hearsay issues" that may arise. The Hearings PAPS is responsible for ensuring the agency representative is fully prepared. Claims Management Section (CMS) staff will attend Administrative Hearings which involve a claim compromise and/or State Tax Refund Intercept.
- D. [At the hearing, the burden of proof for the case action is the responsibility of the agency. The agency representative, worker, or individual attending the hearing must be prepared to present the facts surrounding the issue/action. Preparation is important because the hearing officer cannot consider any information or documentation not presented at the hearing.

- E. After completion of the hearing, the hearing officer drafts a recommended order. The recommended order is not a final order. DO NOT take any case action based on the recommended order. The recommended order is sent for review to:
1. The individual and/or representative by mail;]
 2. The Regional Contact person via the Hearings Module; and
 3. The Department for Medicaid Services, if the issue involved patient status in a skilled nursing home.

If any of the parties disagree with the recommended order, an exception can be filed with the Cabinet Secretary/Secretary's Designee within 15 calendar days of the mail date of the recommended order. For detailed procedures, refer to Volume 1 [MS 0510](#).

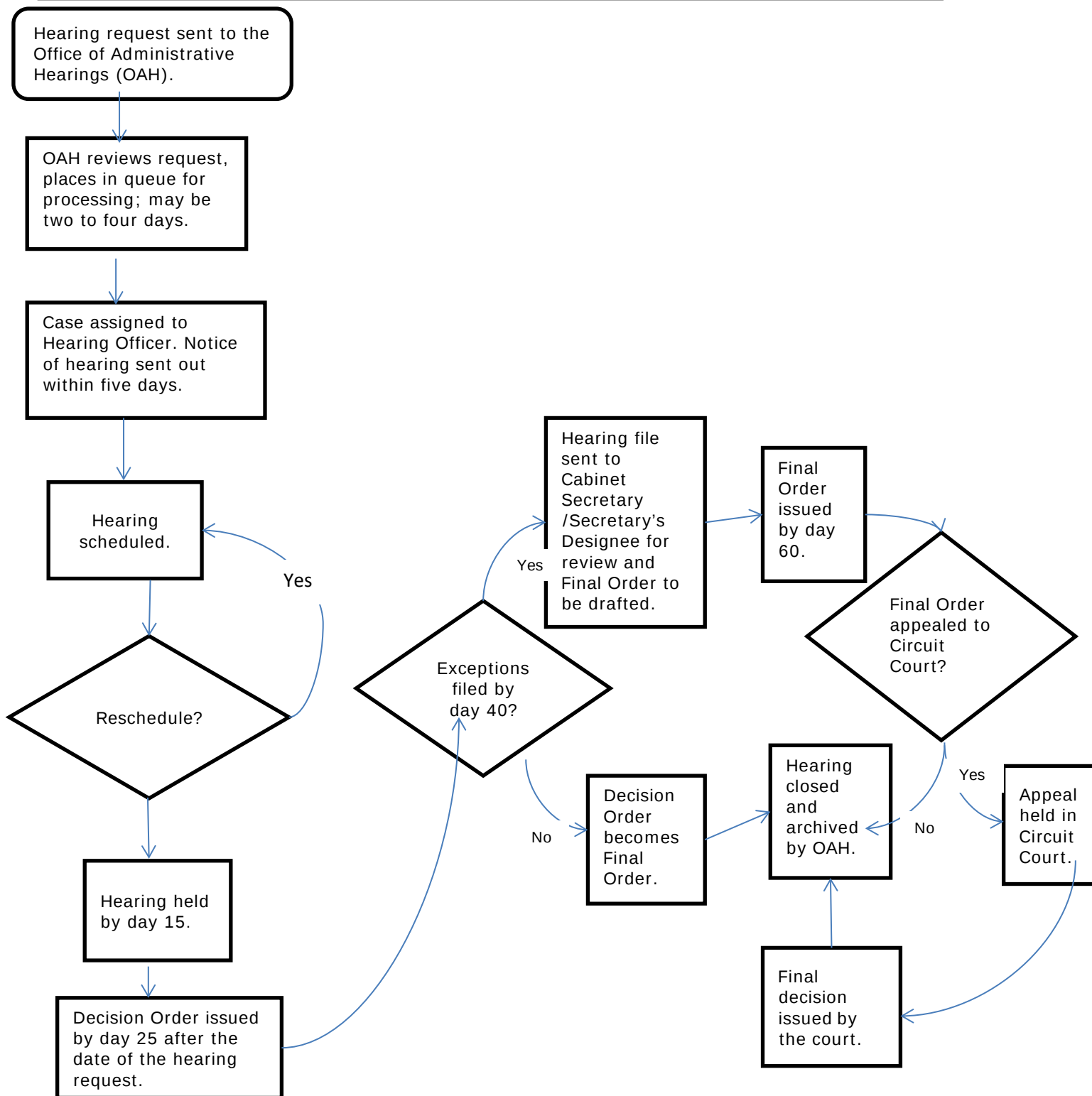
- F. [Staff review all timely exceptions to the recommended order and draft a final exception/rebuttal for submission to the Cabinet Secretary/Secretary's Designee.
- G. If there are no exceptions taken to the recommended order, for all SNAP-related hearings, the recommended order becomes the final order at the close of business on the 15th calendar day. The agency can take appropriate action on the 16th calendar day. For ALL other programs, a final order must be issued by the Cabinet Secretary/Secretary's Designee before the agency can take action.
- H. The Cabinet Secretary/Secretary's Designee signs the final order and sends copies to the individual, representative, if any, and the Hearings PAPS via the Hearings Module.]
- I. Once the final order is received in the local office, the case worker takes the appropriate action indicated by the final order. Refer to Volume 1 [MS 0520](#).

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MS 0455 - R. 7/1/25 - OMTL-674

Hearing Process Flow Chart

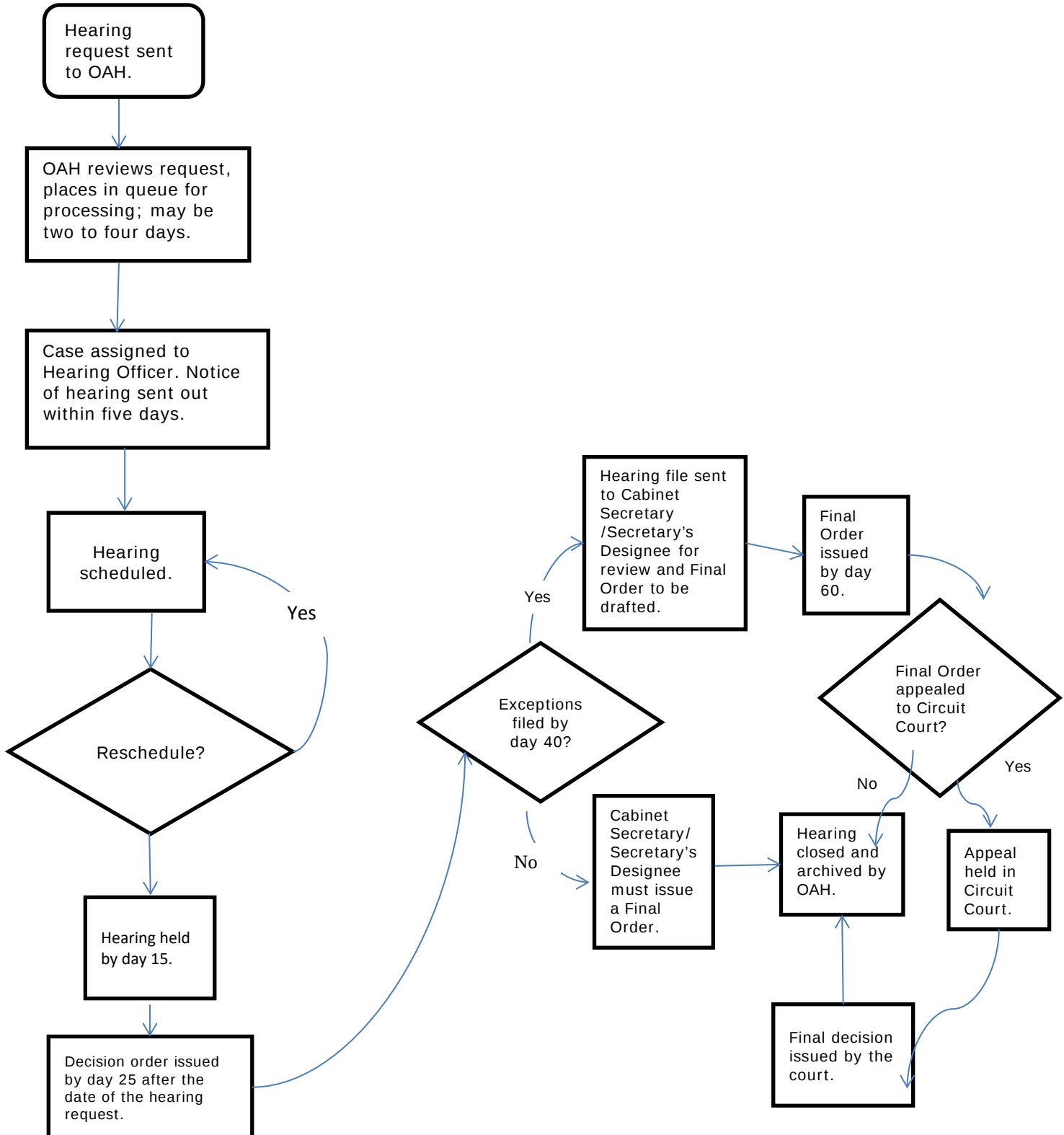
Supplemental Nutrition Assistance Program (SNAP) Fair Hearings



A. Supplemental Nutrition Assistance Program (SNAP) Fair Hearing Process Flow

1. Hearing request sent to the Office of Administrative Hearings (OAH).
2. OAH reviews request, places in queue for processing; may be two to four days.
3. Case assigned to Hearing Officer. Notice of hearing sent out within five days.
4. Hearing scheduled.
5. Reschedule? If yes, return to step four.
6. Hearing held by day 15.
7. Decision Order issued by day 25 after the date of the hearing request.
8. Exception(s) filed by day 40? If yes, continue to step nine and 10. If no, see step 11 and 12.
9. Hearing file sent to Cabinet Secretary/Secretary's Designee for review and Final Order to be drafted.
10. Final Order issued by day 60.
11. Decision Order becomes Final Order.
12. Hearing closed and archived by OAH.
13. Final Order appealed to Circuit Court? If yes, continue to step 14 through 16.
14. Appeal held in Circuit Court.
15. Final decision issued by the court.
16. Hearing closed and archived by OAH.

Medicaid (MA), Kentucky Transitional Assistance Program (KTAP), Kinship Care (KC), Kentucky Works Program (KWP), Family Alternatives Diversion (FAD), and Child Care Assistance Program (CCAP) Fair Hearings



A. Medicaid, Kentucky Transitional Assistance Program, Kinship Care, Kentucky Works Program, Family Alternatives Diversion, and Child Care Assistance Program Fair Hearing Process Flow Chart.

1. Hearing request sent to OAH.
2. OAH reviews request, places in queue for processing; may be two to four days.
3. Case assigned to Hearing Officer. Notice of hearing sent out within five days.
4. Hearing scheduled.
5. Reschedule? If yes, return to step four.
6. Hearing held by day 15.
7. Decision Order issued by day 25 after the date of the hearing request.
8. Exception(s) filed by day 40? If yes, continue to step nine and 10. If no, see step 11 and 12.
9. Hearing file sent to Cabinet Secretary/Secretary's Designee for review and Final Order to be drafted.
10. Final Order issued by day 60.
11. Decision Order becomes Final Order.
12. Hearing closed and archived by OAH.
13. Final Order appealed to Circuit Court? If yes, continue to step 14 through 16.
14. Appeal held in Circuit Court.
15. Final decision issued by the court.
16. Hearing closed and archived by OAH.

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MS 0460 - R. 1/1/19 - OMTL-538

The Hearing Request

A hearing request is a clear expression, either oral or written, to review a decision made by the Agency.

- A. The request must be made by the client, a household member, his/her counsel, or an individual acting on behalf of the household or recipient.
- B. Requests for a Hearing, Appeal or Withdrawal, either written or oral, are requested through Worker Portal for the client.
 - 1. When requesting a hearing through Worker Portal for an Employment and Training Program/Kentucky Works Program (ETP/KWP) work program-related issue, indicate that the hearing request involves an ETP/KWP issue.
 - 2. If received by phone or through the mail, indicate this in the comments section when requesting the hearing.
 - 3. When a client has moved out of state and subsequently requests a hearing, tell the individual they may request a hearing to be held telephonically.
- C. When completing a request for a hearing, be specific when describing the client's reason(s) for the hearing request. Use statements like: "The client does not agree with the amount of earnings counted in her Kentucky Transitional Assistance Program (KTAP) case". Avoid vague statements such as "client request" or "client disagrees with denial". In addition, if the hearing involves an emergency situation, clearly annotate on the Note screen that it is an emergency.
- D. A request for a Department for Community Based Services (DCBS) hearing may be submitted by the client or their representative directly to the Office of Administrative Hearings (OAH).
- E. [The client may voluntarily withdraw the hearing request any time prior to the hearing. If the client wishes to withdraw the request, complete a hearing request search through the Hearings Module, locate the client's hearing request, and click the "Postponement/Withdrawal Request" button. Form PAFS-277, Hearing Withdrawal Confirmation Notice, will generate automatically to the client. Print the system-generated notice and attach in the Hearings module as is part of the official Hearings Record. Enter comments in the Hearings module as well as the respective Worker Portal case or claim. Be specific when describing the client's reason(s) for the hearing withdrawal.]
- F. A request for a hearing related to Medicaid-covered service issues is heard by the Department for Medicaid Services (DMS). DCBS staff are not responsible for these hearings. Furthermore, DCBS staff do not attend these hearings.
 - 1. Hearings may include, but are not limited to:
 - a. Patient level of care status determinations in any type of vendor payment case;

- b. Denial of payment for services;
 - c. Services provided through Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); and
 - d. Issues related to managed care services or participation.
- 2. Clients can also request DMS hearings by calling the Administrative Services Branch directly, at 502-564-8196, ext. 3175.
- 3. [The only appeal process which applies to DMS hearings is a judicial review. The Cabinet Secretary/Secretary's Designee does not review these cases.]
- 4. DCBS staff is responsible for hearings on Medicaid (MA) eligibility and follows the regular procedures for requesting an administrative hearing.
- 5. There are no fair hearing procedures for managed care, as the delivery method of MA is not a qualifying event for a fair hearing. Managed Care has a grievance procedure for issues such as dissatisfaction with a provider assignment. This is explained in more detail in the member handbook.

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MS 0465 - R. 10/1/19 - OMTL-553

Hearing Requests Involving Medical Review Team Determinations

A client may request an administrative hearing if he/she disagrees with a determination made by the Medical Review Team (MRT), only after negative action is taken on his/her case based on that determination.

- A. At the point of the original request for a hearing, ask the client if there is new medical evidence or a change in the client's condition to justify resubmitting the case to MRT for redetermination.
1. If the client states there is new evidence or the condition has worsened, ask if the client has been to a doctor or medical facility or had tests run since the last MRT determination was submitted.
 2. If there is new evidence or a worsened condition not considered by MRT, ask the client if he/she would like to resubmit the case to MRT. Advise the client that if he/she disagrees with the result of the redetermination, he/she can ask for a hearing based on the new action or inaction in the case. Resubmitting the case to MRT could eliminate the need for a hearing and provide benefits to the client in a timelier manner. It is the client's choice to resubmit to MRT or to request the hearing.
 3. If the client agrees to the submission of new information to MRT:
 - a. Take a new application if the application or extension request was denied or reinstate the benefits of a discontinued case (other than an extension to 60 months of KTAP benefits);
 - b. Complete form PA-601T, Referral for Determination of Incapacity/Disability, to include the new information provided by the client and annotate in red on top of the form that it is a redetermination based on new information;
 - c. Have the client sign an original form MRT-15, Authorization to Disclose Information to the Cabinet for Families and Children, for each medical source (doctor, hospital, lab, clinic, etc.) plus two additional forms MRT-15. Sign the forms as a witness; and
 - d. Upon completion of forms PA-601T and MRT-15, immediately forward to MRT the forms along with:
 - (1) The last MRT determination packet, including:
 - (a) Medical information;
 - (b) The last form PA-601T,
 - (c) PA-6, Incapacity Determination; or
 - (d) PA-610, Certification of Permanent and Total Disability; and
 - (2) Any new information/documentation the client may have provided.

MRT will make a determination considering the new information provided by the client. Upon receipt of MRT's determination, take appropriate action on the case. If the client disagrees with the action taken on the case, based on the new determination, the client can request a hearing.

- B. If there is no new evidence or worsened condition or the client does not want to resubmit information for an MRT determination, submit a Request for Hearing, Appeal or Withdrawal through the Worker Portal by accessing the Hearings tab at the top of the navigation page. Advise the client of his/her right to request continuation of benefits pending the hearing and the obligation to repay benefits if the hearing officer does not rule in his/her favor.
- C. At the hearing, the client may present new medical information such as hospital records, new test results, a new specialist's report, or appointment to support his/her claim of incapacity/disability.
- D. When a hearing involves an MRT determination, take a copy of the last packet of medical information, including form PA-601T and PA-601T, Sup. A, Supplement to Referral for Determination or Redetermination of Incapacity/Disability, if appropriate, that MRT used to make the determination along with several blank forms MRT-15 that can be completed, if needed, and form PA-6, Incapacity Determination, or form PA-610, Certification of Permanent and Total Disability, to the hearing. If this is done, and the client presents new medical information, the hearing officer can submit the information along with the interim order directly to MRT. Otherwise, the worker is responsible for submitting the information to MRT.
- E. At the hearing:
 - 1. If the client does not provide any new evidence, the hearing officer drafts a recommended order based on the information presented by both parties.
 - 2. If the client provides new medical evidence, the hearing officer drafts the interim order to remand the case to MRT for a redetermination. The interim order lists the new medical evidence to be considered by MRT.
 - a. If all the information is available at the hearing, the hearing officer can send the redetermination request and interim order directly to MRT.
 - b. If all the information is not available at the hearing, the worker is responsible for obtaining the information needed and submitting it to MRT. The worker must submit the request for redetermination to MRT within seven calendar days of the hearing.
- F. Once the request for redetermination is submitted to MRT, MRT has 30 calendar days from the date of the interim order to make a determination. If MRT needs additional time, it can request a 30-day extension.
- G. MRT will send form PA-6/PA-610 to the hearing officer. If it is a denial, MRT will also send the new information on which the redetermination was made. The hearing officer makes a decision based on additional information.
- H. [After 30 days, or 60 days, if an extension was granted, if the hearing officer has not received the MRT determination, a recommended order can be drafted without MRT input. A final order is required to be issued by the Cabinet Secretary/Secretary's Designee. If the Agency is upheld in the final order, the client can request an appeal.

- I. The interim order process is designed to facilitate the process for cases that are remanded to MRT. Workers are **not** to act on recommended orders. A final order is required to be issued by the Cabinet Secretary/Secretary's Designee.]

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MS 0470 - R. 7/1/16 - OMTL-504

Medicaid Hearing Request Due to the Loss of SSI

In Kentucky, the Social Security Administration (SSA) determines Medicaid (MA) eligibility for individuals who receive a Supplemental Security Income (SSI) payment. Any individual who applies for SSI is also applying for MA. If SSI is approved, the individual is also approved for MA. If a recipient's SSI is discontinued and a hearing is requested, the recipient can continue to receive MA during the hearing process only when they continue to receive the SSI payment.

- A. [Individuals who contact the local Department for Community Based Services (DCBS) office to appeal the termination of their SSI benefits must be referred to the SSA. Individuals approved by SSA for a continuation of SSI benefits while they are in the appeal process will receive MA coverage automatically and have a payment status code of C01, M01, or M02. Refer to the State Data Exchange (SDX) User Guide Payment Status Codes.
- B. If the SSI individual contacts the local DCBS office requesting a hearing due to the loss of their MA, the DCBS office handles the hearing request through the Worker Portal.
- C. Upon receipt of an MA hearing request, the worker should become familiar with the situation and be able to give the reason why MA benefits ended. Review and take the following information to the hearing:
 - 1. PA-10-SSI notices which are located in the Worker Portal Correspondence Module;]
 - 2. SDX screens (pages one and two of the discontinuance action) showing the pay status code and MA discontinuance date; and
 - 3. An explanation of the discontinuance reason, which is located in the SDX manual under pay status codes.

Copies of the SDX screens are presented at the hearing and may be viewed by the other attending parties to document the reason for the discontinuance. To ensure that the Internal Revenue Service (IRS) information is kept confidential, black out the wage information on page two of the SDX screen before other parties view the screen. Prior pages of the SDX record may need to be reviewed to find the correct discontinuance reason. However, a copy of the screens is NOT to be given to the hearing officer or the appellant. Once the hearing is over, shred the SDX screens.

Provide a verbal explanation of the information contained on the SDX screens during the hearing.

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MS 0475 - R. 7/1/25 - OMTL-674

Hearing Time Frames

- A. For Kentucky Transitional Assistance Program (KTAP), Kinship Care (KC), Medicaid (MA), Family Assistance Short Term (FAST), Work Incentive Reimbursement (WIN), State Supplementation, a hearing request is considered timely if received by the Department:
 - 1. Within 40 calendar days from the date form KIM-105 or MA-105 is sent on a proposed action;
 - 2. Within 30 calendar days from the date form KIM-105 or MA-105 is sent on an action already taken; or
 - 3. Whenever the hearing issue is a delay in action on the case and the action is still pending.
- B. For Supplemental Nutrition Assistance Program (SNAP), a household or member is allowed to request a hearing on any action by the Department or any loss of benefits which occurred in the prior 90 calendar days.
 - 1. The household may request a hearing any time within the current certification period, only if disputing its current level of benefits.
 - 2. Action by the Department shall include a denial of a request for restoration of any benefits lost more than 90 calendar days but less than a year prior to the request.
- C. For Child Care, a hearing request is considered timely if received by the Department within 30 calendar days from the effective date of the adverse action, not the date the DCC-105, Child Care Denial/Discontinuance Notice, is sent.
- D. [The Office of Administrative Hearings (OAH) acknowledges all hearing requests, conducts a hearing, and issues a recommended order within 60 to 90 days from a request for a hearing, the Cabinet Secretary/Secretary's Designee shall consider the record.
- E. If the hearing request is untimely, forward the request and any information concerning why the request was untimely to OAH through Worker Portal. The hearing officer determines from the information provided whether the household had good cause for submitting an untimely request.]
- F. Individuals whose Supplemental Security Income (SSI) is discontinued and who request a hearing must be referred to the Social Security Administration (SSA) to appeal the termination of their SSI benefits. Individuals requesting a continuation of MA benefits must make that request with the SSA agency. If SSA approves the continuation of SSI benefits while they are in the appeal process then the individual will receive MA coverage automatically and they will have a payment status code of C01, M01, or M02.

- G. For claims, the household may only request a hearing on the establishment of a claim following the respective program's hearing time frame. For example, a hearing for a SNAP claim must be requested within 90 calendar days from the claim establishment date. Any request made after the 90th day is considered an untimely hearing request.

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MS 0480 – R. 6/1/26 – OMTL – 696
Scheduling the Hearing

- A. [The Hearings Branch notifies the individual of the date, time, and place the hearing will be held via form, "Notice of Hearing", in a language and format the individual can understand.

The form also contains information regarding:

1. The individual's right to bring an attorney and/or witnesses if desired.
 2. An explanation that if the individual or a representative does not appear for the hearing, the individual will have a period of ten days to advise the Hearings Branch of the reason for not appearing. The Hearings Branch considers the reasons and determines if good cause exists. The request is considered abandoned and dismissed unless good cause for the absence can be shown.
 3. All parties to the hearing are provided at least 10 days timely notice of the hearing to permit adequate preparation of the case, except for Temporary Assistance for Needy Families (TANF)-related, Low Income Home Energy Assistance Program (LIHEAP), or State Supplementation hearings. TANF-related, LIHEAP, or State Supplementation hearings require at least 20 days timely notice. However, the household may request less timely notice to expedite the scheduling of the hearing.
- B. The individual may request and is entitled to a postponement without good cause if the request is made **before** the hearing. The postponement cannot exceed 30 days, and the time limit for action on the decision is extended for as many days as the hearing is postponed. For example, if a hearing is postponed by the household for 10 days, notification of the hearing decision is required within 70 days for SNAP or within 100 days for IM from the date of the request for a hearing. The worker notifies the hearing officer of the postponement.
- C. Before conducting a claim hearing, review the Fraud Referral Overview Suspected Internal Program Violation (IPV) Screen on Worker Portal to determine if the claim location code is "Court". If the claim is being prosecuted, contact the hearing officer or ask for a pre-hearing conference to inform the hearing officer that the court holds jurisdiction over the matter and request the hearing to be dismissed. Contact the [Claims Management Section](#) to verify if the claim has been referred for prosecution.
- D. For Medical programs, an individual or their representative may request a delay of the hearing for reasons beyond the control of the individual. The decision to grant the delay is made by the hearing officer.]

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MS 0485 - R. 6/1/21 - OMTL-577

Program Participation Pending the Hearing – IM Programs

- A. [When the individual requests a hearing within 10 days of the date on the timely notice, the benefits remain reduced or inactive pending a hearing decision unless the individual specifically requests that the benefits, including supportive services, continue.

Explain to the individual that if the Agency's decision is upheld, any overpayments resulting from continuation of benefits will have to be repaid.

If the request is received within 20 days of the date of the timely notice, and the individual claims good cause for not reporting within 10 days, determine if the reason for the delay meets the following good cause criteria:

1. The individual was away from home during the entire timely notice period;
2. The individual was unable to read or comprehend the timely notice and the right to request a fair hearing;
3. The individual moved, which resulted in a delay in receiving or failure to receive the timely notice;
4. The individual had a serious illness; or
5. The delay was no fault of the individual.

If good cause is determined and the individual requests continuation of benefits, reinstate the case within five work days.

Accept the individual's statement for good cause unless there is reason to doubt.

- B. If the case is active and benefits are reduced and the individual requests a hearing within 10 days of the date on the timely notice, benefits remain reduced unless the individual specifically requests benefits continue. If the individual requests benefits continue, reinstate benefits within five work days at the level prior to the timely notice.
- C. If benefits are discontinued and the individual, within 10 days of the date on the timely notice, requests a hearing and continuation of benefits:]
1. Complete a Request for Hearing, Appeal or Withdrawal through Worker Portal by accessing the Hearing tab at the top of the navigation page.
 2. If reason for discontinuance is "failure to keep recertification interview," complete a recertification.
 3. [For all other reasons for discontinuance, annotate case notes in Worker Portal.]

4. On the day of the hearing request, authorize approval of benefits at the level prior to timely notice with the current month as effective date.

- D. For checks received in the local office, follow procedures found in Volume 1, [MS 0120](#).

[A monthly printout of all checks with a local office address is generated for reconciliation purposes. The supervisor is responsible for ensuring each check on the printout was cancelled or delivered to the individual.

- E. An individual may reapply for discontinued or denied benefits during the hearing process. Accept and process a reapplication based on a change in circumstances.

Approval of a case based on a change of circumstance does not affect the hearing status unless the individual voluntarily withdraws the hearing request.]

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MS 0490 - R. 2/1/15 - OMTL-481

Program Participation Pending the Hearing - SNAP

Depending upon the circumstances of the case, the recipient is entitled to participate during the hearing process. The worker explains to the recipient that:

A. Participation is continued in the following circumstances:

1. If the recipient requests a hearing during the 10-day timely notice period, participation is continued on the basis authorized immediately prior to the timely action notice unless the recipient specifically waives continuation of benefits. The recipient is advised that if the hearing finds the agency's decision was correct and the household was ineligible for all or part of the Supplemental Nutrition Assistance Program (SNAP) benefits received pending the hearing officer's decision, a claim is established against the household for the value of extra benefits received.
2. If benefits are reduced or terminated as a result of a mass change without individual notice of timely action, benefits are reinstated on the prior basis only if the issue contested is that eligibility or benefits were improperly computed or that federal law or regulations were misapplied or misinterpreted by the agency and if the household requests the continuation.

B. Once continued or reinstated, benefits are not reduced or terminated unless:

1. The certification period expires. Upon expiration of the certification period, the recipient can reapply and have eligibility redetermined.
2. A change affects the household's eligibility or basis of issuance while the hearing decision is pending, and the household fails to request a hearing after the subsequent notice of adverse action.
3. A mass change affects the household's eligibility or basis of issuance while the hearing is pending.
4. The hearing officer makes a preliminary determination in writing, and at the hearing, that the sole issue is one of federal law or regulation and the household's claim that the State Agency improperly computed the allotment or misinterpreted or misapplied such law or regulation is invalid. The household is notified by form KIM-105, General Notice of Action, when benefits are reduced or terminated pending the hearing officer's decision.
5. [The household fails to appear for the hearing, and the Office of Administrative Hearings (OAH) notifies the local office that the hearing request has been abandoned. If the household fails to appear, reduce benefits effective with the next monthly issuance. The household is notified by form KIM-105.]

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MS 0495 - R. 7/1/25 - OMTL-674

Denial/Dismissal of Hearing Request

- A. [The Office of Administrative Hearings (OAH) may dismiss a hearing request if:]
1. The request is untimely;
 2. The issue relates to a determination by another agency;
 3. There is no issue; or
 4. The request is abandoned.
- B. [The individual may withdraw a request for a hearing verbally or in writing at any time prior to the release of the hearing officer's decision. If the individual wishes to withdraw the hearing request, complete a hearing request search through the Hearings module, locate the individual's hearing request, and click the "Postponement/Withdrawal Request" button. Form PAFS-277, Hearing Withdrawal Confirmation Notice, will generate automatically to the individual. Print the system-generated notice and attach in the Hearings module as it is part of the official Hearings Record. In all instances in which the individual has a representative or attorney, the individual is advised to consult with the representative before requesting the withdrawal. If the original request was made by a representative, the worker personally assures the representative concurs in the withdrawal. If the representative does not concur with the withdrawal request, indicate this on the Notes screen when submitting the request to withdraw from the hearing.]
- C. If the individual or representative fails to appear for a hearing and the reason is unknown, a notice is mailed by OAH. The notice advises the individual to contact the hearing officer, in writing or by telephone, within 10 days, if they wish to continue the hearing and can present good cause for failing to keep the appointment. If the individual replies but does not show good cause or fails to reply, the request is considered abandoned. If good cause is shown, the hearing is rescheduled.]

