MINUTES OF THE MEETING
HUMAN SERVICES SUBCOMMITTEE
MONTANA STATE
HOUSE OF REPRESENTATIVES

February 6, 1985

The meeting of the Human Services Subcommittee was called to order by Chairman Cal Winslow on February 6, 1985 at 8:05 a.m. in Room 108 of the State Capitol.

ROLL CALL: All members were present.

Eligibility Determination

Lee Tickell (35:A:032) discussed an overview of the Eligibility Determination program and spoke from his prepared testimony (EXHIBIT 1).

Testimony was heard from the following people:

Carole Graham (35:A:440), county director for Ravalli County, discussed that an eligiliby technician has to be sensitive and task-oriented. She gave everyone sets of forms that her office in Ravalli County uses for AFDC, food stamps, nursing homes, GA, and state medical (EXHIBIT 2).

Discussion followed concerning what the Repayment Agreement form was under GA. It was explained that it was for recipients under immediate need that get benefits and have not told the state of all their income. They are to repay the benefits received under this agreement.

Kathy McGowan (35:B:001), from the Citizen's Advocate Office, discussed the increase of calls from people wanting information and how those calls are getting more violent and angry. She supported the need for more eligibility technicians.

Senator Story asked how many calls her office receives in one day; approximately 100 per day.

Jim Greer (35:B:095), Yellowstone County Director, discussed the increased workload and the increased caseload; he said in the last two years, they have not been able to provide assistance to people on a timely basis. because of the requirement to verify more information. The clients believe that the delay is because the worker does not trust them. There is pressure on the employee and the client. He also said the clients have to wait for a long time for an appointment. He gave everyone a set of letters from his eligibility technicians

(ET), a list of the forms required for each program and the purpose of this form, and the time involved in all the steps (EXHIBIT 3).

Sue Stephens, an eligibility technician from the Missoula County Office, read from her prepared testimony (EXHIBIT 4).

Senator Manning asked how many employees are in her office; there are 58 total employees. He asked how many people she could work on during the day; up to 20, depending on how many people come through the doors. She said she does not see the people that are first served.

Harold McLaughlin (35:B:249), Great Falls County Director, gave everyone a summary of information concerning ETs and their determination workload (EXHIBIT 5).

Questions followed concerning whether his office puts in overtime, if they have any busy months, and about the high turn over in the clerical staff.

Terry Frisch (35:B:495), an ET for Lewis & Clark County, spoke on the morale problem that presents itself with the increased workload and the anger that appears with this pressure. He supports meaningful staffing levels.

Jim Adams (35:B:525), Director of Field Operations for the Montana Public Employees Association, spoke on the increased workload and the stress caused by this, and the result of real illness from this stress and pressure.

Norman Waterman, Lewis & Clark County Director, has seen many changes during the years in regard to the problems the ETs have to face. He said it is hard to imagine what is being expected from ETs. He urged the committee to seriously consider increasing the FTEs.

Bonnie Mueller, Lake County Director, re-emphasized the stress with the eligibility technicians and frustrated clients and employees.

Judy Carlson, representing the Montana Chapter of the Association of Social Workers, urged the committee to consider all that had been said in the meeting.

Jim Smith, representing the Montana Human Resource Development Councils, supports the need for increased ET staff.

Questions followed concerning if these new positions are in state assumed counties; the PFP initiative that

calls for 18 positions in FY86 and 36 in FY87; it is broken down to have 10 from state assumed counties and 8 in non-state assumed counties.

Additional questions followed concerning the error rate and the sanctions put on by the error rate.

Lee Tickell discussed the sanctions; they are assessed by taking the percentage the office is over the tolerated error rate and apply it to the federal dollars paid during that period. If there is $20 million of federal funds during a fiscal year with a 5 percent error rate, the office will pay $1 million.

Chairman Winslow (36:A:054) asked if there could be a point where there would be more money spent to save money; not yet, but it is possible.

Senator Christiaens asked if the extra 18 FTEs phased in could possible save that sanction.

County Assumption

Since county assumption has been discussed previously, Lee Tickell briefly discussed how to address the problem of counties that want to become state administered.

Lee Tickell discussed a set of charts and graphs that he gave everyone concerning GA (EXHIBIT 6).

Chairman Winslow asked if there are any kinds of studies of those people that are on GA for a few months, off of GA and working for a few months, and then back on GA again.

Chairman Winslow asked about the limitations of deleting those able-bodied persons under 35.

Representative Rehberg asked what the average GA recipient receives in unemployment for 26 weeks, and then when they go on to GA, does that figure go up or down from the average unemployment payment; the average unemployment payment is approximately $160 per week.

Senator Christiaens said he would like to see as many different variations as possible; he said he does not think there will be a reduction of $9 million if the benefits are cut from one month.

Representative Bradley asked if any county directors or eligibility technicians can address any information on how long people are on GA, what the circumstances are

that caused them to go on GA, and whether they have been in that county for a long time.

Jean Johnston (36:A:475), Missoula County Director, discussed the survey did in Missoula county concerning GA. They found the average age of the single, or the adult without children is approximately between 30 and 33. She said out of the total of 417 receiving benefits, 78 were families, and the rest were single or two people households. There was 21 out of the single or two people household group who were on assistance because their unemployment compensation ran out. She summarized why she thought some people were asking for assistance.

Harold McLaughlin, Cascade County Director, said the studies that his office put together indicate that 25 percent of the GA recipients in Cascade County are Native American; this is the result of three Indian reservations. He said that 18 percent of the recipients of GA had not lived in the county for longer than six months.

The meeting was adjourned at 10:10 a.m.

Cal Winslow

CAL WINSLOW, Chairman

DAILY ROLL CALL

Human Services Subcommittee

49th LEGISLATIVE SESSION -- 1985

Date 2-6-85

NAME	PRESENT	ABSENT	EXCUSED
Rep. Dorothy Bradley	X		
Sen. Chris Christiaens-Vice Chair	X		
Sen. Richard Manning	X		
Rep. Dennis Rehberg	X		
Sen. Pete Story	X		
Rep. Cal Winslow, Chairman	X		

Exhibit 1
2-6-85

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

TED SCHWINDEN, GOVERNOR

P.O. BOX 4210

STATE OF MONTANA

HELENA, MONTANA 59604

Testimony of Lee J. Tickell
Deputy Administrator
Economic Assistance Division
Department of Social and Rehabilitation Services
P.O. Box 4210
Helena, Montana 59604
444-4540

Regarding: Eligibility Determination Program #03

Mr. Chairman, members of the committee, my name is Lee Tickell, Deputy Administrator of the Economic Assistance Division of SRS. My testimony