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MS 0497 – R. 6/1/26 – OMTL – 696
Individual Hearing Rights

[An individual not only has the right to request a hearing but also has additional rights.

- A. Explain to the individual or their representative the following rights in a language and format they understand:
 - 1. The right to a qualified interpreter if the individual is Limited English Proficient (LEP) and rights to reasonable modification and auxiliary aids and services for individuals with disabilities;
 - 2. To present the case themselves or to have it presented by legal counsel or another representative. Inform the individual of the availability of free legal services;
 - 3. To review the case record relating to the issue;
 - 4. To bring witnesses to support their case in the hearing;
 - 5. To present arguments without interruption;
 - 6. To question any testimony or evidence and cross-examine witnesses; and
 - 7. To submit evidence establishing pertinent facts and circumstances in the case.
- B. Explain to the individual that the department does not provide payment for legal counsel but, if available, will refer them to a legal aid agency.
- C. Provide the individual and the individual's representative or legal counsel with adequate opportunity to examine all documents and records to be used at the hearing, a reasonable time before the date of the hearing, as well as during the hearing. The contents of the case file, including the application form and documents of verification used by the agency to establish the household's ineligibility or eligibility and allotment, are made available. Confidential information, such as names of individuals who have disclosed information about the household without its knowledge or the nature or status of pending criminal prosecutions, is protected from release. If requested by the household or its representative, the agency provides a free copy of the relevant portions of the case file. Confidential information protected from release and other documents or records that the household will not otherwise have an opportunity to contest or challenge are not presented at the hearing, and do not affect the hearing officer's decision.
- D. If the individual, after requesting a hearing, is dissatisfied with the medical evidence used in making the case decision, the individual may request an examination from another medical examiner. If an examination by an internist or specialist was received within three months prior to the date of the hearing request, the individual must specify the reason for the additional examination.

1. The request for another medical examination is submitted to the Hearings Branch and includes the type of examination requested. If the hearing officer considers the additional medical assessment necessary, an appointment is made by the Hearings Branch after departmental approval for payment of a specified fee. No payment will be made without prior authorization, and payment for unauthorized examinations is the responsibility of the recipient. The examination is made by an internist or specialist in the field of the individual's major ailment.
2. The individual, and, as appropriate, the individual's attorney, are notified of the date of the appointment by the Hearings Branch. If represented by legal counsel, a copy of the individual's new medical report is mailed to the attorney by the Hearings Branch.
3. If a request for additional examination at department expense is denied, the hearing officer sets forth the reason for the denial in writing. The hearing officer may request additional medical examinations at no expense to the individual.]

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MS 0500 - R. 8/1/18 - OMTL-533

Conduct of the Hearing

- A. Hearings are conducted by an impartial hearing officer who is knowledgeable of the Department's law, policy, and procedures. The Office of Administrative Hearings (OAH) operates independently and recommended orders are based only on information presented at the hearing.
- B. Hearings are privately conducted at a place convenient to the client and:
 - 1. Are orderly but informal;
 - 2. Conducted without the use of strict technical rules of evidence and procedure;
 - 3. Provide a method by which the client can speak freely regarding facts and circumstances of the situation, refute testimony, and examine all papers and records introduced as evidence;
 - 4. Provide the client the opportunity to submit additional evidence and to cross-examine witnesses; and
 - 5. Concluded when the hearing officer is satisfied that sufficient evidence has been introduced to resolve the issue.
- C. The hearing is attended by the worker and/or supervisor and by the client or his/her representative or both. The hearing may also be attended by friends and relatives of the client, if the client so chooses. However, the hearing officer has the authority to limit the number of persons in attendance at the hearing if space limitations exist.
- D. At the hearing, the worker or individual must be prepared to present the facts surrounding the issue/action. Preparation is important because the hearing officer cannot consider any information or documentation not presented at the hearing. The preparation includes:
 - 1. Reviewing the case record to become familiar with the case situation.
 - 2. Drafting a presentation that is clear and concise. The written presentation can be entered into evidence after the oral presentation, if needed.
 - 3. For hearings involving a Medical Review Team (MRT) determination, the medical information used by MRT for the determination must be presented in chronological order for each provider. The MRT packet contains a form titled "Case Development Sheet". This form provides names and dates of requested medical information and contacts. In the MRT packet, the form follows the MRT decision.
 - 4. [Making at least two copies of any forms, notices, documentation, and system screen prints (including Worker Portal comments) that are to be presented as evidence to support the issue or action. One copy is for the hearing officer and the other is for the client.]

5. Making two copies of all pertinent manual sections that support the issue/action – one for the hearing officer and the other for the client. Use only Operation Manual Sections, including updates, and Family Support memorandums issued by the Division of Family Support Central Office. Do not submit training materials, forms, or items not issued or sanctioned by the Division of Family Support as evidence at the hearing.
 6. Contacting individuals that may be witnesses for the Agency to notify them of the time and place for the hearing. Witnesses, if available, may agree to testify telephonically. These witnesses may include an individual from the MRT, Medicaid (MA), Targeted Assessment Project (TAP), Claims Management Section (CMS), Determining Eligibility through Extensive Review (DETER), etc. Witnesses should be briefed on the issue or action in order for them to testify effectively. When an individual agrees to testify as a witness for the Agency, information from the case record pertinent to the hearing issue is copied and forwarded to that individual. This will allow the individual to be prepared to testify.
 7. If a collateral contact was used to verify a household situation and an administrative disqualification hearing is to be held, contact the persons who provided statements about the case to ask if they will attend the hearing. If the person will not attend, ask for a signed written statement supporting verbal information indicated in Worker Portal comments. Worker Portal comments alone are not acceptable sources of verification in a hearing. The worker who spoke to the collateral contact must also attend the hearing to verify statements made on Worker Portal and should be notified well in advance of the hearing date to ensure their attendance.
 8. Taking the case record to the hearing to assist in responding to questions asked during the hearing.
 9. Dressing professionally.
 10. Using professional language when presenting the summary and evidence. When called upon to present the Agency's position, speak clearly. Explain the policy and procedure used in terms that everyone attending the hearing can understand. If unsure of a response to a question, advise those present that the information is not available at the hearing but will be provided if necessary.
- E. If conclusive evidence is not produced at the hearing, the hearing officer may continue the hearing. If the hearing officer continues the hearing, the hearing process must still be completed within 60 calendar days of the hearing request for the Supplemental Nutrition Assistance Program (SNAP) or 90 calendar days for MA. If the hearing is continued, the client and workers are notified 10 days in advance of the time and place of the continued hearing.

A client or representative may request the hearing officer to delay the recommended order for a reason beyond the control of the client. The decision to grant the delay and continue the hearing is made by the hearing officer.

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MS 0510 - R. 7/1/25 - OMTL-674

Recommended Order

After completion of the hearing, the hearing officer drafts a recommended order. For Medicaid (MA), State Supplementation, Kentucky Transitional Assistance Program (KTAP), Kinship Care (KC), Kentucky Works Program (KWP), Family Assistance Short Term (FAST), and Child Care Assistance Program (CCAP) hearings, the recommended order is not the final order; therefore, action is not taken on the case until a final order is received. For Supplemental Nutrition Assistance Program (SNAP) related hearings, recommended orders will become the final order if no exceptions are taken, after the 15th day from the mail date of the recommended order.

A. The hearing officer:

1. Reviews all evidence and drafts a recommended order. A recommended order:
 - a. Summarizes the facts of the case;
 - b. States the reason for the recommended order;
 - c. Identifies the supporting evidence and the pertinent Operation Manual sections; and
 - d. Cites pertinent state and federal regulations.
2. Ensures that the recommended order complies with federal and state law or regulation and is based on the hearing record.
3. Mails a copy of the recommended order for review to:
 - a. The individual;
 - b. The individual's representative, if one was present at the hearing; and
 - c. The Department for Medicaid Services (DMS), if the issue involved patient status in a skilled nursing home.
4. Uploads the recommended order to the Hearings Module, creating a task for the Hearings Public Assistance Program Specialist (PAPS) to review the order and take appropriate action.

B. If at the hearing, the individual presents new medical evidence which may affect the determination of incapacity, disability or good cause the hearing officer will issue an Interim Order sending the case back to the Medical Review Team (MRT) for a redetermination using the new medical information. The hearing record will be held open for 30 days. Refer to [MS 0465](#).

C. The recommended order is reviewed by the parties listed in item A.3 and A.4. The parties have 15 calendar days from the mail date indicated on the recommended order to review and file any exceptions and/or rebuttals. Exceptions or rebuttals filed after the 15th calendar day are disallowed.

1. If the Agency determines that no exception is required in response to a denied Administrative Disqualification Hearing (ADH) or Fair Hearing

recommended order, the worker must visit the Hearings Module within five calendar days and click on the “Exceptions Request” button and select “No” to answer the question, “After reviewing the recommended order, do you believe exceptions should be filed?” After making the selection, briefly provide your explanation in the comments box and “Save” and “Submit”. This will create a task for Central Office staff to review.

- a. For SNAP-related hearings, if no exceptions to a recommended order are submitted to the Cabinet Secretary/Secretary’s Designee by the 15th calendar day, the recommended order becomes the final order then on the 16th day and the agency can take appropriate action on the case.
 - b. For all other program-related hearings (MA, State Supplementation, CCAP, KTAP, KWP, FAST, KC), regardless of whether an exception is filed to a recommended order by the 15th calendar day, a final order is required to be issued by the Cabinet Secretary/Secretary’s Designee. The agency does NOT take any action until a final order is received.
2. The recommended order is reviewed to ensure that it is in accordance with regulations. If there are no exceptions or rebuttals to a SNAP program related recommended order received within the 15-day period, then on the 16th day the recommended order becomes the final order.

[Note: Central Office will no longer receive notification of the recommended orders from the Office of Administrative Hearings (OAH) or final orders from the Cabinet Secretary/Secretary’s Designee. Hearings PAPS will receive notification through Worker Portal and be responsible for reviewing the orders to determine if an exception is required. If an exception is required, follow instructions below and follow the hearing procedure process for administrative disqualification hearings through Worker Portal.]

3. Exceptions by the Agency are filed by Division of Family Support (DFS) Central Office staff.
- a. Use the following procedures to file an exception;
 - 1) Upon receipt of a recommended order, the worker and their supervisor have **five calendar days** from the date it was mailed to determine if an exception is needed. An exception can only be based on the facts and evidence presented at the hearing. New information or evidence may not be used to take exception.
 - 2) The region drafts an exception outlining why the recommended order should be changed.
 - 3) If the Agency determines that an exception is required in response to the ADH or Fair Hearing recommended order, the worker must visit the Hearings Module by the 5th calendar day from the date it was mailed and click on the “Exceptions Request” button and select “Yes” to answer the question, “After reviewing the recommended order, do you believe exceptions should be filed?” After making the selection, briefly provide your explanation and specify the evidence you are referring in the comments box and “Save” and “Submit”. This will

create a task for Central Office staff to review. A draft copy of the exception should also be emailed to the respective program inbox.

[Program Integrity Branch - Claims Management Section](#)

[Family Self-Sufficiency Branch - KTAP Section](#)

[Nutrition Assistance Branch - Food Benefits Policy](#)

[Medical Support and Benefits Branch - Medicaid Policy](#)

[Program Integrity Branch - Integrity and Analysis Section](#)

- 4) Central Office staff are responsible for uploading the final draft of the exception to the Hearings Module and mailing a copy of the exception to the individual/individual's designee.
- 5) After the exception is submitted to the Hearings Module, Hearings PAPS will receive a task to review the exception. A task will also generate to the Cabinet Secretary/Secretary's Designee to review and draft a final order. Field staff are required to scan a copy of the final draft of the exception to the Electronic Case File (ECF) in Worker Portal.
 - a) If an exception is filed timely by either party, the other party can file a rebuttal to the exception within the 15 day period. If the 15 days have elapsed, no rebuttal can be made.
 - b) The Cabinet Secretary/Secretary's Designee staff reviews all timely exceptions to the recommended order and will draft and sign a final order.

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The Final Order

[The Cabinet Secretary/Secretary's Designee issues the final order for the hearing.]

- A. The final order accepts the recommended order, rejects or modifies the recommended order, or returns the issue back to the hearing officer for further action before a final order is issued.
- B. The Cabinet Secretary/Secretary's Designee has 60 to 90 days to issue a final order from the date the hearing request.
- C. The Cabinet Secretary/Secretary's Designee will sign the final order and upload it to the Hearings Module, creating a task for the Hearings Public Assistance Program Specialist (PAPS) to review and assign for appropriate action. The Cabinet Secretary/Secretary's Designee will also mail a copy of the final order to the following:]
 - 1. The recipient;
 - 2. The representative;
 - 3. If the issue involved patient status in a skilled nursing home, to the Department for Medicaid Services (DMS).
- D. The final order becomes part of the record and approves or rejects the recommended order and provides the available appeal rights.
- E. A final order is followed until the next time the household's eligibility is redetermined.

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MS 0520 - R. 1/1/19 - OMTL-538

Local Office Follow-up to a Final Order

[When the final order signed by the Cabinet Secretary/Secretary's Designee is received in the local office, the final order and recommended order are reviewed by the supervisor and worker for any reference to future action in the case.

- A. For reversals of denials or discontinuances of Income Maintenance (IM) cases, take case action to approve or reapprove the case and return the case record to active status.

For reversals involving reduction of IM benefits, take case action within 10 days to restore benefits effective the date of the reduction action on which the hearing was held and authorize supplemental benefits, if appropriate.

- B. Final orders which result in an increase in the household's ongoing Supplemental Nutrition Assistance Program (SNAP) allotment or the issuance of a supplemental or restoration must be reflected in the benefit allotment within 10 days of the receipt of the final order.

If the final order is a result of a request for a casualty replacement that was denied, the casualty replacement must be issued within 10 days of the receipt of the final order.

Determine if the recipient has an existing claim. If so, offset benefits, if appropriate.

- C. When a final order is received that instructs the worker to resubmit a case to Medical Review Team (MRT) for a determination of incapacity or good cause for the Kentucky Works Program (KWP) or for a determination of disability for Medicaid (MA), do the following:

1. Within two days of receipt of the final order, send an appointment letter to the client to complete an MRT Referral. Request the client bring in new or updated medical information.
2. At the appointment, complete an MRT Referral and include any new or updated medical information the client presented at the hearing or has been received since the hearing. Also, have the client sign form MRT-15, Authorization to Disclose Information to Cabinet for Families and Children.
3. Once the MRT request is completed on Worker Portal, a task is generated for MRT staff to complete the disability/incapacity determination. Once a determination has been made, a task is generated for a worker to take appropriate action based on MRT's decision.

If the client disagrees with the action taken based on the new determination, the client can request a hearing.

- D. If the final order includes recommendations for referrals to, for example, Rehabilitation Services, immediately follow up such recommendations.

- E. In cases when the Agency is upheld, the notification advises the client of the right to file an appeal with the Cabinet Secretary/Secretary's Designee. In cases in which assistance has been continued during the hearing process, the worker takes action based on the final order to correct the case and the amount of benefits.

Do NOT continue benefits pending an appeal to the Cabinet Secretary/Secretary's Designee.

If appropriate, initiate a claim and collection action against the household for any overpayment caused by a continuation of benefits pending the hearing. Initiate claims action even if the case is inactive.

- F. The hearing officer's responsibility ends with the issuance of the recommended order. If pertinent records or facts of substantive value become available after the final order, this additional information is considered as a basis for reapplication. If the case is pending review by the Cabinet Secretary/Secretary's Designee, the Cabinet Secretary/Secretary's Designee is notified of additional evidence by memorandum from the local office.]
- G. Enter a brief statement of action, including the issuance date of the final order on Worker Portal "Comments" screen.
- H. Volume 4A, MS 3680, and Volume 4A, MS 3690, contain specific procedures relative to hearings in which the issue relates to patient status in a Long Term Care facility.

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MS 0530 - R. 10/1/19 - OMTL-553

Appeal to the Cabinet Secretary/Secretary's Designee

An appeal to the Cabinet Secretary/Secretary's Designee is the final administrative review available to a recipient dissatisfied with the decision of the hearing officer.

- A. Requesting an Appeal. If the recipient disagrees with the hearing decision, the recipient must appeal within 15 days of the date the hearing decision was mailed. The mailing date is the date on the hearing decision. The Cabinet Secretary/Secretary's Designee, if requested by the recipient, may grant a 10-day extension to the 15-day time standard, if good cause for the delay is established according to [MS 0475](#).

Whenever an appeal is not made within the 15-day time standard, submit a memorandum with the appeal explaining the cause of the delay and request the Cabinet Secretary/Secretary's Designee to determine if good cause for the delay exists.

The recipient's request for appeal may be either a verbal or written request. The date of the verbal request is the date of the appeal; however, any verbal request must be confirmed in writing by the recipient. The written request is a letter from the recipient that is uploaded as an "exception" in the Hearings module. The date the letter is received establishes the date of the request for appeal. Encourage the recipient to make the appeal in the local office or via phone to avoid delay in requesting the appeal within the prescribed time frame.

- B. Forwarding the Appeal/Exception Request. Attach the appeal request in the Hearings Module as an "exception" document and annotate in comments that an exception was filed by the client. A task will be generated to the Cabinet Secretary/Secretary's Designee to take appropriate action. Do not send the case record unless it is requested. The Cabinet Secretary/Secretary's Designee will have the necessary material and tape of the hearing record.
- C. [Action after Submitting Request. Central Office will mail the client a copy of any exception filed by the Agency. All exceptions filed, regardless of origin, create a task for the Hearings Public Assistance Program Specialist (PAPS) to review. Parties may request permission within seven calendar days from the date of the filed exception to submit written arguments or new evidence regarding the appeal to the Cabinet Secretary/Secretary's Designee. The Cabinet Secretary/Secretary's Designee will send Medicaid hearings recipients an acknowledgement letter indicating the receipt the appeal/exception request.]

If the Cabinet Secretary/Secretary's Designee orders a special examination, the recipient is notified of the date, time, and place of the examination, with a copy of the notification sent to the local office.

The recipient notifies the local office if they are unable to keep the appointment and the supervisor emails the [Cabinet Secretary/Secretary's Designee](#) to advise and schedule a new appointment.

- D. Reapplication before Decision from the Cabinet Secretary/Secretary's Designee.
If the recipient reapplies during the appeal process, before a decision is reached, process the application.

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MS 0535 - R. 1/1/19 - OMTL-538

Hearing of Appeals

[The Appeal Unit in the Department of Law will present the appeal to the Cabinet Secretary/Secretary's Designee. All appeals are heard based upon the records of the Department and evidence and exhibits introduced before the hearing officer unless the recipient specifically requests an additional hearing. Such additional hearings are only granted for the purpose of introducing new and additional proof not available for introduction at the original hearing.]

The Cabinet Secretary/Secretary's Designee may direct the taking of additional evidence if needed to make a decision. Such evidence will be taken by the Board after seven days notice to the parties, giving the parties the opportunity to object to the introduction of additional evidence or to rebut/refute any additional evidence.]

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MS 0540 - R. 1/1/19 - OMTL-538

[The Cabinet Secretary/Secretary's Designee Decision

The Cabinet Secretary/Secretary's Designee decision is mailed to the recipient and the recipient's legal counsel by the Cabinet Secretary/Secretary's Designee. The Cabinet Secretary/Secretary's Designee decisions are confidential case information and may be released only to the recipient, the recipient's power of attorney or legal representative, or the recipient's attorney. Whenever the hearing officer's decision is upheld, the letter of transmittal advises the recipient of the right to appeal to the Circuit Court in his home county within 30 days of the date the decision is mailed.

The decision of the Cabinet Secretary/Secretary's Designee is mandatory and irrevocable except by judicial action, until such time as investigation or reapplication establishes that facts surrounding the issue have altered to the extent that the decision is no longer appropriate.

- A. **Retroactive Payments.** If the Cabinet Secretary/Secretary's Designee reverses the decision of the hearing officer, payment and/or medical entitlement retroactive on a month-by-month basis is authorized in the local office, along with authorization for continuing action, provided it is established that the recipient is currently eligible.
- B. **Field Action.** Field Action on the Cabinet Secretary/Secretary's Designee decisions corresponds to hearing decisions in that:]
1. Document the case comments;
 2. Reversals are set up for appropriate redetermination; and
 3. If the decision contains recommendation for referrals, treatment, etc., follow-up on the recommendation is made immediately.

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MS 0545 - R. 1/1/19 - OMTL-538

Judicial Review of the Cabinet Secretary/Secretary's Designee

The recipient may request the Circuit Court in the county of residence to review any Cabinet Secretary/Secretary's Designee decision.

- A. A request for review must be filed within 30 days from the date of the Cabinet Secretary/Secretary's Designee decision.
- B. The Office of Administrative Hearings certifies the official hearing record and forwards it to the court.
- C. The court reviews the record as certified by the Secretary, Cabinet for Health and Family Services, and no other evidence can be admitted.
- D. The court reviews the case to determine if:
 - 1. There was sufficient probative evidence to support the Cabinet Secretary/Secretary's Designee decision;
 - 2. The regulations on which the decision was based are reasonable; or
 - 3. The Appeal Board acted arbitrarily, unlawfully, or in a manner that constitutes an abuse of discretion.
- E. If the court upholds the decision of the Cabinet Secretary/Secretary's Designee, the case record is returned to the local office with appropriate notation.
- F. If the court reverses the decision, the Appeal Unit reviews the record and judgment to determine whether appeal on the part of the Cabinet is justified.

If no further appeal is needed, official notification of reversal is issued by the Cabinet Secretary/Secretary's Designee.]

- G. See [MS 0520](#) for local office procedures after the appeal decision is received.

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MS 0560 – R. 6/1/26 – OMTL – 696
Documentation of Alien Status

[Verify the status of an alien who is applying for benefits through the United States Citizenship and Immigration Services (USCIS) documentation.

Under **no circumstances** may a State agency:

- A. Require any information about the citizenship or immigration status of anyone who is **not applying** for the Supplemental Nutrition Assistance Program (SNAP);
- B. Deny SNAP to applying household members because a non-applicant household member has not disclosed their citizenship or immigration status or social security number; or
- C. Try to establish or verify immigration status through any means other than the procedures outlined below. The Department of Homeland Security (DHS) has primary responsibility to determine the status of non-citizens.]

Aliens who left their homelands under emergency situations may not have all the required documentation for eligibility, such as verification or documentation of birth, marriage, divorce, or relationship. In the absence of the regular sources of verification, use Form I-94, I-151, I-551, or other entry documents to verify required information (e.g., age, relationship, or immigration status). Review and accept any documents brought from their homeland that verify the alien's situation. The individual's statement may be accepted for verification of marriage, divorce, relationship, and death. USCIS documents may be used to verify date of birth. The individual's statement is **not** acceptable to verify immigration status. Immigration status **must** be verified by USCIS documents.

Use the following chart as a guide to the USCIS documentation. This is not an inclusive chart. An individual may have a different USCIS document that identifies the immigration status and date of entry. Accept any USCIS documentation provided by the individual that verifies status and date of entry, unless it is questionable. Have the alien resolve any questionable status through USCIS.

Note: Concerning Form I-94, Arrival/Departure Record: On 4/30/13, Customs and Border Protection (CBP) automated the I-94 process **at air and seaports only**. Most non-alien visitors entering the country via air and seaports will no longer be issued a paper I-94. Instead, the admission information generally provided in the paper I-94 will be stamped on the traveler's foreign passport (i.e., COA, date of entry, and expiration date), with the exception of the I-94 admission number. Aliens have to visit the [U.S. Customs and Border Protection](http://www.dhs.gov/immigration-customs-and-border-protection) website to print their I-94 admission number. Also, if an alien is unable to provide a passport with the admission stamp, a copy of their record of admission can be printed by the alien at this website.

[CBP no longer issues the paper I-94 card to refugees at Ports of Entry (POE); they will need to obtain the I-94 record online. CBP will stamp the refugee's transportation boarding letter upon admission to the U.S., which is provided to the

Principal Applicant of each refugee case. The transportation boarding letter will be the only document provided to the refugee with an official CBP refugee stamp.】

Derivative asylees and parolees will continue to receive a paper I-94. CBP will strike out the pre-printed number and hand-write the true I-94 number on the document. Use the handwritten I-94 number when verifying immigration status.

The I-94 has a letter that indicates the entry status. The letter will have a number after it, such as A-2, H-3, etc. Letter codes A through L indicate they entered the U.S. for a temporary reason.

The following list defines the specific letter codes:

- A – Foreign government official;
- B – Visitor for business or pleasure;
- C – Alien in travel status;
- D – Alien crewman;
- E – Treaty trader, investor, and family;
- F – Student;
- G – Representatives and personnel of international organizations;
- H – Temporary worker;
- I – Members of foreign press, radio, or other information media;
- J – Exchange visitor;
- K – Fiancé or fiancée of a U.S. citizen and their children; or
- L – Intra-company transferees and their families.

If the I-94 has an entry other than codes A through L, the alien has entered the U.S. for permanent residence. The entry indicates the status of the alien, such as refugee, asylee, victims of human trafficking, and eligible relatives, etc.

Status of Alien	USCIS Document
Permanent resident alien before August 22, 1996	I-151 (Registration Receipt Card), commonly known as the "Green Card", was replaced with the I-551 (Permanent Resident Card) in March 1996
Permanent resident alien on or after August 22, 1996 If a veteran of the US Military If active-duty US Military	I-551 (Valid for 10 years) DD-214 Discharge Certificate Any document showing an active status
Refugee	I-94 marked with "admitted under INA 207, "Refugee", or "Refugee - Conditional Entrant."
Asylee	I-94 marked with "admitted under INA 208" or USCIS letter
Deportation Withheld	I-94 marked with "admitted under INA 243(h)" or letter from immigration Judge
Amerasians	I-94 or I-551 marked with an identifier in comments - AM1, AM2, AM3, AM6, AM7 or AM8
Parolees	I-94 marked with "admitted under INA 212(d)(5)" The date will read "Indefinite".
Conditional Entrants	I-94 marked with "admitted under INA 203(a)(7)"

Cuban/Haitian Entrants	I-94 may be marked "admitted under INA 207", "Refugee", or "Refugee - Conditional Entrant".
Battered Alien	I-94 admitted under INA 204(a)(1)(A) or (B), or whose deportation is suspended under INA 244(a)(3)
Victims of Human Trafficking and Eligible Relatives	I-94 or visa with "T-1" category. Eligible relatives of the victims have T-2, T-3, T-4, or T-5 category designations.
Afghan/Iraqi Special Alien	Passport with an alien visa (IV) stamp noting the individual has been admitted under the IV category SI1; DHS stamp or notation on passport or form I-94 showing date of entry or form I-551 (green card) SI6.
Spouse of an Afghan/Iraqi Special Alien	Passport with an alien visa (IV) stamp noting the individual has been admitted under the IV category SI2; DHS stamp or notation on passport or form I-94 showing date of entry or form I-551 (green card) SI7.
Unmarried dependent child of an Afghan/Iraqi Special Alien	Passport with an alien visa (IV) stamp noting the individual has been admitted under the IV category SI3; DHS stamp or notation on passport or form I-94 showing date of entry or form I-551 (green card) SI9.
Iraqi Special Alien under Section 1244	Passport with an alien visa (IV) stamp noting the individual has been admitted under the IV category SQ1; DHS stamp or notation on passport or form I-94 showing date of entry or form I-551 (green card) SQ6.
Spouse of an Iraqi Special Alien under Section 1244	Passport with an alien visa (IV) stamp noting the individual has been admitted under the IV category SQ2; DHS stamp or notation on passport or form I-94 showing date of entry or form I-551 (green card) SQ7.
Unmarried dependent child of an Iraqi Special Alien under Section 1244	Passport with an alien visa (IV) stamp noting the individual has been admitted under the IV category SQ3; DHS stamp or notation on passport or form I-94 showing date of entry or form I-551 (green card) SQ9.
Native Americans born in Canada	Form I-181, Memorandum of Creation of Record of Admission for Lawful Permanent Residence, form I-551 with the code S13, an unexpired I-551 stamp in a Canadian passport, form I-94 with the code S13, or a letter or other tribal document certifying at least 50% American Indian blood

	combined with a birth certificate or other satisfactory evidence of birth in Canada.
Form I-185	Canadian border crossing card.
Form I-186	Mexican border crossing card.
Form SW-434	Mexican border visitor's permit.

[Those with Limited English Proficiency (LEP) may require interpreter services. When requesting additional information, make every effort to ensure that the individual understands the request by contacting a qualified interpreter in accordance with the Cabinet for Health and Family Services (CHFS) policy. If the individual is in the office with an interpreter or has a relationship with a refugee resettlement agency, discuss the possibility of signing Form DCBS-1, Informed Consent and Release of Information and Records, to allow the sharing of the request for information with the appropriate entity or individuals.]

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MS 0562 - R. 6/1/26 - OMTL- 696

[Documentation for Alien Victims of Trafficking]

Traffickers force young men, women, and children into prostitution, slavery, and forced labor through coercion, threats of physical violence, psychological abuse, torture, and imprisonment. The worker doesn't need to determine whether someone is a victim of a severe form of trafficking or to contact the United States Citizenship and Immigration Service (USCIS) or any division of the Department of Justice (DOJ) to consult on these issues.

The Trafficking Victims Protection Act of 2000 (Public Law 106-386) provides that "victims of a severe form of trafficking" are eligible for benefits and services administered by the Department for Community Based Services (DCBS). Individuals identified as victims and their eligible relatives are treated as aliens who are admitted to the United States as refugees and are not barred from receiving benefits during their first five years in the United States. Eligible relatives include the spouse and dependent children of the victim, and if the victim is a child, the child's parents and siblings. This eligibility is without regard to the actual immigration status of such victims.

The Office of Refugee Resettlement (ORR) is designated to certify that an adult is a victim of a severe form of trafficking. Children under 18 years of age do not need to be certified. However, the child must still be determined eligible for benefits as a minor victim of a severe form of trafficking. ORR issues a certification letter for adults and a letter, similar to the adult certification letter, for children. These letters serve as verification that the individual is a victim of trafficking.

Use the following policy and procedures when processing cases that contain a member who is a victim of human trafficking.

- A. Applications for Kentucky Transitional Assistance Program (KTAP), Medicaid, or Supplemental Nutrition Assistance Program (SNAP) who are victims of a severe form of trafficking must present their letter from ORR to the worker.
 1. Accept the ORR letters in place of Immigration and Naturalization Service (INS) documentation. Victims of a severe form of trafficking are not required to provide proof of their immigration status. Do not complete a Systematic Alien Verification for Entitlement (SAVE) inquiry on the victims.
 2. [Email ORR](#) to confirm the validity of the ORR letter and to notify ORR of the type of benefits for which the individual has applied.
- B. The entry date for the individual is the certification date that appears in the body of the ORR letter.
- C. If the individual does not have documents to verify identity, contact ORR for assistance.
- D. If the individual does not have or cannot obtain a Social Security Number (SSN) for work purposes, assist the individual in obtaining an SSN for non-work

purposes by providing the individual a letter for the Social Security office that includes:

1. The Cabinet's letterhead;
2. The individual's name;
3. The reason a non-work number is required; and
4. A statement of eligibility for the program benefits. This means that all the eligibility factors are verified and entered into the system for approval.

The letter cannot be a form letter, photocopied, or generic.

Do not delay, deny, or discontinue assistance pending the receipt of the SSN.

- E. Determine technical and financial eligibility for the program and issue benefits, and if eligible, to the victim in the same manner as refugees.

If the application includes a member who is not a victim of a severe form of trafficking, this member is subject to the five-year ban for receipt of benefits unless their immigration status meets one of the statutory exceptions.

- F. [Email ORR](#) at recertification.

1. If it is verified that the victim of a severe form of trafficking is recertified with ORR, take no further action until the next recertification.
2. If it is verified that a victim of a severe form of trafficking is not recertified with ORR, take action to have the recipient contact DCBS and determine if ongoing benefits are appropriate in another alien status.

- G. At this time, there are no procedures to de-certify victims of severe forms of trafficking. The recipient should have an original updated letter of certification or a similar letter for children at recertification. The recipient's ORR certification period is eight months and, in most cases, will not correspond with a given program's certification period. If the household does not have an original updated letter from Health and Human Services (HHS), [email ORR](#) for assistance.

If, during an interview, it is determined that the alien is not or is no longer eligible based upon an email response received from ORR, determine eligibility using other criteria for them.

- H. Anytime an applicant or recipient believes they may meet the definition of a victim of "severe forms of trafficking", provide the individual the phone number of the Department of Justice, Division of Civil Rights, 888-428-7581, or the Refugee State Coordinator with Catholic Charities of Louisville, 502-636-9263.

If it is believed that a child has been subjected to a severe form of trafficking, the worker is to make a referral to Protection and Permanency (P&P). P&P makes the decision if the alleged maltreatment meets the adult or child eligibility criteria for intake.]

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MS 0565 - R. 6/1/26 - OMTL- 696

Aliens Sponsored On or After Dec. 12, 1997

[Privately sponsored aliens must meet additional income and resource requirements. A private sponsor is an individual, not an organization or group.

A. Some aliens are not required to have a private sponsor as a condition of entry into the U.S. on or after Dec. 12, 1997. These aliens are:

1. Refugees under Section 207;
2. Asylees under Section 208;
3. Individuals whose deportation is being withheld under Section 243(h);
4. Cuban/Haitian entrants; or
5. Amerasians.

These aliens can be publicly sponsored by an organization or group. Publicly sponsored aliens are **not** subject to income deeming.

B. Privately sponsored aliens who enter the U.S. on or after Dec. 12, 1997, must complete and sign before a notary public a sponsorship agreement, United States Citizenship and Immigration Services (USCIS) form I-864, Affidavit of Support.

Form I-864 shows that an alien has adequate means of financial support and is not likely to become a public charge. Signing the form constitutes a legally binding contract between the sponsor and the United States (U.S.) Government in which the sponsor agrees to support the alien and any spouse and/or children immigrating with the individual. The sponsor's obligation continues until the sponsored alien:

1. Becomes a U.S. citizen;
2. Can be credited with 40 qualifying quarters of work. For 40 quarters determination, see Volume 2, MS 2900 A. 2;
3. Departs the U.S. permanently; or
4. The sponsor dies.

An alien may have joint sponsors if one sponsor cannot meet the income requirement. The joint sponsor must also complete Form I-864.

C. Aliens currently in the U.S. who previously completed sponsor agreements are **not** subject to the new affidavit requirements. Forms I-134, Affidavit of Support, or I-361, Affidavit of Financial Support and Intent of Petition for Legal Custody,

were not obsoleted. These forms were used as sponsor agreements prior to Dec. 12, 1997.

- D. Sponsored aliens entering the U.S. on or after Dec. 12, 1997, and completing the new affidavit of support are responsible for:
1. Providing forms I-864 and I-864A as appropriate and verifying the income and resources of the sponsor and the sponsor's spouse. The sponsor's total income and resources, as well as the spouse's, are deemed available to the sponsored alien;
 2. Obtaining cooperation from the sponsor's household necessary to process the application;
 3. Reporting all changes concerning the sponsor's household that affect the sponsorship of the member, such as income changes; and
 4. Reporting a change in sponsor or termination of the sponsorship agreement.]

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MS 0566 - R. 6/1/26 - OMTL- 696

Consideration of the Sponsor's Income and Resources

[The income and resources of the sponsor and the sponsor's spouse are deemed as available to a sponsored alien who completed the affidavit of support on or after Dec. 12, 1997.

- A. Deeming the sponsor's income applies to all aliens sponsored by individuals. Deeming continues until the alien gains citizenship.
 - 1. The total income and resources of the sponsor and spouse are considered available to the alien's household. Consider the deemed income as unearned income.
 - 2. If a change in sponsorship occurs during the recertification period, verify and recalculate the deemed income and resources.
- B. There are exceptions for deeming a sponsor's income. Do not deem the sponsor's income to the alien if one of the following exceptions applies:
 - 1. If the alien is determined to be indigent. Apply the following conditions to determine indigence:
 - a. The amount of the sponsor's income and resources given to the alien does not exceed the amount agreed to in the affidavit; and
 - b. Without the assistance of the Cabinet, the alien would be unable to obtain food and shelter. In determining if the alien is indigent, consider the alien's own income, plus any cash, food, housing, or other assistance provided by other individuals, including the sponsor.

Count only the amount actually provided by the sponsor for a 12-month period. The 12-month period for the indigent exception starts with the month the determination is made.

If an alien is determined indigent, forward the names of the sponsor and sponsored alien involved to the appropriate program branch in the Division of Family Support.
 - 2. If the alien or alien's child has been subjected to extreme cruelty or has been battered in the United States (U.S.) by:
 - a. A spouse or parent; or
 - b. A member of the spouse's or parent's family living with the alien or alien's child, and the spouse or parent allows the cruelty or battery; or
 - 3. If the alien is a child who lives with a parent who has been battered or subject to extreme cruelty in the U.S. by:

- a. A spouse; or
- b. A member of the spouse's family living in the same household, and the spouse allows the battery or cruelty.

To claim this exception, the alien child and parent may not be living with the individual committing the battery or extreme cruelty. This exception lasts 12 months **unless** the child and parent move back into the abusive situation.]

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MS 0570 – R. 6/1/26 – OMTL - 696
Systematic Alien Verification for Entitlement (SAVE)

Federal law requires that the immigration status of aliens applying for benefits be verified. The Systematic Alien Verification for Entitlement (SAVE) is the U.S. Citizenship and Immigration Services (USCIS) system of verification for this purpose. SAVE is used to re-verify the initial documentation of the immigrant's status received from the alien. Any applicant who is not a U.S. citizen or national is required to carry immigration documentation that contains an Alien Registration Number (A-Number) or an I-94 Admission Number. These numbers are used to access SAVE.

[For aliens who have permanent resident status, the SAVE process is completed only once. For all other aliens, the SAVE process is repeated at every application or recertification, or until they are granted permanent resident status.]

Do not complete a SAVE inquiry on victims of human trafficking. However, do complete a SAVE inquiry on eligible family members of trafficking victims.

[Do not complete a SAVE inquiry on individuals who are not applying to receive benefits.]

Under **no circumstances** may a State agency:

- A. Require any information about the citizenship or immigration status of anyone who is **not applying** for the Supplemental Nutrition Assistance Program (SNAP);
- B. Deny SNAP to applying household members because a non-applicant household member has not disclosed his or her citizenship or immigration status or Social Security Number(SSN); or
- C. Try to establish or verify immigration status through any means other than the procedures outlined below. The Department of Homeland Security (DHS) has primary responsibility to determine the status of non-citizens.]

Use the following procedure when an alien applies for benefits.

- A. Initiate a request for verification by SAVE. Send a memorandum with the following information to the Regional Office:
 - 1. Case name and number;
 - 2. For each alien member: name, the corresponding alien registration number, birthdate, the type of documentation provided, and if available, SSN and the I-94 admission number; and
 - 3. Worker name, code, and phone number.

Only Medicaid and State Supplementation must be pending for a SAVE response before processing the case. All other programs may be processed without waiting for the response from SAVE.

B. Within three business days from receipt of the request, the regional contact person accesses the web-based program to obtain SAVE information and:

1. In response, the Verification Information System (VIS) assigns a verification number, which is used as a reference number if further verification from USCIS is needed.
2. VIS also provides the name, alien registration number, birthdate, and SSN, if available, which is retained by the VIS database.
3. The Regional Office compares the information provided in the original memorandum to the information provided by VIS and decides whether further verification by form G-845, Document Verification Request, is necessary.
4. The Regional Office annotates the original memorandum with the SAVE information and their decision and then returns the memorandum to the local office.

C. When the SAVE information is received from the Regional Office:

1. If SAVE verifies immigration status: document the SAVE response in comments and scan it into the Electronic Case File (ECF).
2. If SAVE does not verify immigration status and requests additional verification:
 - a. The Regional Office completes form G-845, Document Verification Request. The form, along with a scanned copy of the alien's document with or without additional information for verification, is submitted electronically to USCIS.
 - b. **Do not** deny or discontinue the case based on immigration status until a response is received.
 - c. If the USCIS response on form G-845 indicates the immigration status document is valid, document the response in comments and scan it into ECF.
 - d. If the USCIS response on form G-845 indicates the immigration status document is not valid, deny or discontinue benefits for the unverified alien.

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MS 0590 - R. 8/1/22 - OMTL-603

Federal Benefit Changes

Retirement, Survivors, Disability Insurance (RSDI), Supplemental Security Income (SSI), Railroad Retirement (RR), Black Lung, and designated Veterans Administration (VA) beneficiaries periodically receive a change in the benefit amount.

A. Federal Benefit Changes

1. Medicaid (MA) and Kentucky Transitional Assistance Program (KTAP):

[All recipients who receive these benefits are affected and are responsible for reporting the change within the appropriate timeframe in guidance with each program requirement.]

Note: Individuals in Long Term Care (LTC) who only receive SSI are not affected by the conversion.

2. Supplemental Nutrition Assistance Program (SNAP):

These changes in federal benefit income are known to the agency and are not required to be reported by SNAP recipients/households.

- a. The federal increase is considered a mass change.
- b. A notice of action taken is required, but a timely notice of a reduction or discontinuance of benefits is not required.

B. [Worker Portal generates all required notices for any case action taken as a result of the conversion.]

C. Verifying Benefits

During the first week of December, request verification of benefits as follows:

1. Railroad Retirement

[Benefits for these individuals may increase or decrease. Use form PAFS-54, Letter to Verify Railroad Retirement Benefits, or the "Active Cases with Black Lung, Railroad Retirement, or Veterans Income" listing to send one alphabetical list of claimants per local office to the appropriate RR District Office shown below. List the claimant's name, wage earner's name, and the claim number as it appears on the Medicare card. The Louisville District Office serves most Kentucky counties except those listed below:]

Counties:

Send to:

Boone, Bracken,
Campbell, Gallatin,
Grant, Kenton,
Mason, Pendleton

Cincinnati District Office
CBLD Center, RM. 201
36 East 7th Street
Cincinnati, Oh. 45202

and Robertson Boyd, Carter, Elliott, Floyd, Greenup, Johnson, Lawrence, Lewis, Martin and Pike	Telephone: 877-772-5772 Huntington District Office New Federal Bldg., RM. 145 640 4TH Ave. Huntington, Wv. 25721 Telephone: 877-772-5772
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Henderson and Union	Indianapolis District Office The Meridian Centre 50 South Meridian, Ste. 303 Indianapolis, In. 46204 Telephone: 877-772-5772
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All other counties	Louisville District Office 629 South 4 th Street Suite 301 Louisville, Ky. 40202 Telephone: 877-772-5772
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[The RR Board enters the new benefit amount on form PAFS-54 or the Worker Portal listing and returns the form to the local office sometime in the month following the change.]

The recipient will receive an International Business Machine (IBM) card from the RR Board showing the benefit amount. If the recipient is contacted for another reason before verification is received from the RR Board, verify the new amount from the recipient award letter.

2. VA Benefits

[Use form PAFS-53, Letter to Verify Veterans Benefits, or "Active Cases with Black Lung, Railroad Retirement, or Veterans Income" listing to send one alphabetical list of claimants per local office to:

- a. Department of Veterans Affairs Regional Office
321 West Main Street, Ste. 390
Louisville, Ky. 40202
Telephone: 800-827-1000
- b. List claimant's name and VA claim number.

The VA indicates the new basic benefit amount plus aid and attendance, if any, on form PAFS-53, Letter to Verify Veterans Benefits, or the Worker Portal listing and returns the verification to the local office. Not all VA beneficiaries receive an increase. VA beneficiaries that will receive an increase will receive an award letter no later than the month before the change occurs. If the recipient is contacted for another reason before verification is received from the VA, verify the new amount from the recipient benefit verification letter.

3. Black Lung Benefits

Send a request for information to the recipient requesting verification of entitled benefit and convert as appropriate. Use the "Active Cases with Black Lung, Railroad Retirement, or Veterans Income" listing to identify Worker Portal cases. Black Lung recipients usually receive a cost-of-living increase; this can be verified through the annual Federal Benefit Rate (FBR) for Black Lung.

4. Social Security Benefit

If an increase in benefits is authorized by the Social Security Administration (SSA), the increase becomes effective January 1st of each year. Verify RSDI entitlement amount by the Beneficiary Data Exchange (BENDEX) inquiry or benefit verification letter at the next recertification. When BENDEX inquiry is accessed to obtain the RSDI benefit amount, use the amount shown as "NET". "NET" is the amount before the Supplementary Medical Insurance (SMI) deduction. For all programs except MA, DO NOT round. Enter the actual "NET" RSDI amount on Worker Portal. When the RSDI "NET" amount is entered for MA, the cents MUST be dropped when entering the amount in the 'Amount Per Frequency' field. If there is an overpayment of RSDI retained in order to pay back an RSDI claim, for SNAP cases only, subtract the current overpayment amount from the "NET" amount to calculate the amount of RSDI to be counted in the case. Contact the individual for verification if unable to verify benefit amount from these sources.]

D. Use the following timeframes for completing manual conversions:

1. When a household applies in January, consider the new amount for issuances in January and thereafter.
2. Reflect the increased benefit amount in an active case as follows:
 - a. [MA and KTAP cases no later than January.
 - b. SNAP cases no later than the March issuance.]
3. For any cases not converted to the new Federal benefit level by the due date, complete a claim.

Volume 1 - General Administration
MS 0640 - R. 3/1/20 - OMTL-563
Voter Registration

Federal and state law requires the Department to distribute voter registration forms, assist individuals in the completion of forms, and ensure the completed voter registration forms reach the appropriate state election office for processing.

- A. Staff are subject to fines, imprisonment up to five years, or both, if convicted of:
 - 1. Seeking to influence political preference or party registration;
 - 2. Displaying any political preference or party allegiance; or
 - 3. Making statements or acting in a way that implies that a decision to register or not to register to vote will have any bearing on the availability of program services or benefits.
- B. At application, recertification, and when an address change is reported, the head of household/applicant meeting the following criteria is provided the opportunity to complete an application to register to vote or update voter registration:
 - 1. [Be included in the assistance application or case; and
 - 2. Be age 17 or over.]
- C. Hard copy versions of the voter registration form SBE 01, Commonwealth of Kentucky Voter Registration Application, are made available to the general public in the reception area.
- D. Other household members may complete form SBE 01 if wishing to register to vote.
- E. Staff must provide the same level of assistance to individuals wanting to register to vote as is provided for other applications. This includes providing assistance in completing the application to register to vote, unless the applicant/head of household refuses help.
- F. Completion of the Voter Registration Form is only an application to register to vote. The State Board of Elections approves or denies the application and sends a notice to the applicant.
- G. General information regarding the voter registration process in Kentucky can be found at the [Commonwealth of Kentucky State Board of Elections Website](#).

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MS 0650 - R. 6/1/25 - OMTL-672

Voter Registration Procedures

A. At application, recertification, and address change for the head of household (HOH) age 17 years or over:

1. For Face-to-Face Interviews:

Enter if the HOH wants to register to vote in Worker Portal.

[Form PAFS-706, Voter Registration Rights and Declination, is system-generated. The HOH signs and dates the form.]

Form SBE 01, Commonwealth of Kentucky Voter Registration Application, is generated when the HOH, who is age 17 or older, states he/she is not registered to vote at the current residence and would like to apply to register.

If the HOH is not present, the authorized representative is given form PAFS-706 and/or the Voter Registration Application, depending upon the response to the question to be completed by the HOH.

2. For Phone Interviews:

Follow the instructions for face-to-face interviews and mail form PAFS-706 and/or the Voter Registration Application, depending upon the response to the question, to the household. Inform the HOH to return the forms along with other verification to the local Department for Community Based Services (DCBS) office.

3. For Mail-In Applications and Recertifications:

The system generates and mails a letter of explanation, form PAFS-706, and form SBE 01 to LIS Medicaid referrals. All Simplified Assistance for the Elderly (SAFE) cases are mailed the explanation letter, PAFS-706, and the Voter Registration application.

4. For Address Changes:

Anytime a home address is changed on the address case change screen, a letter of explanation, form PAFS-706, and the Voter Registration Application will be system-generated to the head of household.

[Note: As the completion of form PAFS-706 is not an eligibility requirement, it will not be included on a Request for Information (RFI).

B. If the individual wants to register to vote, the individual completes the Voter Registration Application by checking the party affiliation, reads or is read the voter declination statement on form PAFS-706 and signs and dates the Voter

Registration Application and form PAFS-706. The individual must be provided the opportunity to complete the Voter Registration Application in private. Provide an envelope for the completed Voter Registration Applications.]

- C. If the individual does not want to register to vote, form PAFS-706 is completed by the HOH.
- D. If the applicant/HOH refuses to sign the form PAFS-706, enter “refused” in the client signature space, sign and date the form, and provide a copy to the applicant/HOH.
- E. Form PAFS-706 is scanned into the Electronic Case File (ECF).
- F. [For a hard copy application or recertification (including FS-1, Application for SNAP, or PA-100, Application/Recertification for KTAP and Kinship Care), provide the applicant/HOH [form SBE 01](#) 706 is read and signed. Provide an envelope for the completed form SBE 01.

Note: An individual may apply online by accessing the [Kentucky Voter Information Portal](#).

- G. Any individuals entering the local office can fill out a voter registration form. Provide the person with form SBE 01.]
- H. Instruct the individual to deposit the sealed envelope containing the system-generated Voter Registration Application or form SBE 01 (Mail-In) into the locked voter registration box in the local office.
- I. Completed registration applications must be transmitted to the local County Clerk’s office **every** Friday. For applications completed within five days before the last day to register to vote in an election, ensure the applications are transmitted to the county clerk prior to the deadline.
- J. Form PAFS-706 is completed by the HOH at every application, recertification, and when a change of home address is reported.

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MS 0670 - R. 10/1/24 - OMTL-654

Income and Eligibility Verification System (IEVS)

[IEVS is a federally mandated system designed to identify case discrepancies by means of various computer matches. IEVS compares the Social Security Numbers (SSN) of Kentucky Transitional Assistance Program (KTAP), Medicaid (MA), and Supplemental Nutrition Assistance Program (SNAP) applicants/recipients with SSNs contained on the computer files of other state and federal agencies. A match is generated when a discrepancy is identified between case record data and computer file information. Compare matches with income and resource information in the case record.]

Resolve any discrepancies between IEVS data and case record information. If required, verify information. Any potential claims discovered through IEVS matches are resolved separately from the IEVS process and timeframes.

[Member information is entered on Worker Portal at application or member add. The system performs a process which is designed to meet IEVS requirements. This is the online computer match.]

- A. Online computer matches are uploaded by the system at application, recertification, and member add. Online match information appears on the appropriate income screens while the case action is pending. Match data must be reviewed and resolved prior to processing.
- B. [The Computer Match process matches IEVS file data against case and member information currently on Worker Portal. This includes all ineligible and disqualified household members. Resolve these matches by starting the task through the Task History section found on the Case Summary screen.]

Information obtained through IEVS matches is subject to the confidentiality provisions as detailed in [MS 0150](#), in addition to IRS safeguarding procedures detailed in [MS 0190](#).

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MS 0675 - R. 10/1/24 - OMTL-654
Resolving Match Discrepancies

Use the following verification procedures when an Income and Eligibility Verification System (IEVS) discrepancy is identified in any program.

A. Match Data Requiring NO Independent Verification:

1. Matching data from Supplemental Nutrition Assistance Program (SNAP), Unemployment Insurance, State Data Exchange (SDX) and Beneficiary Data Exchange (BENDEX) (Unearned Income) files require no independent verification UNLESS the data is questionable.
2. If the matching data is questionable (i.e., conflicts with previously verified case information), document the reason on Worker Portal. Resolve the discrepancy and take appropriate case action within 30 days of the match date.
3. If the matching data is not questionable (i.e., does not conflict with previously verified information), resolve the match within 30 days after the match date.
4. For data received from these sources which is not considered in the case record, adjust benefits within 30 days after the match date.

B. Match Data Requiring Independent Verification:

1. Matching data from Wage Records, Internal Revenue Services (IRS) (Computer Matching Data) and BENDEX (Wage and Pension) files require independent verification since the data obtained in the match is several months old and may not reflect current household circumstances.

Attempt to resolve 100 percent of matching data requiring independent verification within 30 days after the control date/match date; however, on an individual worker basis, 20 percent may remain unresolved for up to 90 days pending verification from the data source. This remaining 20 percent must be resolved within 90 days after the control date/match date. The 30 and 90-day timeframes DO NOT apply if the case is due for recertification prior to those timeframes. Resolve all matches before the recertification is processed.

2. General Procedure for Independent Verification:

- a. When a Match requiring verification is received the month prior to the recertification month, do not take action (issue an Request for Information (RFI)) AFTER the date of Cut-Off or Negative Action. Document Case Notes that a match has been received, the reason for not acting on it at that time, and that it must be acted on during recertification.

- b. For Matches acted on during the month of recertification, discuss the match during the interview and request the individual provide the required verification to resolve the match before the recertification due date. Explain to the individual that the verification must be provided before the recertification can be approved. Document Case Notes thoroughly to ensure the worker processing the recertification is aware of the match and the requested verification.

Note: For Medicaid cases without a recertification interview, contact the individual to discuss the match and request the individual provide the required verification to resolve the match. Issue an RFI and document in Case Notes.

- c. For cases not due for recertification, enter the information on Worker Portal and allow the system to issue an RFI requesting the necessary verification. If the requested verification is not returned timely, the system will take appropriate action. Allow the household 10 calendar days from the date of the notice to provide the requested verification. For Medicaid, allow the household 30 calendar days to provide the requested verification. Follow the below procedures and if the individual does not return the information, discontinue the case.

When requesting verification by RFI, **DO NOT** list Federal Tax Information (FTI) on the form. FTI is data derived from the IRS such as:

- (1) BENDEX earned income;
- (2) IRS matching data; and
- (3) Other unearned income IRS computer matches.

All screens containing FTI can be easily identified by the banner which states, "This screen contains IRS data – do not print."

The RFI must only request general information. **NEVER** list any specific information found on income match or computer match screens, such as the employer's name or the amount of income.

Example: A match shows that Bob earned wages of \$3,000 from Wal-Mart in the 3rd quarter. On the RFI, the worker requests that the individual contact the Department for Community Based Services (DCBS) to discuss the income. The worker does not specify the name of the employer, amount of the wages, or any other information obtained from the computer match screens. When Bob contacts DCBS the worker asks if he works at Wal-Mart and requests his check stubs. No information from the match is listed on the RFI; therefore, no FTI is shared. The RFI and the check stubs are scanned into ECF.

- d. When verification, other than what was originally requested, is required as a result of contact with the recipient prior to expiration of the 10-day period, prepare another RFI, as appropriate and allow 10

calendar days for the recipient to return the additional verification.
For Medicaid, allow 30 days for the recipient to return the verification.

- e. Upon receipt of verification, send the appropriate notice of eligibility/ineligibility, if required, and adjust benefits timely.
 - f. Document all actions thoroughly and completely.
 - g. [Resolve the exception through the Computer Match task.]
3. Wage Records. Use the following criteria to determine when a match requires independent verification.
- a. The matches which determine whether independent verification is required are the last available Wage Records quarter and the quarter prior to the last available Wage Records quarter.

[Example: If the last available Wage Records quarter is the third quarter of 2023 (shown as 3/23) the quarter prior to the last available Wage Records quarter would be the second quarter of 2023 (shown as 2/23).

 - (1) If there are no matches for either of those quarters, no independent verification is required to resolve the Wage Records match. Resolve the exception through the Computer Match task.
 - (2) If a match is shown for either or both quarters, determine whether the income is currently being received by the member.]
 - (a) If the case record contains adequate verification for resolution, document accordingly and resolve the Computer Match.
 - (b) If independent verification is required, refer to item B. 2.
 - b. After IEVS resolution, process any possible claim in accordance with [MS 0870](#).
4. Computer Matching Data Information. Should recipients inquire about the source of Agency information, indicate the data was secured through computer matches made by the Agency. Use the following criteria to determine when a match requires independent verification.
- a. Independent verification is not required if the match data is currently considered in the case record or the case record contains adequate verification for resolution. Document accordingly and resolve the Computer Match.
 - b. Independent verification is required if the case record does not contain adequate verification. Refer to item B. 2. Additionally, if a bank account has been closed, a statement from the bank or source is required to verify the closure.
 - c. After IEVS resolution, process any possible claim in accordance with [MS 0870](#).

[Note: When processing income matches with verification available on Eligibility Advisor (EA), it is not appropriate to use the income unless the individual confirms the employer's name and wages shown on EA are correct. Refer to [MS 0680](#).

C. Public Assistance Reporting Information System (PARIS) Veterans Match – Individual Summary:

PARIS Veterans Match – Individual Summary, is a quarterly report that matches the Social Security Number (SSN) of Worker Portal members receiving Veterans Administration (VA) benefits against the PARIS Veterans File. The report lists the case information, member information, and the VA matched data.

The report includes a two-character Entitlement Code (ENT CODE) that identifies the payment type of the award. The first character indicates the type of service and the second character indicates if the payment is Pension or Compensation (Example: ENT CODE '71' is 'Vietnam Service Compensation').

Note: ENT CODE '51' indicates a one-time compensation payment for the Month-of-Death. It is not identified in the key.]

Use the key below to determine the payment type.

First Position	Second Position
0 - Gulf War Service	1 - Compensation
1 - WWI Service	2 - Protected Pension (veteran)
2 - WWII Service	4 - Section 306 Pension (veteran)
3 - Korean Conflict Service	5 - Death Compensation
4 - Peacetime Service	6 - Protected Pension (survivor)
7 - Vietnam Service	7 - Dependency Indemnity Compensation
9 - Philippine Service	8 - Section 306 Pension (survivor)
	D - Improved Pension (survivor)
	L - Improved Pension (veteran)

The gross, net, and check amounts in the VA data portion are shown in whole dollars only (no cents). Therefore, if the individual receives a VA amount that includes cents, then the amount shown on the report will be less than the actual amount received.

1. If the VA income is already counting in the case for the member and the amount on the report differs **within 0.99 cents**, no change is required to the case except documentation of the match.
2. If the VA income is already counting in the case for the member and the amount on the report differs **more than 0.99 cents**, consider the income verified upon receipt of the match, the match amount as accurate, and correct the case accordingly.
3. If the VA income is not counting in the case, consider the income verified upon receipt of the match, the match amount as accurate, and correct the case accordingly.

Take appropriate action on cases requiring correction and determine if an over-issuance has occurred. Identified claims are to be entered on Worker Portal within 10 days.

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MS 0680 - R. 12/15/25 - OMTL-686
IRS Safeguarding Issues

The Internal Revenue Service (IRS) requires that measures be taken to protect or safeguard confidential information. The IRS audits the Cabinet for Health and Family Services (CHFS) annually for compliance with these safeguarding requirements. The following procedures have been developed as a result of these requirements.

A. General Safeguarding Procedures:

Staff should take all precautions necessary to protect information that must be safeguarded, such as the following:

1. All Federal Tax Information (FTI) – including Computer Match, Income and Eligibility Verification System (IEVS), Beneficiary Data Exchange (BENDEX), earned income, and any other information that comes from the IRS. Worker Portal screens containing FTI are identified by the banner stating, “This screen contains IRS data – do not print.” FTI must **NEVER**:
 - a. Be copied, e-mailed, printed, or faxed; or
 - b. Be scanned into the Electronic Case File (ECF).

2. Two-barrier security is required for FTI. This means access to the material is locked by two locks.

Place [form DTA-FTI-1](#) (included as an attachment to the annually issued FSM, “IRS Safeguarding Procedures”), to the front of all file drawers or locked boxes (with two barrier security) where any potential FTI is held, identifying that those files contain FTI. Also, attach Form DTA-FTI-1 to the front of any file folders within the file so that it is visible to anyone who looks at those records.

3. Any material containing an individual's Social Security Number (SSN) must be safeguarded. Limit access to the case and other recipient-related information.
4. Minimize public access to confidential information:
 - a. Secure work areas against unauthorized and unsupervised access;
 - b. Ensure that during an interview, only the case record pertinent to that individual is visible on the desktop or surrounding areas;
 - c. Ensure that computer terminals only display information related to that individual during interviews; and
 - d. Sign off or lock computer terminals when not in use or when leaving the work area.

5. Keep mailed information secure:
 - a. Check mail trays for recipient information regularly; and
 - b. Do not leave recipient information in mail trays overnight.
6. Properly dispose of case record material and other recipient information as follows:
 - a. Shred the material into 5/16 inch or smaller strips; or
 - b. Place in a designated box:
 - (1) Seal the designated boxes and store in a secure location, preferably one that can be locked; and
 - (2) Complete the Certificate of Disposal form.

B. Procedures for Safeguarding IRS Information – Computer Match:

1. When an IRS match is received on the computer, and independent verification is required, **do not print** any Worker Portal screens containing IRS data. These screens can be identified by the banner, which states, “This screen contains IRS data – do not print.” **Do not specify** the IRS data in case comments
2. If verification is available through system inquiry for the match, and no claim is established, contact the individual to verify the information is accurate, then file the information in the case record and comment accordingly. If verification cannot be obtained through system inquiry, or the individual cannot be reached, the case must pend for the required information. Allowable comments in the case concerning the resolution of the match would be “Computer Match dated ‘mm/dd/yyyy’ resolved”. Generic employment information should be entered for Request for Information (RFI) that are mailed as a result of a computer match.

Example: While processing an income match for wages from ABC Employment Agency, staff are unable to reach the individual to confirm that the wages shown on Eligibility Advisor (EA) are representative of anticipated ongoing income. Enter generic employer information when entering into Worker Portal, such as, but not limited to, Job beginning xx/xx/xxxx. It is important that the employer's name is not entered into the case until it is confirmed with the individual that the information is correct. The RFI must not state the name of the matched employer.

3. If verification returned as a result of the request indicates the need for a claim referral, follow normal procedures in establishing a claim.

Note: Form PAFS-7, Notification of Appointment/Request for Verification, is obsolete effective May 1, 2011; however, the log used to track FTI-1 is kept in a locked file and maintained for five years after the last item on the log is destroyed, at which point it is destroyed per procedures found in General Safeguarding Procedures, item D.

C. Procedures for BENDEX Information:

1. Do not scan any BENDEX information into ECF. BENDEX information is:
 - a. Earned income data found on Worker Portal screens identified by the banner which states, "This screen contains IRS data – do not print;" and
 - b. Retirement, Survivors Disability Insurance (RSDI) income data and earned income data found on BENDEX Inquiry and Kentucky Information Management System (KYIMS) Job Menu, program 39, New BENDEX.
2. Do not mention BENDEX in case comments. Document that the income amount was verified by system inquiry on mm/dd/yyyy.
3. If it is necessary to print and keep any BENDEX screen information, it must be stored under two-barrier security in a folder or file labeled with form DTA-FTI-1. The case record may only reference where verification is filed.
4. Do not copy, fax, or e-mail BENDEX information.

D. Purging IRS Federal Tax Information found in Case Records:

[Case records cannot contain any BENDEX information, IEVS information, or Department of Child Support Services (DCSS) screens containing IRS data.

1. Check all active and inactive case records for BENDEX information, IEVS information, and DCSS screens containing IRS data.
2. Purge BENDEX information, IEVS information, and DCSS screens containing IRS data found in the active and inactive case records. The purged information must be disposed of following the procedures in General Safeguarding Procedures, item A.6.]

E. Penalties for Failure to Safeguard IRS Information:

1. Unauthorized inspection or disclosure of Federal income tax returns or return information may be punishable by a \$5,000 fine, five years imprisonment, or both, plus the cost of prosecution, per Internal Revenue Code Section 7213(a);
2. A taxpayer may bring suit for civil damages in a US District Court for unauthorized disclosure or unauthorized inspection of returns and return information, per Internal Revenue Code Section 7431. This Section allows for punitive damages in case of willful inspection or disclosure or gross negligence, as well as the cost of the action; and
3. These civil and criminal penalties **apply to the individual worker** even if the unauthorized disclosures or unauthorized inspection were made after employment with the Agency terminated and if the individual is no longer an employee of the Commonwealth of Kentucky.

F. Improper Inspection or Disclosure:

1. If an improper inspection or disclosure is discovered or witnessed, report the violation to the Service Region Administration Associate (SRAA) for your Region. The SRAA forwards the report to the Director of Service Regions. The SRAA takes action to ensure the violation does not occur again.
2. Additionally, if an improper inspection or disclosure has occurred, notify the IRS by calling the Chicago Field Division at 312-886-0620 or 1-800-366-4484 or by writing to:

Treasury Inspector General for Tax Administration
901 D Street SW, Suite 600
Washington, D.C. 20024-2169

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MS 0690 - R. 5/1/25 - OMTL-669

Prisoner Match

Workers must view the State Verification & Exchange System (SVES) prisoner match report found on the Living Arrangement screen for **ALL** household members age 15 and older at each application, recertification, and member add. A banner is also provided within the Living Arrangement details screen when the system has reviewed the report and a match is found for individuals in the case. The banner will continue to display until the case is disposed.

When completing a Supplemental Nutrition Assistance Program (SNAP) application, recertification, or member add:

- A. [Check SVES for each household member age 15 and older and discuss any records found within the prior six months with the individual. Detailed notes are only required when verification must be requested for an individual with incarceration matches that include the date of confinement and discharge date for each record found within six months of the application date. Verification is not required for any periods of incarceration with a discharge date more than six months before the individual received SNAP benefits. Comments are not required for those members who do not have a match.]
- B. If a household member was incarcerated during the SNAP certification period, or six months prior to their SNAP application, verification of their release must be provided. Pend the case for verification of release date, if not readily available. A Request for Information (RFI) is generated requesting verification. The individual has 30 days to provide the verification if the record is reviewed at application or untimely recertification, and until the end of the month for a timely recertification. At member add, the information must be provided within 10 days. If the individual is unable to provide their release paperwork, a collateral contact should be made to the facility where they were incarcerated. The facility's contact information is available on the report.

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MS 0730 - R. 12/1/16 - OMTL-510

Electronic Disqualified Recipient Subsystem (eDRS)

The Electronic Disqualified Recipient Subsystem (eDRS) is a national database of all individuals disqualified due to an Intentional Program Violation (IPV) in the Supplemental Nutrition Assistance Program (SNAP).

IPV disqualifications must be entered on the Worker Portal in order to track occurrences and to allow the matches of out-of-state disqualification information. The eDRS system sends and retrieves data via real time web service interface to transmit SNAP IPV disqualification information.

- A. [Effective March 16, 2016, staff in the Division of Family Support (DFS) who are working from the Program Integrity queue will receive eDRS tasks via the Worker Portal for disqualifications entered by other states.

An eDRS query will be sent for each adult household member requesting SNAP benefits on Worker Portal at application, recertification, and at member add, if the new member is age 18 or older.

If the query results in a match:

1. An eDRS task is created and sent to the Program Integrity queue. The disqualification details will automatically populate the IPV screen. This will provide the details of the IPV disqualification, including occurrence, decision date, start date, and length of the disqualification. Contact information for the originating state is also provided.
2. The worker starting the task must contact the originating state to request documentation of the IPV. In order to enter the IPV in the Worker Portal, one of the four types of supporting documentation must be obtained; either:
 - a. A signed waiver of an Administrative Disqualification Hearing (ADH);
 - b. An ADH order;
 - c. A deferred adjudication agreement; or
 - d. A court order.

The document will verify the disqualification time period and how the IPV was determined.

3. The originating state has 20 days to provide the documentation. Non-expedited cases will not dispose until after the 20th day in order to allow time for the verification to be obtained.
 - a. For cases meeting expedited criteria, process the case without the IPV verification and document in comments that information relating to an out-of-state IPV has been requested but not provided by the originating state.
 - b. For cases not meeting expedited criteria, if the documentation is not received by the 20th day or by the 10th day for a member add, process the case without the information and document in comments that information

relating to an out-of-state IPV has been requested but not provided by the reporting state. The task will remain open with the Program Integrity worker.

4. Once the verification documents are received from the originating state, the appropriate disqualification is entered on the Worker Portal.
 5. Scan all the documentation received from the originating state to support the disqualification into the electronic case file and attach to the disqualified individual within the "Claims and Hearings" category and under "Out of State Verification" type.
 6. Eligibility must be ran when the individual's disqualification is verified for a current time frame and they are actively receiving benefits. Failure to verify eDRS matches timely could result in agency errors. A call to eDRS must be made for each adult household member at every application, recertification or member add.
- B. Kentucky's Locality Contact is the Claims Management Section (CMS). Other states contact CMS to obtain Kentucky's disqualification verification for their matches.

CMS will review the case file on Worker Portal for the disqualification verification. If CMS is not able to locate the verification, CMS will request it from the Regional Claims Worker (RCW). Field staff must provide the verification to support the disqualification, within five work days of receiving a request.]

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MS 0740 - R. 8/1/22 - OMTL-603

State On-Line Query (SOLQ)

[SOLQ is a match process with the Social Security Administration (SSA) to verify a Social Security Number (SSN) in real time. The match occurs for numbers that have never been verified on Worker Portal. Once a number is verified by SOLQ, the SSN field is protected and the verification code "Verified Through SSA" is system-applied.

- A. At application or member add if SOLQ indicates the SSN is not verified, review the name, date of birth, and SSN with the applicant to ensure no mistakes were made in the entry of information.
 - 1. If corrections are needed to the initial entries, a second SOLQ transaction is submitted.
 - 2. If the number remains unverified, Worker Portal assigns a pseudo number. When a pseudo number is assigned, request the individual verify an SSN by a copy of the SSN card or written verification from SSA.
 - 3. When the SSN is entered for an individual and cannot be verified by the Federal Hub, two additional attempts can be made. When the SSN for the individual fails to be verified by the Federal Hub, a pseudo number will be assigned.
- B. Names must match with SSA records. If the individual's name has changed since issuance of the SSN, the individual must report the change to SSA.]

Volume 1 - General Administration

MS 0800 - R. 7/1/21 - OMTL-580

How to Prevent a Claim

The following measures are used to avoid errors and detect fraud:

A. All points of eligibility are explored, verified, and documented in the case record.

Ensure the following actions occur:

1. Thoroughly question the individual on all aspects of eligibility;
2. Verify statements by examining documents the applicant provides or by obtaining information from appropriate third party sources;
3. Verify a report of new employment or termination of employment by employer contact. If contact is not possible, document the reason in case comments.

[Note: For Child Care, all new employment must be verified three months from the hire date. All questionable forms of verification must be matched against the Wage File Data, Eligibility Advisor (EA), or tax records.]

B. Clarify inconsistencies;

C. Make sure applications are signed, accurately dated, and maintained in the electronic case file;

D. Inform individuals of the:

1. Responsibility to provide correct and complete information;
2. Responsibility to report changes correctly and timely;
3. Consequences of incorrect statements or omissions including the potential of being prosecuted for fraud;
4. Requirement to repay benefits received in excess of the eligible amount;

E. [Supplemental Nutrition Assistance Program (SNAP) recipients are informed of:

1. The proper use of SNAP benefits; and
2. Simplified Reporting (SR) requirements.]

F. Medicaid recipients are informed of the proper use of the Kentucky (KY) Health card.

G. Supervisors or designated personnel review a sample of cases before final disposition;

- H. Workers should complete thorough interviews with open-ended questions.
- I. Use the Determining Eligibility Through Extensive Review (DETER) process where operational. See [MS 0900](#); and
- J. Enter disqualifications timely.
- K. [Cash assistance and SNAP recipients are informed of the proper use of the Electronic Benefit Transfer (EBT) card.]

Volume 1 - General Administration

MS 0810 - R. 8/1/26 - OMTL-703

How to Identify a Claim

- A. [Identification of claims is an automatic process if an overpayment is detected by the Integrated Eligibility and Enrollment System (IEES) during case processing. For example, field staff make appropriate case changes and IEES detects a potential overpayment. At disposition, an automatic Discrepancy Referral information screen is triggered. Field Staff can create an overpayment discrepancy task for the Regional Claims Worker (RCW) to review from this screen. All other claims are manually referred.
- B. A Manual Claim referral is created when the following occurs:
1. Supplemental Nutrition Assistance Program (SNAP) benefits are trafficked;
 2. Benefits designated for a specific purpose are used to purchase unapproved items or services;
 3. Claims identified as occurring prior to implementation of IEES and were not processed on Kentucky Claims Debt (KCD) Management System;
 4. Medicaid Fraud;
 5. Individual Child Care Fraud;
 6. Child Care Provider Fraud;
 7. Some supportive service payments are overpaid; or
 8. When any overpayment is detected by field staff that is not automatically detected by IEES.
- C. When completing a claim referral or while establishing a claim, staff will utilize one of the following detection code associated with how the claim was identified:
1. Batch Match/Computer Match: Used when computer file data from the Income and Eligibility Verification System (IEVS) is matched against case and member information on Worker Portal and the discovery of unreported income/resources results in an overpayment or incorrect issuance of benefits for all Family Support assistance categories;
 2. Public Assistance Reporting Information System (PARIS): Used when a recipient match is received showing benefits were issued in more than one state for the same timeframe;
 3. Hotline: Used when an overpayment is found due to a citizen, known or anonymous, contacting the Food and Nutrition Administration (FNA) through a Whistleblower Complaint or the Office of Inspector General

(OIG) through a Hotline Complaint with information pertaining to a benefit recipient that may be unreported or unknown to the agency. FNA or OIG will then route these complaints to the designated contact for investigation and dissemination;]

4. Quality Control (QC) reviews: Used once the QC process has been completed and a positive error for an over issuance has been detected;
5. Audit: Used when an overpayment is detected via the evaluation process conducted by the United States Department of Agriculture (USDA), Department of Health and Human Services (DHHS), Auditor of Public Accounts (APA), or the Government Accounting Office (GAO);
6. Quality Assurance (QA) review: Used when an overpayment is found by a supervisor, principal, Case Review Team (CRT), or the Division of Family Support (DFS) during any case review process;
7. Management Evaluation (ME) reviews: Used when an overpayment is detected during the review of SNAP cases conducted by ME staff;
8. Central Office: Used when an overpayment is detected by central office staff or when there is an overpayment involving an employee or Simplified Assistance for the Elderly (SAFE) claims;
9. Worker: Used when an overpayment is found during the course of regular casework via application, recertification, or case processing and the worker generates a claim referral, or while processing Fidelity Information Systems (FIS) fraud alerts;
10. Office of the Inspector General (OIG): Used when an overpayment is detected during an OIG investigation;
11. Client: Used when an overpayment is found from a report from the household;
12. Department of Child Support Services (DCSS): Used when an overpayment is found due to unreported child support income and DCSS informs the Department for Community Based Services (DCBS) of the income;
13. Third Party: Used when an overpayment is detected from information provided by a source outside of the agency (i.e., an employer);
14. Eligibility Advisor (EA): Used when an overpayment is detected by unreported income discovered via EA; or
15. National Accuracy Clearinghouse (NAC): Used when an overpayment is detected by the receipt of a notification from the NAC system for the receipt of duplicate benefits in more than one state for the same timeframe.]

D. Claims may also be identified by:

1. Changes – An individual reports a change, but after the worker verifies the situation, it is discovered the change was not reported timely;
2. Analysis of expenses vs. income – An individual's expenses exceed the income, which may be an indicator of unreported income;
3. Worker Interview – A thorough interview increases the likelihood of the applicant reporting other income, such as contributions from family members or friends, which may not be counted in the case;
4. Income – Check stubs reflect an increase due to a change in pay rates or overtime worked;
5. Deductions given in error - such as the Standard Utility Allowance (SUA), Basic Utility Allowance (BUA), 30 and 1/3 deduction;
6. Whistleblower complaints; or
7. SNAP Simplified Reporting (SR) Households – Determine:
 - a. If the household's monthly gross income exceeds the allowed limit for the household size; or
 - b. If any member of the household, age 18 through 64, failed to report working fewer than 20 hours a week (paid or unpaid) or participating in the Employment and Training Program (E&T) to meet the time limit work requirements.

E. [When completing a review to determine the overpayment period for claims for establishment, use the policy that was in effect at the time the claim occurred.]

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MS 0820 - R. 7/1/21 - OMTL-580

Benefit Management

[Benefit Recovery within the Benefit Management Module provides automated support to manage claims and collection activity. Access is available on the Integrated Eligibility and Enrollment System (IEES) under Benefit Management located on the menu bar.

Benefit Management is used by claims staff to:

- A. Record and calculate claims;
- B. Document the circumstances of the claim and related activities;
- C. Correct and track a completed claim;
- D. Issue claim-related notices;
- E. Track claim payments; and
- F. Inquire the status of claims.

Benefit Recovery is used by field staff to manually refer potential claims for review.]

Volume 1 – General Administration
MS 0830 – R. 7/1/21 – OMTL-580
[Responsibilities for Claims]

A. [Field Staff are to take the following actions:

1. Enter a change to a case and run eligibility which prompts the Discrepancy Overpayment screen.
2. Enter the Discrepancy Overpayment detail, which creates a task for the Regional Claims Worker (RCW) to begin the claims process.
3. Manually process disqualifications that are not automatically imposed on the Integrated Eligibility and Enrollment System (IEES) (i.e. Employment & Training (E&T) disqualifications).
4. Create manual claim referrals as appropriate. See [MS 0820](#).
5. Identifying and referring suspicious case situations prior to approval to the Determining Eligibility Through Extensive Review (DETER) program where it is operational. Refer to [MS 0900](#).

B. RCWs are responsible for the following:

1. Processing automatic claims.
2. Processing Supplemental Nutrition Assistance Program (SNAP) and Child Care Assistance Program (CCAP) individual-only disqualifications for Intentional Program Violations (IPV).
3. Determining whether to validate and establish or No Claim the referral and update the status in the system.
4. Determining the claim type and verifying the claim amount.
5. Establishing a Manual Claim.
6. Initiating Fraud Referrals to the Office of Inspector General (OIG).
7. Submitting requests for claim adjustments.
8. Contacting the household to determine and discuss the reason for a claim and to explain the computation of the claim amount.
9. Scanning all claim-related documents to the associated claim(s) electronic case files.
10. Screening claims for suspected fraud and taking the following action:
 - a. Referring the claim(s) meeting criteria to the OIG for further investigation and possible prosecution. See [MS 0910](#); or

- b. For SNAP claims, sending forms FS-80, Notice of SNAP Suspected Intentional Program Violation (SIPV), and FS-80A, Voluntary Waiver of SNAP Administrative Disqualification Hearing, to a SNAP household with a claim that does not meet criteria for OIG referral or OIG does not pursue prosecution.
- c. RCWs are to update comments on IEES whenever any action is taken on a claim and to ensure that all appropriate dates and codes are entered on the Benefit Recovery screen, in order to document that appropriate action is taken during the claim process. For SNAP claims, update when:
 - 1. Form FS-80 and FS-80A are mailed to the recipient;
 - 2. Form FS-80A is signed and dated by the recipient and returned;
 - 3. Form FS-111, Deferred Adjudication Disqualification Consent Agreement is signed and dated; or
 - 4. An Administrative Disqualification Hearing (ADH) is requested, scheduled, affirmed, or reversed.

Note: This information is reviewed for accuracy during the Case Review and the Management Evaluation (ME) review process.

- 11. Requesting and participating in SNAP ADHs or court proceedings to give testimony to identify a recipient and testify to the explanation given of the recipient's rights and responsibilities.
- 12. Verifying and imposing SNAP disqualifications identified by the electronic Disqualified Recipient Subsystem (eDRS).
- 13. Providing an explanation of benefit reduction to affected households.
- 14. Responding to fraud hotline requests generated by OIG.
- 15. Accepting non-cash payments (checks, money orders, or EBT) and issuing receipts for payments brought to the local office for established claims. Non-cash payments are to be mailed to:

Claims Management Section
275 E. Main St. 3E-I
Frankfort, KY 40621.

Advise the recipient to send any future payments to the Claims Management Section (CMS).

- 16. Referring questions relating to the payment of claims, other than those relating to benefit reduction, to CMS at 502-564-3440.
- 17. Referring all questions relating to tax intercepts, garnishment of wages, and other intercepts to CMS at 502-564-3440.

18. Reporting alleged SNAP retailer and Medicaid provider fraud to the OIG Fraud Hotline at 1-800-372-2970.
19. Forwarding bankruptcy information to CMS.
20. Documenting information regarding alleged trafficking activity. The value of trafficked benefits is determined by the recipient's statement, adjudication, or the documentation that forms the basis for the trafficking allegation. A record of actual transactions on the Electronic Benefit Transfer (EBT) website account is provided to OIG by CMS.]

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MS 0840 – R. 7/1/21 – OMTL-580

Claims Management Section Information and Responsibilities

A. The Claims Management Section (CMS) is located in the Division of Family Support (DFS). The section can be reached by:

1. Phone - 502-564-3440
2. Fax - 502-564-9810
3. Email - chfs.dfs.claims@ky.gov

[4. Mail - Cabinet for Health and Family Services
Division of Family Support
Program Integrity Branch
Claims Management Section
275 East Main Street 3-EI
Frankfort, KY 40621

B. CMS is responsible for:

1. Pursuing collection of all claims not repaid by benefit reduction.
2. Responding to individual inquiries regarding the repayment of claims.
3. Reviewing all field referrals to the Office of Inspector General (OIG).
4. Monitoring the progress of claims referred to or identified by OIG.
5. Reviewing recommended and final orders related to claims.
6. Preparing and routing exceptions to recommended orders related to claims.
7. Providing information to other states regarding food benefit disqualifications appearing on the electronic Disqualified Recipient Subsystem (eDRS).
8. Processing repayment agreements.
9. Accepting, posting, and providing receipts for payments on claims.
10. Suspending or terminating collection efforts on claims.
11. Monitoring collections on claims by various intercept programs.
12. Maintaining and monitoring bankruptcy information.
13. Completing actions on Integrated Eligibility and Enrollment System (IEES) to compromise a claim (if determined appropriate).
14. Approving all claim debt adjustments and applying corrections to the claim balance. This includes court-compromised amounts, which must be entered

by CMS on IEES. After the claim corrections or court-compromised amounts are determined by the Regional Claims Worker (RCW), a claim adjustment is entered, and CMS will receive a task to approve or deny the adjustment. The RCW enters comments on IEES and clearly explains the intended action pending for CMS approval.]

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MS 0850 – R. 7/1/21 – OMTL-580
Electronic Claims Files

All claims records contain sufficient documentation to support establishing a claim and are maintained as Electronic Case Files (ECF). Retain hardcopy case records for claims established prior to implementation of ECF. The case record may be scanned into ECF if it applies to a newly discovered claim after ECF was implemented in your region.

A. [Scan ECF information **only** relating to the claim not retained on another system. Claims that require Beneficiary Earnings and Data Exchange (BENDEX) verification will be maintained in a hardcopy control folder.

1. Information used to establish the claim, such as:

- a. Form PAFS-431, Claim Referral (for claims prior to the Integrated Eligibility and Enrollment System (IEES))
- b. Verification, such as Income and Eligibility Verification System (IEVS) records (see [MS 0680](#), IRS Safeguarding Issues, regarding Federal Tax Information (FTI)), employer statements, and written statements
- c. Recipient's signed DCC-90, Subsidized Child Care Assistance Application Summary
- d. Signed DCC-94, Child Care Service Agreement and Certificate
- e. DCC-99B, Claims Calculation Sheet
- f. DCC-99C, Client Provider Sheet, if applicable
- g. Information from the Office of Inspector General (OIG), such as form IR-1, Investigative Report
- h. Quality Control (QC) reports
- i. E-mails
- j. Hotline referrals
- k. Determining Eligibility Through Extensive Review (DETER) investigation reports]

2. Legal documents and hearing results:

- a. Correspondence from OIG
- b. Court order/decision
- c. Final order from a fair hearing

- d. Administrative Disqualification Hearing (ADH) final order
 - e. FS-80, Notice of SNAP Suspected Intentional Program Violation, FS-80A, Voluntary Waiver of SNAP Administrative Disqualification Hearing, FS-111, Deferred Adjudication Disqualification Consent Agreement, DCC-84, Notice of Suspected Intentional Program Violation, DCC-84 Supplement A, Voluntary Waiver of Administrative Disqualification Hearing, or DCC-83, Deferred Adjudication Agreement
3. [IEES maintains the comments, calculations, and notices. Copies of the following must be maintained in the ECF:
- a. Claim-related correspondence manually sent to the individual
 - b. Completed Repayment Agreement (KCD 1.11), if appropriate
 - c. Correspondence to and from the Claims Management Section (CMS)
 - d. Payments forwarded to CMS from the local office]
4. Copies of receipts for payments received in the local office.
5. Refer to [MS 0040](#) for information on Purging Obsolete Material.

Volume 1 – General Administration
MS 0860 – R. 7/1/21 – OMTL-580
Time Frames for Establishing a Claim

[Claims must be established within 90 calendar days from the date of discovery. Pending claims not established within 90 days appear on the Pending Claims and Discrepancies Past Due report accessed via the Integrated Eligibility and Enrollment System (IEES).]

Kentucky Transitional Assistance Program (KTAP) and related programs must be established by the end of the quarter following the quarter the claim is discovered.

[The Division of Service Regions (DSR) Regional Claims Section monitors this report monthly and advises Regional Claims Staff to take action on pending and past due claims.]

The Pending Claims and Discrepancies Past Due report is available to claims staff for use in monitoring the completion of claims within the required time frames.

Volume 1 – General Administration
MS 0870 – R. 8/1/26 – OMTL-703
General Procedures for All Claims

[Potential claims are identified for active and inactive cases via an automatic Discrepancy Referral or a manual claim referral. For active cases, the Regional Claims Worker (RCW) responsible for reviewing claim referrals is assigned based on where the household or member lives. For inactive cases or households that have moved out of state, the RCW responsible for reviewing claim referrals is assigned based on the last region of residence where benefits were received.

- A. The basic process for task creation for claim referrals includes the following:
1. During case processing, field staff process a change that creates the Discrepancy Overpayment information screen in the Integrated Eligibility and Enrollment System (IEES) or create a manual claim referral when IEES does not detect the potential overpayment.
 2. Field staff create a manual Claim Referral for potential claims under the Benefit Management tab for Medical Assistance (MA), Temporary Assistance for Needy Families (TANF) related programs, Simplified Assistance for the Elderly (SAFE), and Supplemental Nutrition Assistance Program (SNAP) trafficking.
 3. RCWs will receive a task for “Discrepancy Referral to Claims Worker” or a “Family Support Claim Referral Task”.
 4. A Claim Referral is not considered a valid claim until it is investigated and moved from a pending claim status to an active claim status by an RCW.

Complete the following actions related to any suspected over-issuance occurring in the SNAP, SAFE, MA, Kinship Care (KC), Child Care Assistance Program (CCAP), Kentucky Transitional Assistance Program (KTAP), and KTAP-related programs administered by Family Support field staff:

- B. Review the circumstances to determine the reason for the error and correct any active case. If an active SAFE case requires corrections, Central Office staff within the Nutrition Assistance Branch (NAB) must be notified via the [SAFE inbox](#) to act on the update.
- C. Determine if any companion cases exist that may be affected by the potential claim.
- D. After entering a change and running eligibility, if you are directed to the Overpayment Discrepancies screen, you will proceed with the following steps:
1. Scroll to the right of the screen to view all details that should be entered.
 2. Select the proper method under the **Detection** drop-down.
 3. Select the cause of the discrepancy under the **Reason** drop-down.

4. Select claim type under the **Category Type** drop-down.
 5. Select refer or not refer to claims.
 6. Enter specific details regarding the discrepancy in the comment box, including why the claim was referred or not referred, including all relevant details regarding the referral.
 7. Click **Next** to submit the discrepancy.
- E. Potential claim referrals are submitted at the case level on IEES.
- Exception:** MA, SNAP Employment & Training (E&T), SNAP trafficking, Kentucky Works Program (KWP), and referrals with no associated case are submitted and entered on IEES under the individual level.]
- F. RCWs are required to enter all available information for the potential claim on IEES within 10 days of the discovery date. The discovery date of the claim is the date that the RCW starts the task.
- G. Scan claim information into the Electronic Case File (ECF). See MS 0850.
- H. RCW staff will schedule an appointment with the household on IEES, if needed:
1. The scheduled appointment is to occur no later than 30 days from the discovery date.
 2. Appointment notices should be sent to the household within 10 days of the discovery date of the claim.
 3. Appointments are not required to be scheduled for Agency Error (AE) claims. Appointments are required for Inadvertent Household Error (IHE) and Suspected Intentional Program Violation (SIPV) claims and can be scheduled as a face-to-face or phone interview (except when a phone number is not available). See MS 1020 for SNAP trafficking procedures.
 4. The RCW is responsible for contacting the individual at the time the phone interview is scheduled. The face-to-face interview is scheduled in the local office of the county where the client is active or last received in. If the individual is not currently receiving benefits and has moved out of the county that has the claim, the individual may travel to the county for the interview, be given a phone interview, or the new region may be asked to handle the claims interview.
 5. Comments regarding the scheduling of the interview are required to be entered when it is scheduled and at the completion of the interview. If the individual is not reachable at the time of the scheduled interview, the RCW is required to leave a message on how to contact them and update comments regarding the outcome. Do not leave any confidential information on the voice recording.

Note: If the claim is split due to household members moving in or out, a second appointment is not required. Only one interview is required.

I. Households that refuse to provide information required to determine ongoing eligibility are discontinued for non-cooperation.

J. Document claim comments as well as IEES case comments:

1. Every action taken and the date it happened.
2. List in chronological order the circumstances that resulted in the claim.
3. The date and time of the scheduled interview, if applicable, and the result of the interview at the time it was scheduled.

Example: 2/12/2020 – Interview appointment scheduled for 2/25/2020 at 1:00 p.m. Eastern Time. Appointment notice mailed to household on 2/12/2020. 2/25/2020 – Claim comments should include the phone number you contacted the client at and thoroughly explain the outcome of the interview appointment. This also includes reaching their voicemail and the need to leave a message for a return call.

4. False, misleading, or untimely statements made by the member(s).
5. List all verification used to determine the claim.
6. An explanation of the category of the claim.
7. An explanation of any corrective action taken to prevent future errors of the type that caused the claim.
8. For claims caused by unreported income, indicate who had the income, the type of income, name of employer if it is earned income, and the time period of receipt of the unreported income.
9. The hearing decision and other actions pertaining to the disposition of the claim, such as completion of a waiver to a hearing, termination of an Office of Inspector General (OIG) referral, or court disposition.
10. Any action by the RCW that deviates from the normal procedures.

K. Compute the claim amount based on available information, i.e., wage records, batch match, Eligibility Advisor, driver's license, etc. RCWs are not to investigate using Facebook, Google, or by calling family, friends, employers, or landlords to seek information about the individual that the household did not verify. If a collateral contact is used to substantiate a claim, request and obtain written verification from the source for the claim record.

[Example 1: The case record contains form PAFS-76 that was completed by the landlord. When the RCW contacts the verification source to determine time period of household composition, it is found it

was not completed by the landlord. In the claim, it is notated that the individual returned false verification, as the landlord did not complete the PAFS-76.

Example 2: The case record contains form PAFS-700 from the individual's employer. The employer can be contacted to verify information pertaining to an individual's employment but is not to be questioned about the individual's living situation.

Example 3: An individual applied for SNAP benefits on 3/21/2023. Over the course of their certification period, the employment reported at the application ended with the last pay received in June 2023. The individual never reported the change to the agency, and the income continued to count in the case. A claim referral was submitted after the recertification interview for a potential overpayment due to the individual starting new employment on 6/15/2023, and the household failed to report exceeding the gross income limit by 7/10/2023. During the claim investigation, the RCW should attempt to verify the income and termination through the use of form CL-700, Verification of Employment and Wages, a collateral contact, or other acceptable forms of verification. The RCW should not consider terminated income in claim calculations if they are able to obtain verification of the termination and final wages, even when the termination is not reported by the household. Claim calculations utilize the household's actual income received during a benefit month when determining if an overpayment of benefits occurred.]

- L. If verification of the claim cannot be substantiated by any available source, determine if the claim should be referred to OIG for further investigation. If the claim does not meet the criteria for a referral to OIG, then no claim exists. If information later becomes available to establish the claim, it can be reentered as a potential claim on the Benefit Recovery Module.
- M. Potential fraud claims that meet the criteria in MS 0910 are referred to OIG for further investigation. If a disability exists or Limited English Proficiency (LEP) is present, prior to completing a referral to OIG, seek an assessment of the individual's ability to understand program rules from the Department of Community Based Services (DCBS) Equal Employment Opportunity (EEO) Coordinator or Cabinet for Health and Family Services (CHFS) EEO Compliance Branch, 275 East Main Street 5 C-D, Frankfort, KY 40621 or call 502-564-7770.
- [N. State Supplementation potential claim referrals are sent directly to the Medical Support and Benefits Branch (MSBB):
 - 1. If detection is made by field staff for a potential State Supplementation claim, a manual claim referral is submitted on the Benefit Recovery module within the Benefit Management tab.

2. RCW staff will reject the referral and submit the referral, thoroughly documenting the reason for the potential claim, via email to their Public Assistance Program Specialist (PAPS) to refer to MSBB.
3. MSBB will review the referral and determine if a claim is valid.
 - a. If MSBB determines a claim is not valid, a response will be sent back to the PAPS advising of their findings and case comments will need to be updated accordingly.
 - b. If a claim is to be established, MSBB will complete the check endorsement verification and forward form PAFS-431, Claim Referral, to the [Claims Management Section \(CMS\)](#) to enter on the Benefit Recovery Module.

Once CMS receives the form PAFS-431 to establish the State Supplementation claim and enters the claim on the Benefit Recovery module, the completed PAFS-431 will be scanned into the claim ECF.]

- O. SAFE claims are investigated by SAFE workers and referred directly to CMS by completing and forwarding form PAFS-431 to [CMS](#) for claim establishment. After the claim is established on the Benefit Recovery module, CMS staff will scan the completed PAFS-431 into the claim ECF.

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MS 0880 – R. 3/1/22 – OMTL-592

General Procedures for a Suspected Fraud Claim

A preliminary determination of suspected fraud is made after review of the information available to the worker regarding the circumstances of the claim and the individual's statements regarding the reason(s) for the claim. The supervisor must agree with the findings of the worker referring the case(s) to the Office of Inspector General (OIG) for possible prosecution. Use criteria in [MS 0910](#) to refer a case to OIG.

A. Fraud is suspected when an individual:

1. Makes a false or misleading statement in order to receive benefits;
2. Misrepresents, conceals, or withholds factual information in order to receive benefits;
3. Commits a violation of the Food and Nutrition Act relating to the use, presentation, transfer, acquisition, receipt, or possession of Supplemental Nutrition Assistance Program (SNAP) benefits. Specifically prohibited is:
 - a. Purchasing a controlled substance using SNAP benefits;
 - b. Purchasing firearms, ammunition, or explosives using SNAP benefits;
 - c. Buying or selling SNAP benefits on or after August 22, 1996; and
 - d. Making a false statement on or after August 22, 1996, pertaining to identity or residence in order to receive duplicate benefits.
4. Permits an individual other than those listed on the Kentucky Health Card to obtain health care benefits;
5. Misuses a Medicaid-covered service, such as medical transportation, for a non-medical purpose; or
6. Misuses supportive service payments.

B. [Suspected fraudulent SNAP claims are established on the Benefit Recovery Module as a Suspected Intentional Program Violation (SIPV). After the claim has been established as SIPV, a change in status must be completed within 90 days. If the claim is not referred to OIG, pursue the Intentional Program Violation (IPV) by sending form FS-80, Notice of SNAP Suspected Intentional Program Violation, and form FS-80A, Voluntary Waiver of SNAP Administrative Disqualification Hearing, to the recipient for signature. If form FS-80A is not returned, is returned unsigned, or without a date, submit a request for an Administrative Disqualification Hearing (ADH) within three calendar days. See [MS 1070](#) for ADH procedures.]

C. A SNAP claim is not considered fraud unless:

1. The recipient voluntarily signs and dates form FS-80A, Voluntary Waiver of SNAP Administrative Disqualification Hearing;
 2. It is determined fraud by a hearing officer in an ADH, confirmed by a final order, and all further appeals are completed;
 3. The recipient signs form FS-111, Deferred Adjudication Disqualification Consent Agreement, to avoid criminal prosecution; or
 4. A court action establishes fraud.
- D. SNAP Claims that are referred to OIG remain as SIPV until OIG:
1. Returns the referral declining to pursue court action; or
 2. Final action is completed in the fraud determination.
- E. Fraud is established judicially for Medicaid and TANF-related programs (Kentucky Transitional Assistance Program (KTAP), Kinship Care (KC), Relocation Assistance Program (RAP), Family Alternatives Diversion (FAD), Work Incentive Reimbursement (WIN), Kentucky Works Program (KWP) Supportive Services). Claims that do not meet the criteria for referral to OIG are categorized as non-court on the Integrated Eligibility and Enrollment System (IEES). KTAP claims referred to OIG remain as Inadvertent Household Errors (IHE) until final action is completed in the fraud determination.
- F. All Medicaid claims occurring due to suspected fraud are referred to OIG. See [MS 1240](#).

Volume 1 – General Administration
MS 0890 – R. 7/1/21 – OMTL-580
How to Determine the First Month of a Claim

To determine the first month of the claim, apply the following rules.

- A. [For applications that are incorrectly processed based on information provided at the interview, the claim is established for the effective month of approval and continues for every subsequent month the incorrect information is used.

Example: The individual applies for benefits and fails to report a source of income. The claim begins the month of approval and continues until the income is considered in the determination of the benefit.

- B. The 10-10-10 formula is used to determine the first month of the claim.

1. Determine when the change became known to the household;
2. From that date, allow the household 10 days to report;
3. Allow the worker 10 days to act on the report; and
4. Allow 10 days for adverse action.
5. The month in which the adverse action period ends determines the first month of the claim. The beginning month of the claim is the next month after adverse action ends.

- C. Simplified Reporting households have until the 10th of the month following the month a change occurs to report a required change.

Example: A household's income increases above the permitted gross limit in August. The individual has until September 10 to report the change. The worker has 10 days to act on the change (September 20), and 10 days (September 30) are allowed for adverse action. The first month of the claim is October.

- D. A reportable Kentucky Transitional Assistance Program (KTAP) or Kinship Care (KC) change is required to be reported within 10 days. When changes decrease benefits or result in discontinuance of a case, the change must be entered on the Integrated Eligibility and Enrollment System (IEES) by either the negative action cutoff or Child Care Assistance Program (CCAP)/KTAP/Medicaid (MA) cutoff date, whichever affects the next month's benefits.

Example 1: An individual reports a member of the benefit group left the home on September 5, 2010. CCAP/KTAP/MA cut-off is September 21, 2010. Negative action cut-off is September 20, 2010. As this change will decrease benefits, the change must be entered by September 20, 2010, to be effective for October

1, 2010. If the change is entered after the negative action date, an Agency Error (AE) claim exists for October 2010.

Example 2: An individual reports a member of the benefit group has left the home on November 5, 2010. Due to holidays, CCAP/KTAP/MA cut-off falls on November 17, 2010. Negative action cut-off is on November 19, 2010. The change must be entered by November 17, 2010, in order to be effective December 1, 2010, or an AE claim exists for December 2010.

- E. For KTAP or KC claims resulting from the failure of the household to report a child's absence from the home within five days, without good cause, the claim will begin the month after the child left the home. Please reference Volume 3 MS 2338 for KTAP and KC good cause reasons.]

Volume 1 – General Administration
MS 0900 – R. 10/1/24 – OMTL-658
Determining Eligibility Through Extensive Review

The Determining Eligibility Through Extensive Review (DETER) program is offered by the Office of Inspector General (OIG) to prevent individuals from receiving benefits fraudulently. A DETER referral is appropriate ONLY if a specific issue affecting eligibility is identified. Cases that appear suspect are referred to the DETER program for investigation.

- A. Refer only applications and reapplications that cannot be resolved through normal case processing. DETER is not used on Expedited Supplemental Nutrition Assistance Program (ExSNAP) applications or State Supplementation applications. Only send a DETER referral if there has been a break in benefits. A break in benefits is defined as there is at least one month in between receipt of benefits.

Example: An individual received benefits in January. The case discontinued effective February. The individual reapplies in February. Do not complete a DETER referral as there has not been a break in benefits.

Example: An individual received benefits in January. The case discontinued effective February. The individual reapplies in March. A DETER referral can be completed since there has been at least a one month break in benefits.

1. Access the DETER function on the case summary screen on the Integrated Eligibility and Enrollment System (IEES).
 - a. Enter detailed comments in the DETER referral window regarding the allegation and what case type is being referred to DETER.
 - b. Scan all related information into the Electronic Case File (ECF).
 2. DETER is operational in all counties.
 3. Caseworkers must explore all avenues available to resolve the issue before referring the case to DETER. An inappropriate DETER referral will be returned to the worker.
- B. After satisfying the verification requirements or when all avenues have been exhausted, use the following guidelines to determine if a referral to DETER is appropriate.
1. During the initial application, the caseworker suspects the individual may have withheld information during the interview.
 2. The individual provides any verification relative to the eligibility determination that appears to have been altered or not authentic.
 3. The applicant provides contradictory information relative to any eligibility factor.

4. The individual does not respond during application or reapplication to questions relating to eligibility.

Example: The individual states rent and utilities are being paid, no income is reported, and individual does not have a valid explanation as to how the expenses are being paid.

- C. [In instances where there are two days or less until the case must be processed, a DETER investigation is not possible. The case should be processed and then a Manual Claim Referral created for regional claim staff to review and submit to OIG.]
- D. After the DETER referral is made, pend the case for up to 15 days or until the case due date, whichever occurs first, to allow the investigator time to gather information and report findings. The investigator has up to 15 calendar days to complete the investigation and provide their findings unless the case due date is less than 15 calendar days from the date of the DETER referral. If there are not 15 days prior to the case due date you must specify, in the DETER comments box, the case due date. Once the DETER investigation is complete, OIG returns the final report to the worker who initiated the DETER referral and the worker's supervisor.
 1. Comment thoroughly the reason for the DETER investigation and pending the application.
 2. Pend the case until forms DTR-2, Case Detail Summary Sheet, DTR-2A, DETER Response and Request for Action, and DTR-3, DETER Investigation Report, are received from the DETER investigator or until the case reaches its due date, whichever comes first. **Do not** pend cases past their due date.

Example: A SNAP application is taken on January 1. After verification had been returned on January 23, the worker noticed an altered verification form and initiated a DETER referral. There are not 15 days prior to the case due date of January 30. When the worker creates the DETER referral, they must specify in the DETER comment box that the investigation needs to be completed by January 29.

Example: A SNAP application is taken January 1. The individual first stated the father of the child was in the home, but then she stated the father of the child was out of the home. The worker, through all avenues of questioning, cannot determine if the father is in the home. On January 1 the worker submits a DETER referral. The worker would not need to specify a due date when the DETER referral is submitted as there is more than 15 days before the case is due.

- E. Caseworkers will receive forms DTR-2, DTR-2A, DTR-3, and a document titled Report Attachments containing any supporting documentation obtained during the investigation via e-mail. Caseworkers must review all information provided

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MS 0910 – R. 11/1/25 – OMTL-685

Referral of Claims to the Office of Inspector General

The Department for Community Based Services (DCBS) contracts with the Office of Inspector General (OIG) of the Cabinet for Health and Family Services (CHFS) to investigate and pursue prosecution of individuals suspected of fraudulently receiving or trafficking program benefits.

A. The following claims are referred to OIG for investigation:

1. Medicaid (MA) claims, regardless of the amount, when an individual has withheld or provided false information to receive assistance. MA claims are not entered on the Integrated Eligibility and Enrollment System (IEES) unless adjudicated through the court system.
2. [A Kentucky Transitional Assistance Program (KTAP), Kentucky Works Program (KWP) supportive services, Kinship Care (KC), Family Assistance Short Term (FAST), Work Incentive Reimbursement (WIN), Relocation Assistance Program (RAP), or Supplemental Nutrition Assistance Program (SNAP) case suspected of fraud, when the claim amount:
 - a. Is estimated to be \$10,000 or more due to unreported wages only;
 - b. Is estimated to be \$3,000 or more for reasons other than unreported income;
 - c. There is a companion case(s), and the combined amount is estimated to be \$3,000 or more; or
 - d. There is a companion MA case with at least one month of suspected ineligibility.
3. SNAP trafficking cases/referrals that are believed to be \$10,000 or more.
4. SNAP trafficking involving controlled substances, firearms, ammunition, or explosives, regardless of the suspected amount.

Note: Any trafficking that does not meet the criteria of items 3 or 4 will need to be handled administratively.
5. Child Care Assistance Program (CCAP) recipient eligibility claims estimated to have a value of \$5,000 or more AND suspected to be fraudulent.
6. Child Care provider claims of \$10,000 or more and evidence of fraudulent billings, limited to the availability of funds.
7. Low-Income Home Energy Assistance Program (LIHEAP) cases, regardless of the amount.]

- B. Take the following actions when suspected fraud is discovered and the claim meets the criteria in Item A:
1. Calculate the claim based on available verification.
 2. Complete form Claim/MA-1, Medical Assistance Eligibility Summary, for claims that include Medicaid.
 3. Navigate to the OIG Fraud Claims Tracking SharePoint site and create a new PAFS-88 referral. Enter all relevant claim information in the referral, clearly explain the allegation, and indicate which programs are associated with the overpayment.
 4. Upload supporting documentation using the Doc Link hyperlink for the referral.
 5. Submit the PAFS-88 referral for supervisor review by updating the referral status. The assigned claims supervisor will review the referral, determine if the referral is appropriate, and ensure all required steps have been completed. The supervisor will have the option to reject the referral or approve and submit the referral for Claims Management Section (CMS) review.
 6. CMS reviews the referral and supporting documentation before submitting the referral to OIG on the OIG Fraud Claims Tracking SharePoint site.
- C. OIG may request a claim to be recalculated based on the findings of the investigation. Complete all recalculations within 15 calendar days of the request by OIG. These computation requests are sent directly to OIG. Contact the OIG investigator and [email CMS](#) if there will be a delay in completing computations.
- D. OIG has a 90-day timeframe to complete the investigation and determine if prosecution will be pursued.
1. If prosecution is not pursued, OIG closes their case and returns the claim to DCBS for administrative action, which must be taken within 10 calendar days.

For SNAP claims:

- a. If fraud is highly suspected, pursue administrative establishment of an Intentional Program Violation (IPV) claim. See [MS 1070](#).
- b. If the claim was caused by the client but fraud cannot be determined, change the category on the Worker Portal form Suspected Intentional Program Violation (SIPV) and complete as an Inadvertent Household Error Claim (IHE).
- c. If OIG determines the claim resulted from an Agency Error (AE), review the claim circumstances. The DCBS claims worker determines the appropriate category of a claim. If an AE is found, change the indicator on IEES, and take appropriate action on the claim.

2. If a portion of the claim is not prosecuted but returned to DCBS for administrative action, a separate claim is established and procedures for the appropriate claim category are followed. Only one disqualification period is entered if both claims are of the same circumstances.
3. If prosecution is pursued, OIG serves as liaison between DCBS and the courts and prosecutors.
 - a. When possible, OIG will notify field staff at least five days in advance of a court or conference that requires their appearance.
 - b. When the case is adjudicated, OIG will provide copies of the order or agreement and update the SharePoint referral status for DCBS to take action.
 - c. DCBS may contact the court directly to obtain court documents if adjudication has occurred. Copies of the court documents are forwarded to the Regional Claims Worker (RCW) and CMS as soon as they are obtained.
 - d. If the SNAP case is prosecuted and the individual found guilty, CMS changes the claim to Intentional Program Violation - Court (IPC) on the Benefit Management Module. A disqualification is entered on IEES within three (3) days of notification of prosecution.
 - e. OIG can initiate an investigation without a referral from DCBS. If notified to do so by OIG, the pending claim is entered on the Benefit Management Module using the date the referral is created by OIG as the discovery date.
 - f. OIG may return a referral to DCBS when they are not able to complete the investigation within the required 90-day timeframe. If the claim is returned and the suspected fraud referral requires further investigation by OIG, another referral is completed on SharePoint and the referral is submitted back to OIG through CMS.
 - g. After disqualification periods have ended, the disqualified member must be added back to the SNAP case as a household member. Complete a case change to add the member.

3. If prosecution is pursued, OIG serves as liaison between DCBS and the courts and prosecutors.
 - a. When possible, OIG will notify field staff at least five days in advance of a court or conference that requires their appearance.
 - b. When the case is adjudicated, OIG will provide copies of the order or agreement and update the SharePoint referral status for DCBS to take action.
 - c. DCBS may contact the court directly to obtain court documents if adjudication has occurred. Copies of the court documents are forwarded to the regional claims worker and CMS as soon as they are obtained.
 - d. If the SNAP case is prosecuted and the individual found guilty, CMS changes the claim to Intentional Program Violation - Court (IPC) on the Benefit Management Module. A disqualification is entered on IEES within 3 days of notification of prosecution.
 - e. OIG can initiate an investigation without a referral from DCBS. If notified to do so by OIG, the pending claim is entered on the Benefit Management Module using the date the referral is created by OIG as the discovery date.
 - f. OIG may return a referral to DCBS when they are not able to complete the investigation within the required 90-day timeframe. If the claim is returned and the suspected fraud referral requires further investigation by OIG, another referral is completed on SharePoint and the referral is submitted back to OIG through CMS.
 - g. After disqualification periods have ended, the disqualified member must be added back to the SNAP case as a household member. Complete a case change to add the member.

Volume 1 – General Administration
MS 0920 – R. 8/1/26 – OMTL-703
Fraud Hotline Referrals

- A. The Office of Inspector General (OIG) maintains a toll-free hotline, 1-800-372-2970, to report suspected fraud.
1. When a caller contacts the local office regarding fraud for any program, provide the toll-free hotline number.
 2. Use this number to report alleged Medicaid (MA) vendor fraud.
 3. Use this number to report alleged employee fraud.
 4. If an individual indicates they are unable to leave a message when they call the fraud hotline, take the information and [email OIG](#).
- B. OIG screens complaints and sends valid hotline referrals via email to the designated contact for each region within the Department of Community Based Services (DCBS). The DCBS contact is required to respond within 20 calendar days with the outcome of the complaint.

[When a hotline referral is received:

1. Scan a copy of the hotline referral to the Electronic Case File (ECF). If there is an individual name and number listed as the complainant, attempt to contact and obtain any supporting documentation from them. Attempt to contact the household to discuss the allegation. **Do not** reveal the complainant's information. Review the case to determine if incorrect benefits were issued. Verify any necessary information and secure substantiating documentation. Document thoroughly in case comments any action taken pertaining to the referral.]
2. If the hotline referral is determined to involve suspected trafficking allegations, refer to [MS 1020](#), Trafficking and Retailer Fraud.
3. If a change becomes known to the agency through a hotline referral, enter the change on the Integrated Eligibility and Enrollment System (IEES). IEES will generate a Request for Information (RFI) requesting verification of the change. When the requested verification is returned, enter the verification in IEES and allow the system to process the change. If the verification is not returned, IEES will act on the change according to policy in Volume 2 MS 6750 and MS 6760, as appropriate.

Example: It is reported that a non-custodial parent (NCP) is in the home with income. Enter the information on IEES and allow the case to pend for verification of household composition and income.

4. If sufficient information is not provided to enter the change on the system, select the Unclear Information button on the Case Summary screen and send the RFI notice requesting the specific verification needed to process the change. Document the case thoroughly as to why the question was utilized and what is requested on the RFI. Allow the household 10 days from the date the RFI is mailed to provide the verification. If the mandatory

verification is not returned at the end of 10 days, the case will automatically deny/discontinue for non-cooperation.

5. If it is determined there is a possible overpayment of benefits, complete the Overpayment Discrepancy screen or enter a Manual Claim Referral on IEES within 15 calendar days from the date of the hotline referral.
 6. If it is determined no overpayment exists based on the hotline referral information, indicate the reason for no action on IEES and return to the designated DCBS contact within 15 calendar days from the date of the hotline referral.
- C. [The Food and Nutrition Administration (FNA) maintains a hotline number for the general public to report suspected fraudulent activity. FNA compiles the Whistleblower complaints and sends a report via email to the Integrity and Analysis Section (IAS) for review. IAS will send valid complaints via email to the designated contact for each region within DCBS.

When a Whistleblower complaint is received:

1. Enter the complaint on the Complaint Module in IEES. Scan a copy of the hotline referral to the Electronic Case File (ECF). If there is an individual name and number listed as the complainant, attempt to contact and obtain any supporting documentation from them. Attempt to contact the household to discuss the allegation. **Do not** reveal the complainant's information. Review the case to determine if incorrect benefits were issued. Verify any necessary information and secure substantiating documentation. Document thoroughly in case comments any action taken pertaining to the referral.

Note: Not all whistleblower complaints will necessarily be fraud. Some complaints may be issues regarding case processing and other general case resolution issues.

2. Review the case to determine if incorrect benefits were issued. Verify any necessary information and secure substantiating documentation. Document thoroughly in case comments any action taken pertaining to the referral.
3. Only use collateral contacts as a verification source as a last resort in these complaints.
4. If a change becomes known to the agency through a Whistleblower complaint, enter the change on IEES. IEES will generate an RFI requesting verification of the change. When the requested verification is returned, enter the verification in IEES and allow the system to process the change. If the verification is not returned, IEES will act on the change according to policy in Volume 2 MS 6750 and MS 6760, as appropriate.

Example: It is reported that a non-custodial parent (NCP) is in the home with income. Enter the information on IEES and allow the case to pend for verification of household composition and income.

5. If sufficient information is not provided to enter the change on the system, select the Unclear Information button on the Case Summary screen and

send the RFI notice requesting the specific verification needed to process the change. Document the case thoroughly as to why the question was utilized and what is requested on the RFI. Allow the household 10 days from the date the RFI is mailed to provide the verification. If the mandatory verification is not returned at the end of 10 days, the case will automatically deny/discontinue for non-cooperation. If it is determined there is a possible overpayment of benefits, complete the Overpayment Discrepancy screen or enter a Manual Claim Referral on IEES within 15 calendar days from the date of the Whistleblower complaint.

6. For Whistleblower complaints alleging fraudulent household composition, please review the complaint thoroughly and if the complaint appears to be valid complete the Overpayment Discrepancies Screen or enter a Manual Claim Referral within the timeframe mentioned above so the complaint can be reviewed and sent to OIG if necessary.

Example: A whistleblower complaint is received and alleges the individual's reported household composition is fraudulent; the father of the youngest child is, and has always been in the home, and the oldest child, which the individual has included in the household, is not in the home. The complaint states there is proof of the individual's statements being false and social services can be contacted to verify. In this instance, an Overpayment Discrepancy or a Manual Claim Referral would be completed. The Regional Claims Worker (RCW) would send the complaint to OIG as the documentation provided by the individual would be considered questionable and the complaint appears to be valid.

7. For Whistleblower complaints alleging unreported wages, use any verification source available to the agency. If wages are found, complete the Overpayment Discrepancies screen or enter a Manual Claim Referral screen within the timeframe mentioned above.
8. For Whistleblower complaints alleging unreported or incorrectly reported self-employment income, complete the Overpayment Discrepancies screen or enter a Manual Claim Referral in the timeframe mentioned above so the complaint can be reviewed and sent to OIG if necessary.
9. If it is determined no claim overpayment exists based on the Whistleblower complaint, indicate the reason for no action on IEES and respond to IAS within 15 calendar days from the date of the whistleblower complaint.
10. If the Whistleblower complaint is determined to involve allegations of suspected trafficking, refer to [MS 1020](#), Trafficking and Retailer Fraud.
11. A summary of actions taken by the agency must be submitted to IAS, using the proper chain of command, within 25 calendar days of receipt of the Whistleblower complaint.]

Volume I – General Administration
MS 0930 – R. 7/1/21 – OMTL-580
Employee Fraud

Employee fraud is defined as fraudulent activity by an employee responsible for administering an assistance program who knowingly obtains benefits or provides assistance to an individual in order to obtain benefits, or receive increased benefits, for which the individual is not eligible. The employee committing the fraud is subject to prosecution. If convicted, this felony is punishable by imprisonment of five to 10 years and/or a fine up to \$10,000 or double the gain.

A Department for Community Based Services (DCBS) or contract employee who knows or suspects that fraud has or may have occurred must report it within 24 hours to their supervisor, Service Region Administrator (SRA)/Division Director, or by calling the Office of Inspector General (OIG) Fraud hotline at 1-800-372-2970. An employee who fails to report suspected fraudulent activity may be subject to disciplinary action and dismissal, as well as relevant criminal penalties.

[Employee fraud claims are completed by a designated individual as determined by the Division of Family Support (DFS).

Do not enter a fraud claim which involves any DCBS employee on the Integrated Eligibility and Enrollment System (IEES). This applies even if the individual is not responsible for administering an assistance program. To complete a Supplemental Nutrition Assistance Program (SNAP) overpayment, use form FS-103, SNAP Worksheet, on the Historical Allotment Calculator located in the DFS Forms Library. For a Kentucky Transitional Assistance Program (KTAP) overpayment, use form PA-30, KTAP Assistance Budget, located in the DFS Forms Library.]

Volume 1 – General Administration
MS 0940 – R. 12/1/21 – OMTL-586
Who Must Pay a Claim

The following persons are responsible for paying a claim:

- A. Each person who was an **adult** member of the household when the claim or Supplemental Nutrition Assistance Program (SNAP) trafficking occurred.

Example: A household consists of four members: two adults and two children. One adult is the head of household (HOH) and the case is in their name and social security number. An overpayment is discovered, and a claim established. Because the individual has an active case, the claim will automatically be repaid by benefit reduction. If the case is discontinued, benefit reduction ceases and a demand letter is issued from the Integrated Eligibility and Enrollment System (IEES) to the head of household. If the other adult member of the household subsequently reapplies for benefits, responsibility for repayment transfers to the active case and benefit reduction will be imposed.

Example: A household consists of four members: three adults and one child. One adult is the HOH and the SNAP Eligibility Determination Group (EDG) is in his name. The second adult is disqualified for failure to comply with the Employment and Training Program (E&T). The third adult is an ineligible student. An overpayment is discovered, and a claim established. In this instance the only liable member is the HOH. Members that are disqualified or are ineligible and not included in the benefit group are not liable for overpayments that occur while they are not included in the benefit group.

- [B. Head of Household (HOH), the individual who signs the SNAP application, regardless of their eligibility in the SNAP case.

Example: Household of three members: two adults and one child, age 15. HOH, who completed the interview and signed the application, is an ineligible student. An overpayment is discovered, and a claim is established. Both adults are liable for the claim, even though the HOH was an ineligible student and not included in the benefit group. The HOH signed the application taking responsibility for the benefits issued on behalf of the household.

Example: Household of four members: two ineligible immigrant adults and two children, ages 15 and 16. Both adult ineligible immigrants would be liable for the claim established as they would otherwise be considered in the benefit group, citizenship aside.]

- C. A sponsor of an immigrant household member if the sponsor is solely at fault;

- D. A person connected to the household, such as an authorized representative, who trafficked food benefits or caused a SNAP claim;
- E. For claims relating to recipients residing in a Drug and Alcohol Abuse (DAA) treatment center, the designated representative of the center or the center. Refer to [MS 1015](#).
- F. An individual court ordered to repay the Cabinet.

Example: A person, not connected to a household, is arrested and convicted for EBT trafficking. The court orders repayment of the fraudulently obtained benefits.

- G. Every month, the Benefit Recovery Module matches the individual number from the claim with active IEES cases. If a "hit" is detected, benefit reduction will begin on the active IEES cases that contain adult members from the claims case.

Example: A SNAP claim contains two adult household members. The HOH has an active SNAP EDG and the other adult household member is active in a separate SNAP EDG; therefore, benefit reduction will occur on both SNAP EDGs simultaneously.

- H. For claims involving emancipated minors, collection is pursued only if the household contained no adults at the time the claim occurred.

Example: A teen couple living alone.

- I. The responsibility to repay a Kentucky Transitional Assistance Program (KTAP) or Kinship Care (KC) claim is with the caretaker relative who was a member of the case or the payee. Repayment is never sought from the children.
- J. Collection may be pursued from a child member of the case at the time the Aid for Families with Dependent Children (AFDC) claim occurred if all adult members are deceased.
- K. The individual or responsible party is liable for repayment of the value of benefits when a determination is made that the benefits were obtained by committing a medical program violation. Refer to [MS 1240](#).

Volume 1 – General Administration
 MS 0950 – R. 10/1/24 – OMTL-658
 Claim Repayment Methods

Claims may be repaid using one of the following methods:

- A. **Lump Sum.** For active or inactive households, if the household elects to pay the claim at one time, collect a lump sum payment. Acceptable methods of payment are a check or money order made out to the Kentucky State Treasurer, Electronic Benefit Transfer (EBT) benefits, or online at [kynect](#) via debit/credit card. **Do not accept cash.**
1. Do not require the household to liquidate all its resources to make a lump sum payment.
 2. It is permissible for the household to make a lump sum payment as partial repayment of the claim.
 3. If the household chooses to make a monthly or lump sum payment from EBT benefits, complete form EBT-6, Claims Repayment Request, for the Supplemental Nutrition Assistance Program (SNAP) claim. Submit to the [Claims Management Section \(CMS\)](#) by postal mail or by fax to 502-564-9810.
 4. If the household voluntarily returns an issued benefit check to use as payment on a claim, issue a PAFS 30.3, Multi-Program Claims Receipt, to the individual. Forward the check along with a copy of the PAFS 30.3 to:
- Department for Community Based Services
 Division of Family Support
 Program Integrity Branch
 Claims Management Section
 275 East Main Street, 3 E-I
 Frankfort, Ky 40621
- B. **Installments.** If the individual with an inactive benefits case chooses to pay by installment payments, form KCD 1.11, Repayment Agreement, is required to be completed and returned to CMS within a designated time frame. An individual who is paying a claim by benefit reduction in an active case can also choose to make additional payments by installment. Notify CMS of the individual's request. Below shows the minimum payment required based on the claim threshold:

\$0 to \$1,000	\$25
\$1,001 to \$5,000	\$50
\$5,001 to \$10,000	\$75
\$10,001 to \$15,000	\$100
\$15,001 to \$20,000	\$125
\$20,001 and higher	\$150

- C. **[Benefit Reduction.** If any liable member is active in a case, the benefits are reduced to recover the remaining claim balance not paid by a lump sum

payment. The Integrated Eligibility and Enrollment System (IEES) reduces benefits automatically. Benefit reduction can occur from more than one case at a time if there is more than one liable member actively receiving in separate cases. The initial benefit, when a household is first certified, cannot be reduced. Benefit reduction cannot be used to repay SNAP Employment & Training (E&T), Family Assistance Short Term (FAST), Work Incentive Reimbursement (WIN), Supportive Services, Remedial Health Care, Summer Electronic Benefit Transfer (SEBT), or Aid for Families with Dependent Children (AFDC) program claims.]

- D. The minimum benefit amount recovered each month by benefit reduction calculated by the Integrated Eligibility and Enrollment System (IEES) is:
1. SNAP Agency Error (AE) or Inadvertent Household Error (IHE) Claims - the greater of 10 percent of the monthly benefit or \$10. The individual can choose to increase the reduction amount.
 2. SNAP Intentional Program Violation (IPV) Claims - the greater of 20 percent of the monthly benefit entitlement or \$20. The individual can choose to increase the reduction amount.
 3. 10 percent of the Kentucky Transitional Assistance Program (KTAP) or Kinship Care (KC) maximum payment for claims established due to overpayments of KTAP, KC, Relocation Assistance, Education Bonuses, or Kentucky Works supportive services. A minimum amount of \$1 is issued in cases with benefit reduction.
 4. The \$16 minimum SNAP benefit level for one and two-member households applies only to the allotment prior to reduction. Actual benefits for any size household may be zero if benefit reduction occurs.
- E. **Tax Intercept.** CMS obtains payment through intercept of State and Federal tax refunds, lottery offsets, stimulus payments, and other options.
- F. **Expunged Benefits.** Expunged benefits are applied to claims. This payment method is an automated function by IEES, and no action is required by staff. If an individual has multiple claims, the expunged benefits are applied to the oldest claim first.
- G. **[Restorations.** Claims can be offset using up to all of a restoration, as needed, for repayment. When a case is owed a restoration, IEES will match prior to issuing the restoration. When a claim(s) exists, update IEES case comments about the payment being applied to the claim(s). IEES will apply the appropriate amount of the restoration towards the amount owed in the claim(s). Any remaining amount of the restoration owed to the individual is issued to the individual by IEES.]

Volume 1 – General Administration
MS 0960 – R. 7/1/21 – OMTL-580
Collecting Payments on Claims

Collection of a claim is either by benefit reduction or by the Claims Management Section (CMS) located in the Division of Family Support (DFS) in Frankfort.

- [A. The Benefit Management module sends notices and pursues collection from households with claims. All repayment notices issued to individuals are maintained on the Integrated Eligibility and Enrollment System (IEES).
- B. IEES will automatically reduce benefits on active households with a claim, unless the claim was adjudicated in court.
- C. Once the court adjudicated claim is outside the court's jurisdiction and benefits are active, IEES begins benefit reduction.
- D. The local office's responsibilities are to:
1. Tell the individual to send payments, made out to the Kentucky State Treasurer, to:

Department for Community Based Services
Program Integrity Branch
Claims Management Section
275 East Main Street, 3E-I
Frankfort, KY 40621
 2. If the individual presents a check or money order in the local office for repayment, please complete form PAFS-30.3, Multi Program Repayments, and provide a copy as a receipt to the client. Local office staff will then need to send the payment and a copy of form PAFS-30.3 to CMS.
 3. If a payment is received via mail in the local office for repayment, local office staff will need to mail the payment to CMS with a date stamp on the envelope of when the payment was received.
 4. Never accept cash payments.
 5. Provide individuals with the [kynect website](#) if they request methods of paying with a credit or debit card.
 6. Notify [CMS via email](#) if the individual requests a hearing regarding their claim.
 7. Advise individuals to contact CMS at 502-564-3440 regarding any questions about their claim.
 8. The transfer of claims to or from other states requires the approval of the CMS Supervisor. [Notify CMS by e-mail](#) of all requests received from other states.]

Volume 1 – General Administration
MS 0965 – R. 10/1/24 – OMTL-658
Compromising Claims

- A. [The Claims Management Section (CMS) determines if a Supplemental Nutrition Assistance Program (SNAP) claim will be compromised. Staff are not to discuss or offer a compromise. If an individual contacts the local office about the inability to pay a claim, refer the individual to CMS at 502-564-3440.

CMS will only compromise SNAP claims if one or more of the following apply:

1. All liable members have entered a medical care facility with no intent to return home; or
 2. All liable members are in prison without the possibility of parole.
- B. Compromised claims differ from terminated claims in that the compromised amount can be added back to the claim amount if the household situation changes. If all liable claim members are deceased, the claim will be terminated.
- C. Advise the household of the right to request a fair hearing if the household disagrees with the agency's decision on compromising their claim.]

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MS 0970 – R. 7/1/21 – OMTL-580

When a Claim is Overpaid

- A. [If it becomes known that a household has overpaid a claim by benefit reduction, the individual is refunded the overpaid amount. The household is refunded the Supplemental Nutrition Assistance Program (SNAP) or Kentucky Transitional Assistance Program (KTAP) benefits, even if it is currently ineligible for benefits.
- B. When a claim is overpaid through cash payments, the Claims Management Section (CMS) will authorize a refund for the overpayment if there are no other appropriate claims for the overpaid balance to be transferred to.]

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MS 1000 – R. 7/1/21 – OMTL-580

Categories of Supplemental Nutrition Assistance Program (SNAP) Claims

[A claim occurs when a household receives benefits to which it is not eligible or traffics SNAP benefits. Refer to MS 1020 for information on trafficking. There are three main categories of claims for SNAP and one temporary category.]

A. Agency Error (AE) – occurs when the claim is caused by a worker's action or failure to take action, which includes:

1. Failure to take prompt action on a client-reported change;
2. Incorrectly computing income and deductions;
3. Failure to take prompt action on a change known to the agency.
4. Incorrect benefit issuance related to system defects or errors.

B. Inadvertent Household Error (IHE) – occurs when the claim is caused by a misunderstanding or an unintended error by the client.

1. This includes claims caused by:

- a. Failure to provide correct or complete information;
- b. Failure to report a change in circumstances timely;
- c. Receipt of benefits pending the outcome of a hearing that upholds the agency;
- d. The agency's inability to prove fraud in a hearing or court proceeding.
- e. Suspected Intentional Violation Claims (SIPV) claims in which the head of household is deceased and there are other adult members in the home.

2. If the agency has sufficient evidence to pursue an Intentional Program Violation (IPV) but the application(s) for the claim period cannot be located, pursue the claim as an IHE.

C. Intentional Program Violation (IPV) – occurs when it is established by an individual signing form FS-80A, Voluntary Waiver of SNAP Administrative Disqualification Hearing, a hearing officer's order is issued granting the IPV, an individual signing form FS-111, Deferred Adjudication Disqualification Consent Agreement, or prosecution through court.

1. This includes claims caused by:

- a. Deliberately made a false or misleading statement.
- b. Deliberately misrepresented, concealed, or withheld facts.

- c. Purchased a controlled substance, guns, ammunition, or explosives with benefits.
 - d. Bought or sold SNAP benefits on or after August 22, 1996.
 - e. Made false statements regarding identity or place of residence in order to receive duplicate benefits on or after August 22, 1996.
 - f. Commits any act that violates the Food and Nutrition Act of 2008, federal SNAP regulations, or state law for the purpose of using, presenting, transferring, acquiring, possessing, or trafficking Electronic Benefit Transfer cards used as part of an automated benefit delivery system.
2. Intentional Program Violation Court (IPC) – is an IPV as a result of a court's determination of guilt, due to fraud.
- D. Suspected Intentional Program Violation (SIPV) – a claim category that occurs when fraud is suspected until a final determination is made. The SIPV claim category is temporary and updated to IHE or IPV, as appropriate.

If unsure if a client had intent to commit fraud, an SIPV should be pursued and the outcome will be decided by admission, hearing, or prosecution.]

Volume 1 – General Administration
MS 1005 – R. 8/1/26 – OMTL-703
No Claim Determination

- A. [A claim cannot be established when it is unclear if the individual completed an application or if an interview was conducted and there is no associated signed application.

The exceptions are:

1. Applications initiated by the individual on the Self-Service Portal (SSP); or
2. Instances of electronic benefit transfer (EBT) card trafficking or misuse. An individual who is alleged to have trafficked or misused benefits must have had their own historical Supplemental Nutrition Assistance Program (SNAP) and been informed of the program rules to be held accountable.

Example: An interview is completed by the Regional Claims Worker (RCW) and the individual states they had not been contacted or been in the office to complete an interview. The RCW's investigation additionally finds no signed application on file. Since there is no clear evidence that the individual made an application, there would be no claim. However, the SNAP case should be discontinued.

Example: An individual applied for SNAP using SSP. The agency approved the application without conducting an interview. Since an application was initiated on the SSP, a claim can be pursued.

Example: An individual purchased SNAP benefits from a household with active benefits. The individual who purchased SNAP benefits has never had a SNAP case of their own and never been informed of the program rules. Since there is no clear evidence the individual who purchased SNAP benefits was aware of the program rules, a claim cannot be pursued.

Example: An individual sold their SNAP benefits to someone outside of their SNAP household. During the recertification, the agency failed to capture a signature on the KIF-101, Application for SNAP Benefits. Since the household has a historical record of completed signed applications, the agency can validate that the individual was made aware of the program rules and a claim can be pursued.]

- B. If the claim referral has been completed and a determination of “No Claim” is made, document the case comments regarding the basis of the determination.
- C. [MS 1010](#), Procedures for Specific Households, should be referenced regarding procedures associated to lost or unsigned applications and electronic signature applications.

Volume 1 – General Administration
MS 1010 – R. 8/1/26 – OMTL-703
Procedures for Specific Households

A. Categorically Eligible

For households failing to report income that results in an overpayment, establish a Supplemental Nutrition Assistance Program (SNAP) benefits claim.

B. Authorized Representatives

1. The applicant is considered the primary liable member responsible for repayment of a claim if they provide incorrect or incomplete information to the authorized representative acting on their behalf.
2. The authorized representative is considered the primary liable member responsible for repayment of a claim when they traffic, misuse, or otherwise cause an overpayment of benefits.

C. Sponsored Immigrant

1. The immigrant is responsible for repayment of a claim that occur when the sponsor unknowingly provides incorrect information.
2. The immigrant and sponsor are responsible for repayment of a claim unless:
 - a. The sponsor cannot be located or the relationship with the household is otherwise broken;
 - b. The sponsor is a nonprofit organization.
3. If the sponsor provided incorrect information in a deliberate effort to obtain benefits for the immigrant, establish a claim where both individuals are liable.]

D. Drug Addiction and Alcohol (DAA) Treatment Center Residents

DAA treatment centers are responsible for any overpayment due to the misuse of benefits or misrepresentation of information. Refer to [MS 1015](#) for procedures.

E. Voluntary Quit

A claim is established for an individual who fails to report a voluntary quit and the non-compliance disqualification is not imposed by the agency timely. The claim period is determined by the occurrence of the voluntary quit violation. Refer to Volume 2A MS 4550, Penalties for Noncompliance, to determine the claim period.

F. Ineligible Members

Review for a potential claim if a household contains an ineligible member and they fail to report a change that would make the ineligible member's status change to eligible, causing their income and resources to count towards eligibility. This includes member statuses such as an ineligible student, a member having a work-related disqualification, a fleeing felon, a probation or parole violator, and ineligible immigrants.

G. Disqualified Members

Review for a potential claim if a household containing a disqualified member fails to report a change in income or resources. Disqualified members are those disqualified for an Intentional Program Violation (IPV), a work penalty, enumeration, child support delinquency, or for failure to meet citizenship requirements.

H. Fleeing Felons

Review for a potential claim if a household member has an outstanding felony warrant and received benefits while the warrant was in effect.

I. Simplified Reporting (SR)

1. SR policy was implemented effective February 1, 2002, and includes all cases with earned income, including self-employment.
2. SR policy was expanded effective March 1, 2003, to include all cases except households in which all members are elderly or disabled with NO earned income.
3. SR policy was expanded effective April 1, 2009, to all households.

J. Dual Participation (SNAP)

An overpayment can occur when an individual gives false or misleading information about their identity and/or place of residency in order to receive benefits in multiple states simultaneously. A claim pursued for dual participation requires contacting the other state(s) and obtaining verification that the benefits were issued for the same time period as in Kentucky, **and** the issued benefits from each state were accessed and used. It is not dual participation if benefits are only accessed in one state.

[Example 1: An individual applies in Kentucky and states they are not receiving benefits in any other state. A report verifies the individual was receiving benefits in another state for the same time period. Verification was received confirming the individual accessed and used the benefits from the other state at the same time the individual was receiving and using benefits in Kentucky. This would be explored as a Dual Participation Claim and pursue the associated Intentional Program Violation (IPV) disqualification.

Example 2: An individual applies in Kentucky and states they are not receiving benefits in any other state. A report verifies the individual was active in another state at the time she was approved for benefits in Kentucky; however, the issued benefits in the other state have not been used. Due to SR rules, there is no claim for benefits issued in the other state as an address change falls under SR guidelines. A claim is pursued for benefits issued in Kentucky as the individual is required at application to report receipt of benefits from another state. Verification of benefit issuance and closure of the other state's case is required to determine the overpayment period. A Dual Participation claim would not be explored as the individual did not use the benefits issued from both states. This does not prevent the claim from being explored as an IPV.]

K. Missing/Unsigned Applications (SNAP)

A missing/unsigned SNAP application does not prevent a SNAP claim from being established.

Example 1: A claim referral is completed on an individual. The referral is split into two claims due to the household situation and each claim will be assigned a different claim number. Both claims are referred to the Office of Inspector General (OIG) for prosecution. The first claim case is prosecuted, but the second claim is returned to the local office for administrative action due to a missing recertification application. The Integrated Eligibility and Enrollment System (IEES) indicates the individual completed the recertification timely, information was updated on IEES, and OIG evidence supports an intentional program violation. However, without the application being located in the case record, there is not sufficient evidence to prove fraud in a hearing or court proceeding. In this instance, the second claim was returned for administrative action because an IPV cannot be pursued. The second claim would be established as an Inadvertent Household Error (IHE).

Example 2: An individual applied for and was approved for SNAP on August 1, 2012. The household exceeded the income limit in September 2012 and did not report it until the recertification interview in July 2013. The claim is referred as a Suspected Intentional Program Violation (SIPV). Upon review, the RCW cannot locate the signed application and without the application, there is insufficient evidence to support an IPV. The overpayment would be pursued as an IHE claim.

[Example 3: The recipient completed a recertification on June 1, 2012. The household exceeded the income limit in August 2012 and the individual reports the change untimely to the agency. The Agency was unable to locate a signed copy of the application from the June recertification. In this instance, the correct category would be an IHE.

Example 4: An individual completed a recertification for SNAP on January 1, 2026. A hotline referral is received March 5, 2026, indicating that the household sold their SNAP benefits to an individual outside of their SNAP household and evidence is found supporting this allegation. The agency submits a claim referral as a Suspected Intentional Violation (SIPV). Upon review, the RCW cannot locate the signed application from the January recertification. In this instance, an IPV can be pursued as there is evidence from the previously signed applications the household was historically made aware of the program rules and separate evidence supporting the trafficking allegation.]

L. Electronic and Voice Signatures

Individuals can choose to sign applications with an electronic signature or voice signature. Field staff comments on IEES as to who was interviewed to complete the application or recertification. Applications completed with an electronic or voice signature are considered signed applications.

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MS 1015 – R. 6/1/24 – OMTL-649

Drug and Alcohol Abuse Treatment Center Claims

Drug and Alcohol Abuse (DAA) treatment centers are responsible for the misuse of Supplemental Nutrition Assistance Program (SNAP) and/or the misrepresentation of information on behalf of a center resident. Pursue a claim in either of these instances. The DAA facility is responsible for repayment of a claim established due to misuse of benefits or misrepresentation of information. These types of claims are established for SNAP over-issuances that occurred on or after January 1, 2010.

Establish a claim in the name of the resident if an agency error occurs. The resident is responsible for repayment of the claim. If the resident has an active case on the Integrated Eligibility and Enrollment System (IEES), it will be subject to benefit reduction.

- A. Establish separate claims for each resident whose benefits are overpaid if the treatment center is the cause of the overpayment or the misuse.
 - 1. DAA facility claims are established under provider/facility claim establishment.
 - 2. The claim is established as an Inadvertent Household Error (IHE) on the Benefit Management module.
 - 3. All DAA facility claims are in the name of the treatment center. The Benefit Management module will assign a 10-digit claim number when the claim is submitted.
 - 4. If there are multiple claims against the treatment center, each claim will have a different claim number.
 - 5. The resident of the DAA is not responsible for the repayment of the IHE claim; therefore, if the resident has an active SNAP case on IEES, he/she is not subject to benefit reduction.
- B. [The organization authorized by the Food and Nutrition Service (FNS) as a retail food store can be penalized or disqualified if it is determined administratively or judicially that benefits have been misappropriated or used for purchases that did not contribute to a certified participant's meals. The office promptly notifies the Nutrition Assistance Branch (NAB) by memorandum through the appropriate chain of command when it has reason to believe that an organization is misusing benefits. NAB notifies FNS upon receipt of the memorandum from the local office. NAB takes no action against the organization or institution prior to FNS action. See Volume 2 MS 2660 for more details regarding claims on DAA facilities.]

Volume 1 – General Administration
MS 1020 – R. 8/1/26 – OMTL-703
Trafficking and Retail Fraud

A. Trafficking is the act of:

1. Buying, selling, stealing, or exchanging Supplemental Nutrition Assistance Program (SNAP) benefits, SNAP Electronic Benefit Transfer (EBT) cards, card numbers, Personal Identification Numbers (PIN), or manual vouchers for cash or consideration other than eligible food either directly, indirectly, in complicity or collusion with others, or acting alone;
2. Attempting to buy, sell, steal, or otherwise affect an exchange of SNAP benefits issued and accessed via EBT cards, card numbers, and PIN, or by manual voucher and signatures, for cash or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone;
3. [Exchanging an EBT card and/or card information or SNAP benefits for firearms, ammunition, explosives, or controlled substances. The Office of Inspector General (OIG) identifies and refers all cases involving firearms, ammunition, explosives, or controlled substances to the Kentucky State Police (KSP);]
4. Purchasing a product with SNAP benefits that has a container requiring a return deposit with the intent of obtaining cash by discarding the product and returning the container for the deposit amount, intentionally discarding the product, and intentionally returning the container for the deposit amount;
5. Intentionally reselling or exchanging eligible food purchased with SNAP benefits for the purpose of obtaining cash and/or other considerations; or
6. Retailers knowingly purchasing products originally purchased with SNAP benefits in exchange for cash or considerations other than eligible food.

B. Trafficking hotline referrals are sent from OIG to the Integrity and Analysis Section (IAS). IAS will refer trafficking hotline referrals for individuals to Regional Claims Workers (RCW) for investigation. If EBT account transactions indicate trafficking or misuse of benefits, follow the trafficking procedures outlined in D of this section, or [MS 1025](#) for EBT misuse. The claim is only entered on the Benefit Recovery module when one of the following requirements has been met:

1. The recipient signs and dates form FS-80A (TR), Voluntary Waiver of SNAP Administrative Disqualification Hearing (ADH);
2. An Intentional Program Violation (IPV) is granted by an ADH;

3. A completed FS-111, Deferred Adjudication Disqualification Consent Agreement, signed by the recipient and the prosecuting attorney, is received; or
 4. The claim has been adjudicated in court.
- C. For allegations received and/or identified by field staff, a manual claim referral is created by accessing the benefit recovery through the Benefit Management tab on the Integrated Eligibility and Enrollment System (IEES).
- D. [When allegations that an individual has trafficked SNAP benefits are received by the regional claims staff, use the following procedures:
1. Access the individual's account on the EBT website and review transaction information for the period described in the allegation. Review transaction history for the following activity. Include only transactional data that would support a strong pattern of trafficking through clear and convincing evidence.

Review EBT transaction history for the following:

- a. Whole dollar transactions. These indicate payments of credit accounts, cash transactions, or gas purchases.
- b. Back-to-back transactions within a time period too short for the scanning of eligible items. This indicates ineligible sales or cash transactions.
- c. Large purchases at a retailer that carries a limited or minimal amount of eligible food items. This indicates payments made on credit accounts or cash transactions.
- d. Vendor location. Determine if the individual bypassed other EBT vendors in their area to make purchases at the vendor's location identified by their EBT transactions. Utilize the [SNAP Retailer Locator](#), which provides locations of retailers who accept SNAP benefits. Bypassing other vendors in their area indicates the individual has a unique reason for making transactions at that specific vendor. During the interview, question the individual regarding the reason.

Note: When retailer trafficking fraud is believed to be occurring by assisting the individual in committing fraud, the retailer should be submitted to IAS for the store to be investigated by the United States Department of Agriculture (USDA).

- e. A large or questionable number of lost or stolen EBT cards and/or substantial requests for replacement EBT cards. This indicates the individual is selling the card, reporting it lost or stolen, and requesting a new EBT card and PIN to receive the next month's benefits.

- f. Rapid benefit depletion. When an individual uses a large portion of their benefits in a short period of time upon receiving them. This indicates purchasing food items for another household or buying food items with the intent to sell for cash.
- g. All day spending. When a pattern of purchases at the same store throughout the day is identified during the review of the EBT transactions. This indicates that the individual is allowing someone outside of their benefit group or not an authorized representative access to use the EBT card to make purchases.
- h. An excessive number of invalid PIN entries or attempted purchases with insufficient funds. These indicate the individual is allowing someone outside of their benefit group or not an authorized representative access to use the EBT card to make purchases.

Example 1: During a claim interview, an individual acknowledges selling their EBT card with \$200 of available SNAP benefits for \$100 by providing their PIN to an individual outside of a local discount store. A review of the EBT transactions confirms the date and the amount of benefits on the card. The actions by both the individual selling their benefits and the individual purchasing the benefits are trafficking. The claim amount is \$200.00 and an IPV is pursued against the recipient and other individual(s) who made the purchase, if identified. If the recipient signs and dates form FS-80A (TR) or an Intentional Program Violation (IPV) is established by an ADH, use disqualification code Trafficking - Administrative Finding.

Example 2: A fraud hotline report is received from OIG alleging that a recipient who has \$400 of benefits on the card sold \$100 of SNAP benefits for \$50. It is the worker's responsibility to confirm that the actual transactions support the allegations in the fraud hotline report. The worker should identify all transactions that support the allegation. A review of transactions on the EBT website confirms the date and amount of the reported transaction and supports the allegation that trafficking occurred. The amount of the claim is the amount of benefits trafficked as verified per transaction. During the interview to discuss the transactions, if the recipient admits to the violation that benefits were sold signs and dates form FS-80A (TR), or an IPV is established by an ADH, use disqualification code Trafficking - Administrative Finding.

Example 3: If items purchased through a store credit account are non-eligible items, the use of the EBT card or benefits on the card

for payment of the credit account is pursued as trafficking. During a claims interview, a recipient admits to paying on a store credit account with an EBT card. A review of the EBT website account confirms numerous whole dollar (\$15.00; \$12.00; \$18.00) transactions which indicate suspicious purchases. Trafficking is pursued and the retailer information needs to be reported to IAS to submit to Food and Nutrition Services (FNS).

Example 4: A hotline referral was received stating that a retailer purchased 20 cases of soda from a recipient who purchased the soda with SNAP benefits. Trafficking is pursued against the recipient and OIG is notified by the person who received the referral using procedures outlined in Item E of this section, of the retailer's participation in the transaction.

2. If after reviewing the EBT transaction history and, using professional judgement, no suspicious activity is found or the identified activity does not indicate a strong pattern of trafficking, the RCW has the discretion not to pursue a trafficking referral. Annotate IEES with detailed comments as to the reason for the determination that no trafficking exists.]
3. If trafficking activity has been identified, take the following action:
 - a. Make copies of the EBT account showing the identified trafficking activities and/or excessive card history.
 - b. Include all supporting documentation, such as hotline reports or third-party reports, in the claim file.
 - c. Schedule a telephonic appointment with the recipient to discuss the trafficking activity identified. Schedule an appointment using the IEES scheduling system. If requested, an in-person appointment can be held in the local office of the county where the recipient resides. Discuss all documentation supporting the allegations with the recipient.
 - d. Thoroughly document the discussion with the recipient as the information obtained is the basis for action taken by the Department of Community Based Services (DCBS).
 - e. If the household later contacts the agency to cooperate, an interview should be conducted. When a claims specialist is not available onsite for a walk-in recipient, each local office will have a designated worker to interview recipients who come in to resolve a fraud or trafficking complaint.
4. If after a review of the documentation and/or discussion with the recipient (if

an interview was conducted), it is determined that no dollar amount can be established, no claim exists, or there was a valid reason for the excessive card replacements, indicate the reason for the action in detailed IEES comments and scan the documentation into the electronic case file.

5. If after a review of the documentation and/or discussion with the recipient (if interview was conducted), trafficking or another program violation is pursued, provide the household with form FS-80 (TR) and form FS-80A (TR). If the recipient reviews the forms and signs and dates form FS-80A (TR), enter a Trafficking - Administrative Finding disqualification on IEES.
 6. If form FS-80A (TR) is mailed and returned signed and dated, enter a Trafficking - Administrative Finding disqualification on IEES.
 7. If form FS-80A (TR) is not returned, is returned unsigned, or is returned without a date, request an ADH. See [MS 1070](#).
 8. Claims pursued as trafficking are not established as Suspected Intentional Program Violation (SIPV) claims. The claim is only entered on the Benefit Recovery module when one of the following requirements has been met:
 - a. The recipient signs and dates form FS-80A (TR);
 - b. An IPV is granted by an ADH;
 - c. A completed FS-111 signed by the recipient and the prosecuting attorney is received; or
 - d. The claim has been adjudicated in court.
- E. When an excessive card task is received by regional claims staff, use the following procedures:
1. When the first excessive card task is received, access the recipient's account on the EBT website and review transaction information for the prior 12 months from the task received date for trafficking activity.
 2. If after reviewing the EBT transaction history no trafficking activity is detected, annotate in IEES with detailed comments regarding the first excessive card task and the determination that no trafficking exists.
 3. If trafficking activity is detected, follow the same procedures outlined in item D of this section. When conducting the appointment, regional claims staff should also discuss proper card security and use with these recipients.
 4. For subsequent excessive card tasks received by regional claims staff, take the following action:

- a. Review EBT transaction history from where the prior excessive card task review ended to present for trafficking activity.
 - b. If trafficking activity is detected, follow the same procedures outlined in item D of this section. When conducting the appointment, regional claims staff should also discuss proper card security and use with these recipients.
 - c. If no trafficking activity is detected and the recipient was not contacted over the initial excessive card task, an appointment is required to be scheduled to discuss the reason behind the excessive number of cards that have been issued and to counsel the recipient on proper card security and use.
 - i. During the appointment, question the recipient to determine if the number of replacement card requests is reasonable. Counsel the recipient on proper card security and use. Enter detailed comments about what was discussed. If the recipient continues to receive subsequent excessive card tasks, a new appointment is not required unless review of EBT transaction history shows additional patterns of trafficking. Comments should be entered to detail the findings of the review.
 - ii. If regional claims staff are not able to reach the recipient for the scheduled appointment, annotate in IEES that the interview was attempted. With subsequent excessive card tasks, regional claims staff must continue to schedule an appointment with the recipient until contact is made to discuss why so many cards have been requested and proper card security and use. Once the recipient is reached and provides a reasonable explanation, if they continue to receive subsequent excessive card tasks, a new appointment is not required unless review of EBT transaction history reveals a pattern that is indicative of trafficking. Review findings for each excessive card task should be annotated in IEES.
- F. [FNA investigates, prosecutes, and disqualifies a retailer when fraud is substantiated.
- 1. FNA notifies IAS that a retailer is disqualified and provides a listing of SNAP benefit recipients who had transactions meeting trafficking criteria at that store during the investigated period.]
 - 2. IAS forwards the information of the SNAP recipients involving high dollar amounts to OIG, which makes a determination whether to pursue prosecution.
 - 3. A list of recipients not pursued by OIG for prosecution is forwarded back to

the IAS, who will then forward it to the appropriate claims staff. Staff are to follow the steps outlined in item D of this section.

4. Recipients identified by IAS must be sent for ADH if the FS-80A (TR) is not signed and dated or returned to the agency.
- G. For EBT cards and/or EBT card numbers that are received by the local office from law enforcement:
1. [Ask law enforcement if they are investigating the household. If law enforcement is conducting the investigation, only document IEES comments that law enforcement is investigating the recipient for SNAP trafficking or EBT misuse. If law enforcement requests additional case or individual information for their investigation, obtain their contact information and submit that and the case information through the Regional Office to the [Policy Development Branch inbox](#), who will review and handle that request.];
 2. If law enforcement is not conducting the investigation, follow procedures outlined in item D of this section.
 3. Destroy any EBT cards that are received in the local office using procedures outlined in [MS 0290](#).
- H. Report any type of alleged retailer fraud directly to the OIG Fraud Hotline at 1-800-372-2970.
- I. Recipients can be convicted of trafficking as a result of an investigation by other law enforcement agencies. DCBS staff are notified when a recipient is convicted of trafficking. If restitution is ordered, it is paid to the Claims Management Section (CMS) in the Division of Family Support (DFS). The claim must be entered on the Benefit Management module. CMS will notify field staff to:
1. Create a claim file; and
 2. Enter the disqualification on IEES for the trafficking offense as indicated in the court order.

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MS 1025 – R. 8/1/26 – OMTL-703

Supplemental Nutrition Assistance Program (SNAP) Electronic Benefit Transfer (EBT) Misuse

A. EBT misuse is defined as:

1. [Using SNAP benefits in any way other than to purchase food for eligible household members.
2. If the benefits were used incorrectly, but not in a way that meets the definition of trafficking in [MS 1020](#), consider the violation to be misuse. The most common example of misuse is maintaining a credit account with a retailer for the purchase of eligible food but redeeming SNAP benefits on a date other than when the food was received to repay the credit account.

B. When an allegation that a recipient has misused SNAP benefits is received or misuse is detected during casework, the Regional Claims Worker (RCW) should not place a pending claim on the Integrated Eligibility and Enrollment System (IEES) Benefit Recovery module for investigation. Instead, the investigation should be annotated in case comments regarding the issue at hand and that field staff are not to discuss the investigation with the recipient. The RCW should follow all other trafficking procedures outlined in [MS 1020](#) when investigating misuse.

C. A claim amount is not required to pursue EBT misuse.

D. Schedule an appointment and pursue an Intentional Program Violation (IPV) disqualification, unless it is determined during the investigation that misuse is no longer suspected.

E. If an Administrative Disqualification Hearing (ADH) is necessary, the hearing type will be ADH - Misuse.]

Example 1: The payment with an EBT card on a credit account in which only eligible food items were purchased is not considered trafficking but is against program rules. SNAP benefits must be debited at the time the food is received.

[Example 2: Allowing someone who is not authorized to use the EBT card and personal identification number (PIN) access to the EBT card and PIN to make purchases. Only members of the approved SNAP household or a designated Authorized Representative (AR) who has been appropriately added to the case may use the EBT card on behalf of the household.

Note: If the only adult household member becomes incarcerated or

deceased, any remaining minors from the benefit group are entitled to any remaining SNAP benefits. If the minors are placed into the care of another individual, that individual may use the remaining benefits issued on the EBT card until they are exhausted. In these situations, if the RCW contacts the individual in possession of the EBT card, they may counsel them on proper card security and use, but an IPV would not be pursued. For more information on processing procedures for when the head-of-household is reported as deceased, reference Volume 2 MS 6732.]

Example 3: Purchasing food with EBT benefits intended for your SNAP household but giving the food to another household.

[Example 4: The recipient is incarcerated from January 1, 2020, through June 30, 2020. During this period of incarceration, the recipient allowed a non-household member access to use their EBT card. If the non-household member had their own historical SNAP case and was informed of the program rules, an IPV is pursued against the non-household member for misuse because they accessed an EBT card to which they did not have ownership of. If the non-household member never had their own historical SNAP case with the agency, an IPV would not be pursued.

In addition, upon the recipient's release, an IPV will be pursued against them along with a claim for the amount of benefits used by the non-household member during the incarceration period. Once the form FS-80A (TR), Voluntary Waiver of SNAP Administrative Disqualification Hearing, is returned signed or an ADH is received affirming the decision of the agency, a disqualification penalty would be imposed, and the claim would be established on the Benefit Recovery module.]

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MS 1030 – R. 7/1/21 – OMTL-580

How to Calculate a Supplemental Nutrition Assistance Program (SNAP) Claim

For each month that a household is suspected of receiving an overpayment, determine the correct amount of SNAP benefits, if any, the household was entitled to receive. Use the policy in effect at the time the claim occurred. When calculating a SNAP claim, the worker is only required to verify and use new information that was not considered when the benefits were authorized. The worker is not required to re-verify all factors pertaining to the household.

Exception: All errors found during any SNAP case review, including Management Evaluation (ME) and Quality Control (QC) reviews, must be corrected to ensure that the basis of issuance is correct based on the review findings.

All claims are calculated on the Benefit Recovery module.

A. Date of Discovery:

1. Agency Error (AE) claims cannot be calculated for more than 12 months prior to the date of discovery. If the claim also extended into the discovery month or subsequent months, these months are included in the claim period.

Example: It is discovered in February 2005 that a household received excess benefits for the period January 2004 through March 2005. A change was completed to correct benefits effective April 2005. The claims months are February 2004 through January 2005 (12 prior months), with the discovery month of February. January 2004 is not a claim month since it is more than 12 months prior to the discovery date.

2. Inadvertent Household Errors (IHE) with a Suspected Intentional Program Violation (SIPV), Inadvertent Household Errors (IHE), and Intentional Program Violation (IPV) cannot be calculated for more than six years prior to the discovery date. If an SIPV claim is not determined to be fraud by admission, hearing, or prosecution, it must be recalculated as an IHE or AE claim.

B. Household Composition

When establishing a claim containing household members that are not active during the entire time frame of the claim, establish separate claims containing the appropriate active household members.

Example 1: A claim contains three adult household members for the period of January through June. The head of household (HOH) is an active member for the entire six months of the certification period. The second adult household member was only an active member of the case from March to April. The third adult household member was only an active member of the case from May to June. Three

separate claims are established. The first claim would contain the HOH and would be established for the months of January and February. The second claim would contain the HOH and second household members for the months March and April. The third claim would contain the HOH and the third household member for the months of May and June.

Example 2: A claim contains three adult household members and one child for the period of July to December. The HOH was active six months of the certification period. The child and second adult household member were active from September to October. The third household member was active from November to December. Three separate claims are established. The first claim would contain the HOH for the months of July and August. The second claim would contain the HOH, the second household member and the child for the months of September and October. The third claim would contain the HOH, the second household member, the child, and the third household member for the months of November and December.

C. Utility Allowance:

Households entitled to use the Standard Utility Allowance (SUA) or Basic Utility Allowance (BUA) were required to use the appropriate standard effective June 2003. Beginning June 2003, actual utility expenses are used only if the household was not entitled to the SUA or BUA. Prior to June 2003, the household had the option of using a standard deduction or actual expenses.

D. Earned Income:

When calculating an IPV or IHE claim involving unreported earnings, do not apply the 20 percent earned income deduction to the part of the earnings the household did not report timely, when this is the reason for the claim.

E. Cash Assistance and Other Related Program Payments:

All cash assistance payments received should be considered in the SNAP claim calculations if the cash assistance payment is not the basis of the claim.

Example: An individual applies for SNAP and Kentucky Transitional Assistance Program (KTAP) benefits for herself and two children. The individual reports wages from employment as well as income from self-employment. The agency failed to enter self-employment income, and SNAP and KTAP benefits are approved considering wages only for the household's income. A KTAP claim is established for the overpayment of KTAP benefits issued to the household due to incorrectly considered income. The full KTAP payment(s) will be considered in the SNAP claim calculations, though a claim has been established to recoup the incorrectly issued payment(s).

F. Reported Information/Changes:

For reported information/changes not considered in the original benefit, use the reported income received for the appropriate household member's reported expenses (except for utility), household size, and any other household circumstances not considered.

1. Reported income at application or recertifications does not have to be re-verified. Use the converted income that was used in the original allotment.
2. When calculating the claim, use all other household circumstances that were correctly considered. Include the actual income that was omitted in error.
3. If wages were known and not acted on, allow the actual dependent care expenses as a deduction. Budget the reported wages that were not acted on by using the anticipated converted income that should have been used in the original allotment.
4. [Reported, but unverified reported wages. If income were reported to the agency and verification was not provided, the worker should first attempt to obtain the missing income verification. If the verification is not returned, the worker may then use wage match data to calculate the claim. When using wage match data, use the gross quarterly income, divide by three months, and round to the nearest dollar to obtain the average monthly amount. If the employment was less than three months, average the gross amount over the period of time between the beginning and end dates of employment. This date may be determined by contact with the employer or client.

Example: An individual reports at the SNAP recertification that they began new employment four months prior to the recertification date. The case was pended for verification of employment to confirm the start date and to ensure the household did not exceed gross income limits. No verification was returned to the agency, and the case discontinued for failure to provide mandatory verification. A claim referral was later submitted for failure to report this income. When investigating, the worker would first attempt to obtain missing income verification before using wage match data.]

5. Consider any countable income from ineligible and disqualified members. Refer to [MS 1010](#).
6. For prorated or annualized income, count the prorated or annualized amount for each month of the claim, even in months when the income was not received (Example: countable student income).
7. Consider any countable unearned income.
8. Consider any deductions that were reported but not acted upon.

9. Consider any deductions that were considered in the case during the claim period.

G. Unreported Changes/Information:

For unreported information/changes that were not considered in the original benefit, use the actual income for the appropriate household member(s) that was not reported, actual household size, and any other household circumstances that were required to be reported.

1. Consider **actual** income. **Do not** average and convert any income that was not reported.
2. Reported income does not have to be re-verified. Use the anticipated converted income that was used in the original budget.
3. When calculating the claim, use all other household circumstances that were correctly considered.
4. **Do not** allow the earned income deduction for that portion of the earned income not reported. If the household reports part but not all of the earned income, allow the deduction on the part that was reported.
5. [Verify wages. If wages are discovered but verification has not been provided, the worker should first attempt to obtain the missing income verification. If the verification is not returned, the worker may then use wage match data to calculate the claim. When using wage match data, use the gross quarterly income, divided by three months, and round to the nearest dollar to obtain the average amount per month. If the employment was less than three months, average the gross amount over the period of time between the beginning and end dates of employment. This date may be determined by contact with the employer or individual.]
6. Consider any countable income from ineligible and disqualified members.
7. For prorated or annualized income, count the prorated or annualized amount for each month of the claim, even in months when the income was not actually received.

Example: Countable student income.

8. Consider any countable unearned income.
9. Consider changes in deductions **if** required to be reported. Otherwise, consider deductions that were used in the case for the claim period.
10. **Do not** consider expenses on unreported self-employment/farm income.
11. **Do not** consider unreported deductions.
12. Consider any deductions that were considered in the case during the claim period.

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MS 1040 – R. 7/1/21 – OMTL-580
Joint Non-Fraud and Fraud Claims

[A joint claim occurs when there is more than one category of claim for the overpaid period. When a claim occurs due to an Intentional Program Violation (IPV) and an Agency Error (AE) or Inadvertent Household Error (IHE), calculate on the Integrated Eligibility and Enrollment System (IEES) each type of claim as outlined below. Enter claim comments in the Benefit Management Module explaining how the claims are computed.

A. Compute the AE or IHE claim prior to completing the IPV claim.

1. Enter the actual amount of benefits the household received during each month in question. To determine the amount the household actually received, do the following:
 - a. Access the Benefit Issuance screen from the IEES Benefit Management tab;
 - b. Search the associated case and benefit period as indicated for the overpaid benefits.
 - c. Any overpayment which occurred more than 12 months (one year) prior to the discovery of the overpayment is not included in an AE claim. An overpayment which occurred more than 72 months (six years) is not included in an IHE claim.]
2. Enter the issuance case data, correcting the AE or IHE claim factor but excluding the IPV factor.
3. The amount of the AE or IHE claim is the difference between the two allotment totals.
4. Establish the claim(s) as active to start recoupment.

B. IPV claim.

1. [Use the data from the associated AE and/or IHE claims and include the IPV change.
2. Subtract the corrected benefit amount, which includes all known changes, from the benefits from the associated AE and/or IHE claims. The difference is the IPV claim amount.
3. Take action as appropriate for IPV claims independently from the AE or IHE portion of the claim.]

Example: An IPV claim is identified due to an individual's deliberate failure to report Retirement Survivors Disability Insurance (RSDI) income. Upon further review, it is discovered that the individual was given a

medical deduction in error during the same time period of the unreported RSDI. Compute the AE claim first, based on the incorrect medical deduction. A separate claim is computed for the IPV due to unreported RSDI, using the benefit amount that was determined to be correct in the AE claim.

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MS 1050 – R. 7/1/21 – OMTL-580

How to Process an Intentional Program Violation Claim

[If a potential Supplemental Nutrition Assistance Program (SNAP) benefits claim occurs in an active or inactive case, enter the claim on Integrated Eligibility & Enrollment System (IEES). A suspected fraud claim is calculated and established as a Suspected Intentional Program Violation (SIPV). The IEES SIPV category code can be calculated for up to six years from the discovery date. A claim is not categorized as an Intentional Program Violation (IPV) until fraud is established by:]

- The individual signing and dating form FS-80A, Voluntary Waiver of SNAP Administrative Disqualification Hearing (ADH);
- A final order issued by the Office of Administrative Hearings (OAH) states IPV occurred;
- The individual signing and dating form FS-111, Deferred Adjudication Disqualification Consent Agreement; or
- A court finding of guilt.

A. Refer the following situations to the Office of Inspector General (OIG) for further investigation. See [MS 0910](#).

1. [The claim amount is estimated to be \$3,000 or more for reasons other than income;
2. Is estimated to be \$10,000 or more due to unreported wages only; or
3. There is a companion Medicaid case with at least one month of expected ineligibility.]

B. For claims that do not include at least one month of Medicaid ineligibility and do not meet the criteria above:

1. Send form FS-80, Notice of SNAP Suspected Intentional Program Violation, to the household within 10 days of establishing the claim.
2. Include form FS-80A with form FS-80 when mailing to a household in which the person suspected of fraud does not have a mental disability. The option to waive a disqualification hearing is not offered to a person with a mental disability.
3. Allow 10 days for return of the FS-80A.
 - a. If the household does not return form FS-80A, refer for an Administrative Disqualification Hearing (ADH). See [MS 1070](#).
 - b. If form FS-80A is returned and the individual waives the ADH by signing and dating the form:

[IEES is accessed, the date the form is signed by the individual is entered on the claim adjustment screen, and the claim category is changed from SIPV to IPV. If the case is inactive, [email the Claims Management Section \(CMS\)](#).

- c. The worker enters the appropriate disqualification for the member on IEES for active and inactive cases using the following steps from the IEES "Manage IPV (eDRS)" on the individual screen:
 - 1) Select Program **SNAP**;
 - 2) Select **YES** under Sources (this is the only option);
 - 3) Select the IPV occurrence;
 - 4) Enter the decision date (the date the FS-80A was signed);
 - 5) Enter the verification date (the date the FS-80A was received by the agency);
 - 6) Enter the start date; and
 - 7) Enter the end date

If the SNAP benefits case is active, you must enter the case and rerun eligibility to impose the IPV disqualification. If there are no active cases, you must go to the individual summary screen and select "Manage IPVs". Once the recipient serves their disqualification period, eligibility will have to be run before the recipient is added back to the SNAP EDG.]

- C. Per federal regulation, no further administrative appeal procedure exists after an individual waives his/her right to an ADH and a disqualification penalty is imposed. The disqualification penalty cannot be changed by a subsequent fair hearing decision. The individual is entitled to seek relief in a court having appropriate jurisdiction.
- D. When OIG advises they will not pursue prosecution in a case, but fraud is still suspected, follow procedures in B. If fraud is ruled out, change the category of the claim to IHE or AE and recalculate the claim amount.
- E. If the final order from the Office of Administrative Hearings (OAH) establishes an IPV, disqualify the member on IEES. If the final order does not establish IPV, change the category of claim to IHE or AE per the findings of the hearing officer. Recalculate an AE claim for 12 months (one year) from the discovery date and an IHE claim for 72 months (six years) from the discovery date.

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MS 1060 – R. 7/1/21 – OMTL-580

Criteria for Pursuing an Intentional Program Violation Claim

The burden of proof to establish an Intentional Program Violation (IPV) is on the agency. Evidence used to demonstrate this must support the accusation of IPV and prove intent to commit food benefits fraud. An IPV may also be pursued due to an out-of-state match via the Electronic Disqualified Recipient System (eDRS).

A. Evidence may include, but is not limited to:

1. A signed Supplemental Nutrition Assistance Program (SNAP) benefits application used to determine eligibility for the claim period. A lost, unsigned, or otherwise unavailable application does not prevent establishing a claim;
2. Computer printouts;
3. Income and Eligibility Verification System (IEVS) records;
4. Form PAFS-700 or CL-700, Verification of Employment and Wages;
5. Form PAFS-76 or CL-76, Information Request;
6. Form PAFS-702 or CL-702, Proof of No Income;
7. [Prior IPV documentation; and
8. Integrated Eligibility & Enrollment System (IEES) notices to the recipient.

Example 1: The individual applied for SNAP on January 1, 2021, for a household of one. The individual reported no source of income for self, which was verified by use of a PAFS-702. The SNAP application was approved on January 16, 2021. On April 1, 2021, the agency obtained verification confirming that the individual went to work on October 1, 2020, and was actively working at the time of the January 1, 2021, application. During the claims interview, the individual admitted that the income was not reported so that more benefits could be obtained as the individual was struggling to pay bills. The evidence would include the application, PAFS-702, IEES comment entries from the SNAP application interview, SNAP approval notice, wage records confirming employment, claim interview comments, and any other documentation supporting the claim establishment and IPV disqualification penalty.

Example 2: The individual applied for SNAP on January 1, 2021,

for self and minor child. Household composition was verified by use of a PAFS-76. The SNAP application was approved January 16, 2021. On April 1, 2021, the agency obtained verification confirming that the minor child has been in foster care since August 1, 2020, and has not stayed with the individual at any time since entry into care. The individual has a prior IPV for application fraud. The evidence would include the application, PAFS-76, IEES comment entries from the SNAP application interview, SNAP approval notice, records obtained from Protection & Permanency confirming the child has not been in the home, prior IPV documentation, and any other documentation supporting the claim establishment and IPV disqualification penalty.

B. IEES will interface with eDRS to:

1. Obtain the latest IPV disqualification information for an individual from states other than Kentucky.
2. Post IPV disqualifications from Kentucky to the national eDRS database.
3. Maintain IPV disqualification records, including the ability to:
 - a. Create, update, and delete IPV disqualifications from the state of Kentucky in IEES, as well as in the eDRS system; and
 - b. Create, update, and delete IPV disqualifications from states other than Kentucky, only within IEES.]

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MS 1070 – R. 7/1/25 – OMTL-674
Administrative Disqualification Hearings

[An Administrative Disqualification Hearing (ADH) is conducted by the Office of Administrative Hearings (OAH) to determine if an Intentional Program Violation (IPV) has occurred. The format of the hearing is similar to that of a fair hearing, except the burden of proof is on the agency.]

- A. Refer a case for a disqualification hearing via form FS-79, Request for an Administrative Disqualification Hearing, by submitting a hearing request from the claim adjustment screen, within three calendar days if there is sufficient evidence to substantiate a claim of IPV and one or more of the following situations apply:
 - 1. The claim does not meet the criteria for referral to the Office of Inspector General (OIG);
 - 2. The facts of the case do not warrant civil or criminal prosecution, and OIG closes its case; or
 - 3. Form FS-80A, Voluntary Waiver of SNAP Administrative Disqualification Hearing (ADH), is not received signed within 10 calendar days of being sent to the household.
- B. [Review Integrated Eligibility & Enrollment System (IEES) for previous disqualifications before completing the FS-80A. Make OAH aware of the prior IPV that was established by indicating on the FS-80A whether it is a first, second, or third offense. If the individual commits an IPV after July 1, 2013, the waiver can be offered to establish an IPV for each program violation.]
- C. Access the “Claim Adjustment” screen on your navigation panel through Benefit Management and click “Request ADH” to start the administrative hearing process. For trafficking-related ADH requests, start the hearing request process via the “Hearings” tab, as a claim will not already be established.
- D. Complete form FS-79 and attach it with all the evidence that will be presented at the hearing in the Hearings module under the appropriate hearing ID “Exhibits – Agency”.
- E. Only evidence listed on form FS-79 can be introduced at the hearing. If information is not listed on form FS-79 or evidence is missing, submit a “Withdraw Request” via the Hearings module before the hearing is scheduled and resubmit a new form FS-79 with the correct information and all necessary evidence following the process outlined in C above. **All** evidence must be labeled as Exhibit 1, 2, 3 or Exhibit A, B, C, etc. prior to uploading to the Hearings Module and mailing to the individual. Complete the FS-79 using the following guidelines:
 - 1. Provide a detailed explanation of the charges, attaching additional sheets if necessary.

2. Evidence should be listed in chronological order that led the worker and supervisor to suspect an IPV occurred, e.g., when and how the claim was discovered, the individual's history of not reporting changes, and the individual's statements regarding the situation, ONLY if it supports the IPV.
3. List each piece of evidence, which should include but is not limited to the following:
 - a. KIF-101, Supplemental Nutrition Assistance Program (SNAP) applications, including electronically signed and voice-recorded;
 - b. FS-2, SNAP Review;
 - c. SNAP approval and information notices issued to the individual pertaining to program eligibility;
 - d. PAFS-700, wage verifications and wage history/pay stubs, wage file data, Eligibility Advisor (EA) verification;
 - e. Certified Court Orders;
 - f. Written statement/emails from the individual or other parties that support the IPV;
 - g. Policy that supports the claim establishment and IPV being pursued.

Include the FS-79 as part of the list of evidence. Redact any private information that should not be disclosed at the hearing.

If your ADH is for SNAP trafficking, include evidence listed above as well as the following (if applicable):

- h. United States Department of Agriculture (USDA) Retail Store Closure-Trafficking letter;
- i. Photos of store inventory;
- j. Electronic Benefit Transfer (EBT) transaction history (detailed and summary);
- k. Summary of suspicious transactions/activity;
- l. Excessive EBT Card Replacement Notice issued to individual;
- m. EBT card issuance history;
- n. Change history for the review period (includes personal identification number (PIN) changes, address changes, etc.);
- o. IEES comments pertaining to the investigation that support the IPV being pursued.

4. Electronic Signature application(s) and dates are verified by IEES inquiry. However, in pursuing the IPV claim, provide the hard copy application to show that the electronic signature was used to process the SNAP application for the period of the claim.
 5. Voice-Recorded Signature applications and dates are verified through IEES. However, in pursuing the IPV claim, you must present the original Voice Signature Application, the completed Voice Signature Application Instruction Letter that was scanned into the Electronic Case File (ECF) for the SNAP case (if available), and IEES comment entries showing who completed the interview for the associated application.
 6. Any prior disqualification verification, i.e., FS-80A, FS-111, court documentation, prior hearing affirmation, or out-of-state disqualification verification, must be included in an evidence packet and be presented during the ADH.
 7. [When a hearing is requested on IEES, tasks are systematically created for the requested hearings based on SNAP, Medicaid, Kentucky Transitional Assistance Program (KTAP), and Child Care Assistance Program (CCAP) eligibility, and Claims. A task will be sent to OAH along with any documentation associated with the hearing request. The type of hearing requested will determine the task that is created by OAH and the type of notice sent back to each region. The regions have assigned a designated Hearings Public Assistance Program Specialist (PAPS) who will be a part of the queue to receive tasks concerning the notices for the different types of hearings. The Hearing PAPS will log the hearing notices and assign a task to the appropriate supervisor/worker for that region. They will monitor the hearing process and track results.]
 8. Once an ADH has been requested through IEES, corrections cannot be made to the hearing request on IEES; instead, "Withdraw Request" will need to be completed, and a new hearing request completed if corrections are required prior to the scheduling of the hearing.
 9. Individuals who are not on IEES or have never had a case on KAMES, i.e., "caseless individuals", must first be assigned an Individual number prior to requesting a hearing. The individual number is created by clicking on the Individual tab at the top of the navigation page through IEES. Enter the required information on the individual. Once all information is entered, the system navigation will take you to the Individual Summary screen. Now that the individual is known to IEES, the worker may create a manual claim against the individual and request a hearing through Benefit Management or the Hearings Module, whichever is appropriate.
- F. [OAH schedules the hearing and provides written notice to the household at least 30 days in advance of the hearing date. The notice advising of the date and time of the hearing is sent to the household and a task is generated for the Hearings PAPS to review.
1. Hearings held telephonically – an agency representative must be present at

each hearing. In the instance that the assigned claims worker is unable to attend the hearing, the agency cannot ask OAH to reschedule. Instead, another claims worker will be assigned to attend the hearing. Additionally, if another worker or individual gathered information for the claim/investigation, include that individual as a witness. Attendance by a Department for Community Based Services (DCBS) worker is mandatory under these circumstances so that the evidence is not considered "hearsay".]

Example: A Protection and Permanency (P&P) worker reported to the local office that the individual lost custody of their children a year ago and they are all residing in foster care. The case was referred to claims for an investigation. The claims worker contacted the P&P worker and obtained written records to confirm the allegation and was the basis for claim establishment based on the household size not being reported accurately. The evidence should include verification obtained from P&P. The P&P worker must be requested to attend as an agency witness to the telephonic hearing to testify to the validity of the investigation and findings.

2. [Hearings held face-to-face - an agency representative must be present at each hearing. In the instance that the assigned claims worker is unable to attend the hearing, the agency cannot ask OAH to reschedule. Instead, another claims worker will be assigned to attend the hearing. Prepare a copy of the evidence for the individual to receive at the scheduled face-to-face hearing. Additionally, if another worker or individual gathered information for the claim/investigation, include that individual as a witness. Attendance by a DCBS worker is mandatory under these circumstances so that the evidence is not considered "hearsay".]

Example: The Office of Inspector General (OIG) conducted an investigation that substantiated an allegation that the recipient was not accurately reporting their household size and income. OIG was able to obtain multiple collateral contacts through the course of the investigation, along with other verification sources to support the allegation. The evidence should include the OIG Investigation received in full. The OIG Investigator must be requested to attend as an agency witness to the face-to-face hearing to testify to the validity of the investigation and findings.

- G. A requested hearing may be withdrawn by utilizing the "Postponement/Withdrawal Request" button on the Hearings Summary page in the Hearings when:
 1. Information becomes available that indicates IPV did not occur. Contact the individual when this occurs.
 2. The individual signs form FS-80A, Voluntary Waiver of SNAP Administrative Disqualification Hearing.
 3. It is later discovered that information or evidence pertaining to the claim

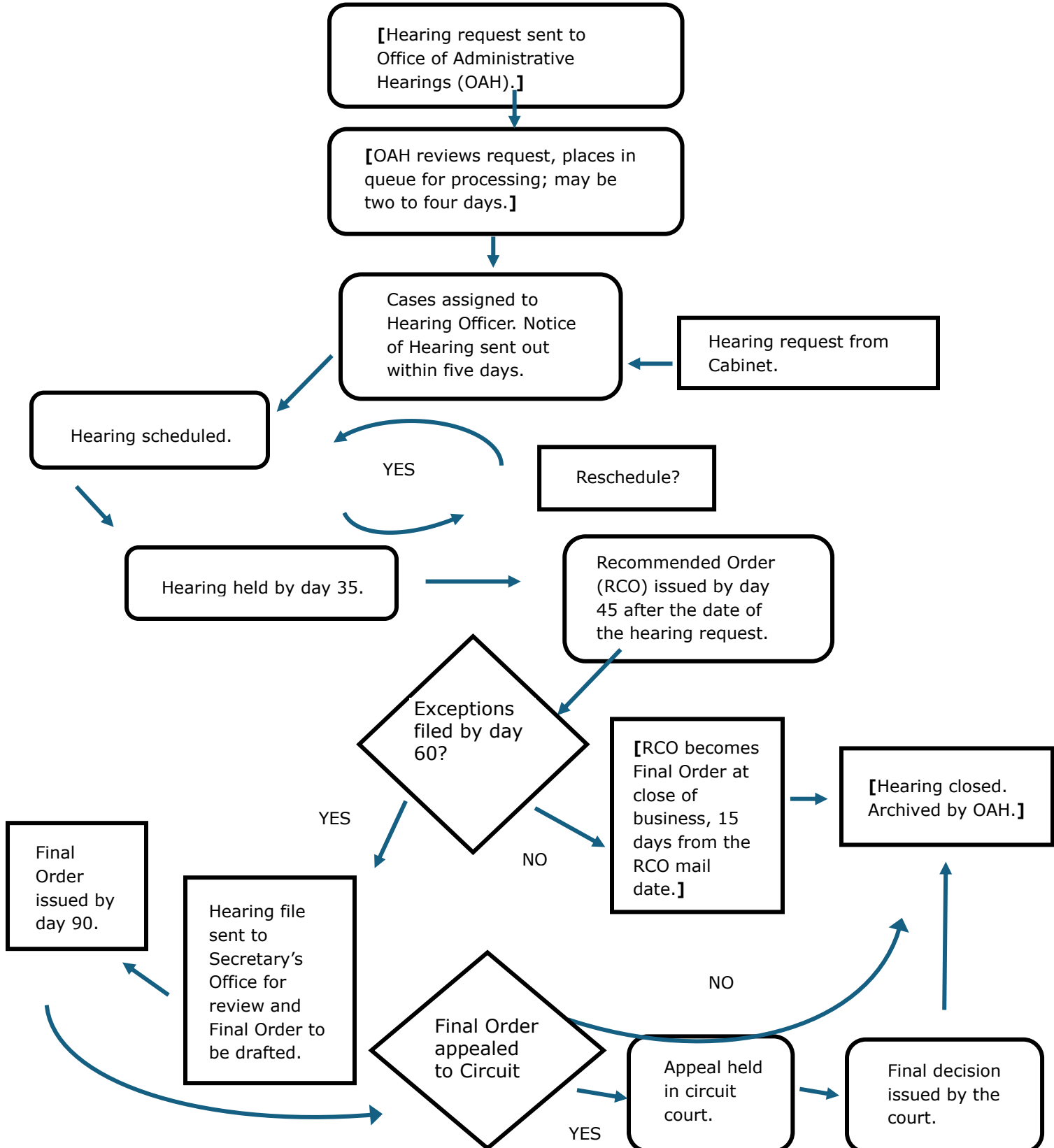
and its establishment is missing. Re-submit a new form FS-79 with the correct information and all the necessary evidence following the process outlined in C above prior to the scheduling of the hearing.

- H. The preparation for and conduct of an administrative disqualification hearing is the same as a fair hearing. Refer to [MS 0450](#) B for more information.
- I. [After the hearing is conducted, OAH issues a hearing officer's order, which is sent for review to all participants at the hearing. Follow policy in [MS 0510](#) C when filing an exception to a hearing officer's order.]
- J. The Cabinet Secretary/Secretary's Designee issues the final order, and copies are mailed to the individual and uploaded to the Hearings module, creating a task for the Hearings PAPS for review.
 - 1. If the final order determines an IPV occurred, enter the IPV disqualification on IEES and update the claim category within three calendar days of receiving the order.
 - 2. If the case is active, change the category to IPV on IEES. If inactive, contact the [Claims Management Section \(CMS\)](#) to change the category, including the individual's name and claim number in the subject line.
 - 3. If the final order determines an IPV did not occur and an SIPV claim has been established, recalculate the claim amount as appropriate and make system entry changes on IEES to show the correct claim category, IHE or AE. If the case is not active, contact [CMS](#) to change the category or terminate the claim if the claim period is more than 12 months (one year) prior to the discovery date for AE claims or 72 months (six years) prior to the discovery date for IHE claims.
 - 4. The claims worker updates IEES to reflect the dates that forms FS-80 and FS-80A are sent and when the ADH hearing has been requested, scheduled, affirmed, or reversed.
- K. If the individual is dissatisfied with the final order, a petition can be filed in the Circuit Court of the county where the member resides within 30 days of receipt of the final order. Although a court appeal may be filed, the disqualification is imposed on IEES; however, it may be subject to change by the decision of the Court.

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MS 1080 – R. 7/1/25 – OMTL-674

Administrative Disqualification Hearing Process Flow Chart



- A. Hearing Request
 - 1. Hearing request is submitted from the Cabinet.
- B. OAH Review
 - 1. The Office of Administrative Hearings (OAH) reviews the request.
 - 2. The request is placed in a processing queue (may take two to four days).
- C. Case Assignment
 - 1. Cases are assigned to a Hearing Officer.
 - 2. Notices of hearing are sent out within five days.
- D. Hearing Scheduling
 - 1. The hearing is scheduled.
- E. Rescheduling Decision
 - 1. If the hearing is rescheduled, return to D.
 - 2. If not rescheduled, proceed to F.
- F. Hearing Conducted
 - 1. Hearing is held by day 35.
 - 2. Decision order issued by day 45 after the date of the hearing request.
- G. Exceptions Filed
 - 1. If exceptions are filed by day 60, proceed to H.
 - 2. If no exceptions are filed, proceed to K.
- H. Secretary Review
 - 1. Hearing file is sent to the Secretary's Office.
 - 2. Final Order is drafted.
- I. Final Order Issued by Secretary's Office
 - 1. Final order is issued by day 90.
- J. Appeal Process
 - 1. Appealed to Circuit Court.
 - 2. Final decision is issued by the court.
- K. Decision Order
 - 1. Decision order becomes Final order at close of business 15 days from the recommended order mail date.
- L. Closure
 - 1. Hearing is closed.
 - 2. Case is archived by OAH.

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MS 1100 – R. 3/1/22 – OMTL-592

Regional Claims Staff Procedures for Acting on Administrative Disqualification Hearing Final Order

When a final order is received and:

- A. [The final order states that the member did not commit an Intentional Program Violation (IPV), take action on the case as directed by the final order within three calendar days.
- B. The member is found guilty of an IPV. Refer to [MS 1110](#) if a claim has been established. The disqualification is entered within three calendar days of the notification.
- C. The hearing was dismissed:
 - 1. Update the Comments screen on the Integrated Eligibility and Enrollment System (IEES) to show the Administrative Disqualification Hearing (ADH) was dismissed, making sure to annotate the reason for dismissal.
 - 2. Scan the final order and the recommended order into the Electronic Case File (ECF) under the Hearings tab under the associated claim number upon receipt. Any hard copy documents in local office storage will need to be scanned to ECF for cases that were prior to ECF.
 - 3. Due to a lack of service, also annotated as “Unclaimed” or “Undeliverable”, if/when a new address becomes known to the Agency, a new FS-80, Notice of SNAP Suspected Intentional Program Violation, and FS-80A, Voluntary Waiver of SNAP Administrative Disqualification Hearing, will need to be generated and mailed to the recipient. Allow 10 calendar days for the return of the FS-80A before requesting an ADH. If the FS-80A is not returned, is returned unsigned, or is returned without a date, request a new ADH within three calendar days.
 - a. Request a new ADH by accessing the claim adjustment screen on the left navigation panel and click the blue “Request Administrative Disqualification Hearing” button under the associated claim number to start ADH request process.
 - b. Upload a new FS-79, Request for an Administrative Disqualification Hearing, and all associated evidence, along with a copy of the previous hearing decision/final order, into the newly associated Hearing ID.
 - c. The agency must have the evidence submitted as an attachment to the associated hearing on the Hearings module and mailed to the individual at least eight days prior to the scheduled telephonic hearing. Prior to attaching the evidence to the hearing and mailing to the individual, **all** evidence must be labeled as Exhibit 1, 2, 3 or A, B, C, etc. Provide a summary of the evidence on the FS-79.

- d. Continue to pursue collection on the Inadvertent Household Error (IHE)/Suspected Intentional Program Violation (SIPV) claim until another hearing can be requested and held.]

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MS 1110 – R. 10/1/24 – OMTL-658

Intentional Program Violation Disqualification Penalties

A disqualification is entered on the Integrated Eligibility & Enrollment System (IEES) within three calendar days of notification that an individual has committed an Intentional Program Violation (IPV).

A. Notification of an IPV is:

1. a signed form FS-80A, Voluntary Waiver of SNAP Administrative Disqualification Hearing;
2. an FS-111, Disqualification Consent Agreement;
3. a final order from an administrative disqualification hearing (ADH); or
4. a court decision or agreement that finds the individual guilty.

B. When it has been determined that an individual has committed an IPV, the individual is disqualified on IEES even if the individual is not currently participating in or has never received, Supplemental Nutrition Assistance Program (SNAP) benefits.

C. When entering an IPV on IEES, take action within three calendar days and follow the below logic as it pertains to your case.

Example 1: A Recommended Order is received with a date stamp of June 7, 2022. The order becomes the Final Order at close of business (COB) on the 15th day if no exceptions are filed. This order becomes Final at COB June 22, 2022, with the first day to act falling on June 23, 2022. Timely action will need to be taken on June 23, 2022, or June 24, 2022, as June 25, 2022 (third calendar day) falls on a weekend and would be lost as an action day.

Example 2: Form FS-80A is returned signed and dated by the individual on May 6, 2022. While the form can be acted on and appropriate action taken the day it is received, the three-calendar-day rule is still applied from the date the form is received for timeliness standards. Timely action will need to be taken by COB May 9, 2022, with May 7, 2022, and May 8, 2022, lost as they fall on a weekend.

D. An individual committing an IPV indicated below is disqualified for the period shown. Multiple disqualifications may be imposed concurrently and not consecutively. Disqualification periods can overlap one another depending on the decision date entered. The disqualification is entered on IEES.

1. Trafficking SNAP benefits of \$500 or more on or after August 22, 1996. Disqualification can only be imposed based on a Federal, State, or local court order.

Disqualification: Permanent for the first offense.

Offense: Court Determined Trafficking \$500 or more on IEES.

2. Makes a fraudulent statement or misrepresentation of identity or residence, in order to receive duplicate food benefits on or after August 22, 1996. This applies to an individual who creates an alias to get SNAP benefits at separate addresses and/or receiving in more than one state simultaneously.

- a. 10 years for the first offense.
- b. 10 years for the second offense.
- c. Permanent for the third offense.

Offense: Duplicate benefits on IEES.

3. Uses or receives SNAP benefits in a transaction involving the sale of a controlled substance.

- a. 24 months for the first offense.
- b. Permanently for the second offense.

Offense: Drug trafficking less than \$500 on IEES.

4. Uses or receives SNAP benefits in a transaction involving the sale of firearms, ammunition, or explosives. Disqualification can only be imposed based on a Federal, State, or local court order.

Disqualification: Permanently for the first offense

Offense: Court Determined Trafficking \$500 or more on IEES.

5. Trafficking as determined by an administrative finding of fraud in a disqualification hearing or signed form FS-80A.

- a. 12 months for the first offense.
- b. 24 months for the second offense.
- c. Permanently for the third offense.

Offense: Trafficking, administrative finding on IEES.

6. Application fraud and/or non-report of changes.

- a. 12 months for the first offense.
- b. 24 months for the second offense.
- c. Permanently for the third offense.

Offense: Application fraud/non-report of changes on IEES.

Example: A recipient applies (or recertifies) for SNAP benefits and reports no income. It is later discovered the individual was employed and was receiving wages at the time of the application interview.

7. Commits an IPV and another IPV listed above does not apply to the offense committed.

Disqualification:

- a. 12 months for first offense.
- b. 24 months for the second offense.
- c. Permanently for the third offense, or
- d. The length of the penalty assigned by the court.

Offense: Application Fraud/non-report of changes on IEES.

- E. The amount of time served while disqualified is determined by the offense and whether it is the first, second, or third occurrence. Disqualification occurrences are counted cumulatively for all offenses.

Example: A person commits an IPV, then a trafficking offense. The trafficking disqualification is added to the IEES as a second occurrence, not a first.

- F. For permanent disqualifications check the box titled "Permanent Disqualification" located under "Occurrence" on the IPV details screen. This will automatically upload "99" in the number of months field. "99" in this instance is not the number of months disqualified, "99" is what is accepted on the Electronic Disqualified Recipient Subsystem (eDRS) for the permanent disqualification.
- G. When an IPV disqualification is entered on IEES, the disqualification "Valid From" date starts the first month action can be taken to change SNAP eligibility. For disqualifications that are the result of a court order, use the circuit/district court entered stamp date as the disqualification decision date. For disqualifications that result from form FS-80A, the disqualification decision date is the date the individual signed and dated form FS-80A. Enter the date the Agency received the form as the verification date.
- 1. If the "Decision Date" is on or before SNAP cut-off, the "Start Date" is the first day of the following month.
 - 2. If the "Decision Date" is after SNAP cut-off, the "Start Date" is the first day of the month after the month following the disqualification decision month.
- H. The "End Date" is entered based on the number of months the recipient is disqualified.

1. Individuals who are permanently disqualified have the "From Date" set as described in Item C above. The "Through Date" is left blank.
 2. The disqualification period is automatically uploaded after all the required disqualification information is entered.
- I. If a notice of IPV determination is received while the case is pending, enter the IPV disqualification on the system.
1. IEES sets the disqualification period based on the information entered.
 2. After IEES uploads the disqualification dates, return to the pending application and rerun eligibility.
 3. If the disqualification period includes the pending eligibility period, the disqualification is applied when the application is disposed.
- J. An IPV disqualification does not pend for adverse action.
- K. Once a disqualification period begins, it continues uninterrupted for the entire number of months, regardless of whether the disqualified individual's household is eligible for benefits. The disqualification period does not start and stop depending on the household's eligibility.
- L. After disqualification periods have ended, the disqualified individual must be added back to the SNAP case as a household member. Complete a case change to add the individual.
- M. If a disqualification is not imposed timely, impose the penalty showing the proper disqualification period. Establish an Agency Error (AE) claim for any months benefits were received when the individual should have been disqualified in accordance with [MS_1030](#).

Example: An individual should have been disqualified for the months of January through December the same year. In June, it is discovered that the disqualification penalty was not imposed. At the time of discovery, enter the disqualification on the IEES showing the disqualification period January through December. Establish an AE claim for January through June if the individual received benefits.

- N. When a determination of an IPV is reversed by a court of appropriate jurisdiction, reinstate the individual if the household is currently eligible. Restore any benefits lost as a result of the disqualification, not to exceed 12 months prior to the date of notification of the court's reversal of the imposed disqualification. An individual is not entitled to restoration of lost benefits for the period of disqualification based solely on the fact that a criminal conviction could not be obtained unless the individual successfully challenges the disqualification in a separate court action.
- O. [When any active disqualification is changed from active to inactive, manually complete form FS-105, Notice of Eligibility or Ineligibility, and issue to the intended individual and scan a copy into the Electronic Case File (ECF). This is

ONLY for instances where the agency has manually completed changes to a disqualification status and is not for instances where the individual has served their disqualification penalty period.]

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MS 1120 – 7/1/21 – OMTL-580

Deferred Adjudication of Intentional Program Violation Claims

After the food benefits claim has been processed by the Office of Inspector General (OIG), an agreement not to prosecute may be reached between the court and the member suspected of the Intentional Program Violation (IPV). This agreement is called deferred adjudication.

- A. If adjudication is deferred, the member accused of the IPV is provided an opportunity by the court to sign form FS-111, Deferred Adjudication Disqualification Consent Agreement.
- B. By signing form FS-111, the accused member does not admit guilt. The member only consents to imposition of the appropriate disqualification period and repayment of the claim.
 - 1. The form must be signed by the accused member and the head-of-household, if different persons, and the prosecuting attorney.
 - 2. The member is under no obligation to sign such an agreement.
- C. OIG is responsible for providing a supply of forms FS-111 to the County/Commonwealth Attorney's office.
- [D. If a case is sent back to the Division of Family Support (DFS) indicating the member has agreed to deferred adjudication but the County/Commonwealth Attorney's office does not send form FS-111, OIG contacts the member and has the form signed.
- E. If the household consents to disqualification, impose a disqualification on the Integrated Eligibility and Enrollment System (IEES) upon receipt of form FS-111.]

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MS 1150 – R. 7/1/21 – OMTL-580
Treasury Offset Program (TOP)

The Treasury Offset Program (TOP) is authorized by federal law to collect delinquent Supplemental Nutrition Assistance Program (SNAP) debts owed to the federal government. SNAP claims are considered federal debts and are subject to TOP collection efforts.

Note: Claims in other programs administered by the Department for Community Based Services (DCBS) are not subject to TOP collection efforts.

The Integrated Eligibility and Enrollment System (IEES) monitors collections of SNAP claims and systematically determines if the claim has reached delinquency status for submission to TOP. Individuals who contact the local office with questions about the collection of their claim through TOP should be directed to the Claims Management Section (CMS) at 502-564-3440.

[Claims in which an intercept has occurred will display on the TOP Claims report on IEES. This report is monitored by CMS.]

A. Individuals must do one of the following to avoid their debt being submitted to TOP:

1. Repay the debt by sending a check or money order payable to Kentucky State Treasury for the full amount owed to:

Cabinet for Health and Family Services
Division of Family Support
Claims Management Section
275 East Main Street 3E-I
Frankfort, KY 40621

2. Agree to and comply with a repayment plan, if unable to pay debt in full, by completing a KCD-1.11, Repayment Agreement form. The individual must agree to a repayment plan acceptable to CMS and make regular payments by the agreed date as required in the repayment plan.

Note: Only one repayment agreement will be accepted/entered on IEES. If a household fails to comply with its agreement, the claim will be referred for TOP action.

3. Request a state review in writing if the individual believes the debt is not owed, past due, or legally enforceable. The individual must send evidence to support his/her position to:

Cabinet for Health and Family Services
Division of Family Support
Claims Management Section
275 E. Main Street 3E-I
Frankfort, KY 40621

CMS will notify the individual of the decision regarding the debt.

4. Verify bankruptcy: If the individual filed for bankruptcy and the automatic bankruptcy stay is in effect, the individual is not subject to offset or other collection actions. Intentional Program Violation (IPV) SNAP claims established by court order, waiver, or Administrative Disqualification Hearing (ADH), are not affected by the bankruptcy petition. CMS receives notification of bankruptcy from the federal court, but will accept official documentation provided by the individual or legal representative.

B. Criteria for sending a delinquent claim to TOP:

1. A SNAP claim;
2. A current claim balance of greater than \$25;
3. Not currently in benefit reduction status;
4. Not in compliance with a KCD 1.11 that was accepted by the agency or failure to return KCD 1.11 timely;
5. Not included under an automatic stay due to bankruptcy; and
6. Not currently under a court's restitution order or a restitution order was issued but the ordered amount to be paid is not being met by the individual.]

C. Collection process before going to TOP:

1. [A claim is considered delinquent when a KCD 1.11 has not been entered into and a payment has not been received within 30 days of the initial demand letter or is one day late on a previously arranged repayment plan.
2. At 90 days after the debt becomes delinquent, the KCD-1.60, 60 Day Notice, is sent to the individual. This notice includes information on how the individual can avoid having the debt submitted to TOP and the type of federal payments that may be offset to collect on the claim. A KCD-1.60 is sent to all adult liable members for the claim period.
3. If after 60 days from the date of the KCD-1.60 the client has not responded, the debt is submitted to TOP.

Note: A total of 120 days must elapse from the delinquent date before a claim can be submitted to TOP.]

D. Eligible Federal Payments:

TOP will reduce or withhold payments in the amount of the debt owed by the individual from the following federal sources:

1. Income tax refunds, including Earned Income Tax Credit.
2. Up to 15 percent of a federal salary payment, including military.
3. Up to 25 percent of a Federal Retirement payment.

4. Military Retirement.
5. Contractor/Vendor payments.
6. Other federal payments, including loans to the individual that are not exempt from offset.
7. Up to 15 percent of federal monthly payments such as Retirement, Survivors, Disability Insurance (RSDI), Railroad Retirement (other than Tier 2), and Black Lung Part B Benefits. The individual is entitled to keep at least \$750.00 per month of his/her federal payment; and
8. Stimulus payments.

Note: Supplemental Security Income payments (SSI) are not subject to TOP intercept. Stimulus payments received by SSI recipients can be intercepted by TOP.

- E. Once a debt is submitted to TOP, the individual's payments may be federally offset until the debt is paid in full.
- F. [TOP is authorized to add penalties, fees or other cost for each offset processed. The fee amount can fluctuate each Federal Fiscal year.]
- G. If an offset is taken from both spouses who filed a joint return and the debt belongs to only one, an amended tax return can be filed with an Injured Spouse form through the tax preparer. These forms may be obtained through their tax preparer or [online](#).
- H. Individuals in TOP filing a rapid refund (which is a short-term loan) with their tax preparer may have their refunds delayed if the refunds are being offset. Any questions regarding how long their tax refund may be delayed will need to be directed to their tax preparer.
- I. TOP will offset only the amount owed. Any remaining tax refund will be sent to the individual directly from the IRS unless other debts for which the individual is responsible and eligible for intercept further prevent the remaining tax refund from being received.

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MS 1200 – R. 6/5/23 – OMTL-626

Cash Assistance and Other Related Program Claims

- A. Claims occur in the cash assistance programs when the benefit issued exceeds the eligible amount and there is a loss to the Agency. This includes receipt of benefits pending resolution of a hearing when the Agency is upheld. Cash assistance programs are:
1. Aid for Families with Dependent Children (AFDC) - the last month benefits were issued in this program was September 1996. A claim must be established and collection pursued for all overpayments discovered on or after April 1, 1982. Use claim type codes 'AFDC' on the Integrated Eligibility and Enrollment System (IEES).
 2. Kentucky Transitional Assistance Program (KTAP) - the month benefits were first issued in this program was October 1996. Use claim type codes 'KTAP' on IEES.
 - a. Claims are established and collection pursued for all overpayments occurring due to recipient error, fraud, or non-fraud, regardless of the discovery date.
 - b. Claims are established and collection pursued for all overpayments occurring on or after February 1, 2025, due to agency error.
 3. Kinship Care Program (KC) – the month benefits were first issued in this program was October 1999. Use claim type codes 'Kinship Care' on IEES.
 - a. Claims are established and collection pursued for all overpayments occurring due to recipient error, fraud or non-fraud, regardless of the discovery date.
 - b. Claims are established and collection pursued for all overpayments occurring on or after February 1, 2025, due to agency error.
- B. Related program claims occur when an individual erroneously receives or uses a payment intended for Kentucky Works (KWP) supportive services or short-term assistance. Use claim type code 'KWP' on IEES. Related programs are:
1. Kentucky Works Supportive Services. Claims are established and collection pursued for all overpayments occurring on or after January 1, 2006. An overpayment occurs when the recipient is not eligible for KTAP but is authorized a supportive service or is KTAP eligible but fraudulently receives the payment.

Forgery of form PA-33, Verification of Kentucky Works Participation, does not automatically establish a claim.

Example: The participant received transportation assistance for August prospectively. In September, they return form KW-33 to verify

participation for August and to request transportation assistance for October. The worker discovers the participant has forged the information on form KW-33. Before authorizing transportation, the worker denies the request for transportation and begins conciliation. If the worker discovers the forgery after transportation has been issued, a claim is established on the transportation issued for October.

Failure to meet KWP participation is not a reason to establish a claim on transportation payments. If transportation was authorized correctly at the time of issuance, there is no claim.

Supportive services are:

- a. Transportation funds;
 - b. Items or services needed to participate in KWP activities or employment;
 - c. Tuition and short-term training;
 - d. Fees;
 - e. Remedial health care; and
 - f. Car repair funds.
2. Relocation Assistance Program (RAP). Claims are established and collection pursued for all overpayments occurring on or after March 1, 2007. A claim occurs when:
 - a. A recipient is not eligible for KTAP but receives RAP; or
 - b. A recipient does not meet the eligibility criteria to receive RAP; or
 - c. A recipient misuses a payment.
 3. [Family Assistance Short Term (FAST). Claims are established and collection pursued for FAST overpayment starting June 5, 2023.
 - a. A recipient is technically or financially ineligible for FAST; or
 - b. A recipient misuses a FAST payment.]
 4. Family Assistance Diversion (FAD). Claims are established and collection pursued for all overpayments occurring on or after June 1, 1999. A claim occurs when:
 - a. A recipient is technically or financially ineligible for FAD; or

- b. A recipient misuses a payment.
- 5. Work Incentive (WIN) reimbursements. Claims are established and collection pursued for all overpayments occurring on or after April 1, 2003. A claim occurs when:
 - a. A recipient is erroneously identified for a reimbursement; or
 - b. A recipient fails to report a change that impacts WIN eligibility.
- 6. Educational Bonus. Claims are established and collection pursued for all overpayments occurring on or after January 1, 2006. A claim occurs:
 - a. When a recipient is not eligible for KTAP or Kinship Care; or
 - b. A payment is issued due to agency error; or
 - c. Verification of educational attainment is falsified.

Volume 1 – General Administration

MS 1210 – R. 1/1/26 – OMTL-689

How to Calculate a Cash Assistance and Other Related Program Claim

A. Claims are calculated and computed on the Integrated Eligibility and Enrollment System (IEES) for Aid for Families with Dependent Children (AFDC), Kentucky Transitional Assistance Program (KTAP), Kinship Care (KC), and Family Assistance Short Term (FAST).

1. Use the actual income and deductions to determine the benefit the case should have received for a given month.
2. A claim does not result solely from normal fluctuations in income which do not last over 30 days. Normal fluctuations include fifth or periodic paychecks or sporadic overtime.
3. Earnings deductions are not appropriate for any month when wages were not reported timely or at all.
4. [If child support is collected by the Department of Child Support Services (DCSS) the amount of a claim may be reduced by the child support collected and retained by the Cabinet. See MS 1230.]
5. When computing a claim for a prior period, use policy in effect at the time the claim occurred.
6. If the case is ineligible, a claim must be established for any supportive services, education bonuses, or relocation payments authorized to a member in the ineligible month.
7. If the claim is established and a subsequent claim for a different time period or different circumstance is discovered, **do not** add the claims together. Complete the claim process; however, do not reduce the benefits or seek cash repayment until the first claim is repaid in full.

Example: A claim has been established for January, February, and March due to unreported wages. Subsequently, the individual fails to report receiving unemployment benefits causing a claim for April and May. Separate calculations are completed for each circumstance. A separate Electronic Case File (ECF) is maintained for each claim.

8. If it is discovered prior to the claim being established, that the individual has not cashed or used the benefits on the Electronic Benefit Transfer (EBT) card for the exact months for which the claim is being established, form EBT-61, EBT Benefits Account Adjustment Request, can be complete to correct the error. For returned checks, complete form PAFS-61, Disposition of Returned Checks.
- B. Claims are manually computed, and the total claim amount entered on Worker Portal for the following types of overpayments:
1. Supportive services overpayments occur when:

- a. The individual is ineligible for KTAP but receives supportive services. The claim amount is the amount of supportive services authorized for or to the individual during the ineligible month. If it is later determined the individual was ineligible for KTAP at the time payment was authorized, establish a claim.
- b. The agency erroneously authorizes payments. The claim amount is the difference between the correct payment and authorized amount.
- c. If it is determined that the individual fraudulently received supportive services, establish a claim. The claim amount is the amount of supportive services that was authorized.

Note: Failure to meet Kentucky Works Program (KWP) participation is not a reason to establish a claim on transportation payments. If transportation was authorized correctly at the time of issuance, there would be no claim.

2. FAST and Family Alternative Diversion (FAD) overpayments occur when the individual is not technically eligible for FAST/FAD. The claim amount is the total of all FAST/FAD payments issued.
3. Relocation Assistance Program (RAP) overpayments occur when:
 - a. The individual does not meet eligibility criteria for a payment. The claim amount is the amount issued for relocation expenses.
 - b. The individual purchases items or services that are not approved by the agency. The claim amount is the amount not spent on approved items.
4. Education bonus overpayments occur when:
 - a. The individual receiving the bonus is not eligible for KTAP or KC in the month of graduation.
 - b. The payment is erroneously issued.
 - c. Proof of graduation is falsified.
 - d. In all instances, the claim amount is the amount of the bonus.
5. Work Incentive (WIN) reimbursement overpayments occur when:
 - a. The individual receiving WIN reimbursements is not employed.
 - b. The household does not contain a dependent child.
 - c. The income of the household exceeds 200 percent of the federal poverty limit.
 - d. The earned income that caused discontinuance of the KTAP benefit is not reported timely.

- e. In all instances, the claim amount is the amount of the reimbursement.

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MS 1220 – R. 7/1/21 – OMTL-580
KTAP Claims for SSI Recipients

When a Supplemental Security Income (SSI) individual is determined not eligible to receive an SSI payment, regardless of the reason:

- A. Determine Kentucky Transitional Assistance Program (KTAP) eligibility for each month the member was excluded from KTAP.
- B. Use actual resources and income received in the specific month, including the resources and income of the member who was receiving the SSI payment. **Do not** include the SSI payment as income.
- C. If the case was **eligible** for KTAP, determine the correct payment and compare it to the amount issued. If the correct amount is less than what was issued, establish a claim for the difference.
- D. If the case was **ineligible** for KTAP for a given month, the KTAP issued is the claim amount.

Example: In January 2008, it is discovered a parent receiving SSI was not eligible for SSI beginning January 2007. The resources and income of the SSI recipient had been excluded in determining KTAP eligibility. Re-determine financial eligibility using all resources and income (**Do not** count the SSI) for all months the family received KTAP and SSI. If the family is KTAP ineligible, the claim amount is the KTAP benefit issued.

- E. No claim exists if the SSI individual is removed from the KTAP case effective the date given to the Social Security Administration (SSA). The initial SSI payment is reduced dollar-for-dollar by the individual's proportionate share of the KTAP benefit amount up to the month of the effective removal from the case.

Volume 1 – General Administration
MS 1230 – R. 1/1/26 – OMTL-689
Retained Child Support

Consider child support retained by the Agency when calculating any Kentucky Transitional Assistance Program (KTAP) or Kinship Care (KC) claim.

- A. [Retained support is the amount of collected support reported by the Department of Child Support Services (DCSS) minus collections forwarded (e.g., escrow) to the recipient as verified on the DCSS External Search accessed from the Kentucky Online Gateway (KOG).
- B. If retained child support is equal to or more than the benefits issued for a month (before benefit reduction), there is no claim.
- C. If the absent parent is known, access the DCSS External Search to determine the retained support by DCSS.
 1. Launch the DCSS External Search application from KOG and select participant/case inquiry to determine if child/spousal support is paid.
 2. Use the column "Distribution Date (MM/YYYY)" on the DCSS Payment Distribution Inquiry Screen to determine the month of receipt.
 3. Use the column "CSUP Retained by State" to determine the amount of State retained support for the month.
 4. If more than one payment is received during the month, the screen will display the total dollars distributed to the participant and/or retained by the State.
- D. Calculate the amount of child support kept by the state and compare that monthly amount to the amount of benefits issued for each month of the potential claim.
 1. If the retained child support for an individual month equals or is greater than the KTAP benefits received for that month, no claim exists for that month. Update the Integrated Eligibility and Enrollment System (IEES) to show the claim was not established.

Example: The individual received \$235 KTAP benefits. The individual was only entitled to \$150. Child support was retained in the amount of \$235.

2. If the retained child support for the month is less than the KTAP issued, subtract the corrected benefit amount for that month from retained child support. Deduct the remaining child support from the overpayment for that month.

Example: \$210 of KTAP benefits is issued. The correct amount is \$100. Child support of \$140 was retained by DCSS.]

Calculate using the following steps:

- a. Determine if a claim exists.

Benefits Issued \$210
Retained Child Support \$140
Child Support retained is less than benefits - claim exists

- b. Calculate the overpayment.

Benefits Issued \$210
Corrected Benefits - \$100
Amount of Overpayment = \$110

- c. Determine if claim can be reduced by the retained child support.

Retained Child Support \$140
Corrected Benefits - \$100
Excess Child Support = \$40

- d. Deduct the excess child support from the claim amount.

Amount of Overpayment \$110
Excess Child Support - \$40
Balance of Claim = \$70

3. If the retained child support for the month is less than the corrected benefit for the month, there is no excess child support. Do not deduct child support from the overpayment.

Example: \$230 is issued. The correct amount is \$180. Child support of \$80 is retained.

Corrected Benefit - \$180
Remainder = \$0

There is no excess child support.

Volume 1 – General Administration
MS 1240 – R. 7/1/25 – OMTL-674
Medical Assistance Claims

- A. Medical Assistance (MA) claims occur when a recipient or responsible party, age 18 or older, causes a financial loss to Medicaid by:
 - 1. Deliberately making false or misleading statements in order to obtain MA benefits.
 - 2. Allowing an individual other than those listed on the Kentucky Health card to obtain health care benefits by use of the household's Kentucky Health card; or
 - 3. Inappropriately using a covered service (e.g., using Non-Emergency Medical Transportation to go to work, etc.).
- B. When an overpayment of MA occurs due to suspected fraudulent actions:
 - 1. [Field staff will complete a manual Family Support Claim Referral task on the Integrated Eligibility and Enrollment System (IEES).
 - 2. A Regional Claims Worker (RCW) will review the MA claim referral and determine if there has been an overpayment of MA benefits.
 - 3. The RCW rejects the MA claim referral on the system and refers the suspected MA claim to the Office of Inspector General (OIG). In situations where the RCW determines there is no overpayment, the RCW will reject the referral on the system and thoroughly comment.
 - 4. When a companion case is suspected of fraud, involving at least one month of MA ineligibility, all cases must be referred to OIG regardless of the dollar amount.
 - 5. Enter comments on the IEES regarding the referral to OIG on all associated cases and/or claims.
 - 6. Complete form Claim/MA-1, Medical Assistance Eligibility Summary, indicating the eligibility status for each household member. OIG will obtain the dollar amount of Medicaid usage for each ineligible month. This will be added to the overpaid benefits from the other programs to determine if prosecution will be pursued.]
- C. A Medical Assistance claim is entered on IEES only when the claim is adjudicated through the court. If OIG determines the medical card was not used during the ineligible period or fraud cannot be established, there is no claim on IEES.
- D. Payments on Medical Assistance claims are handled by the Claims Management Section (CMS). OIG may recommend the collection of

erroneously issued Medicaid benefits where prosecution is not pursued. In those instances, collection efforts are the responsibility of the Department of Medicaid Services (DMS).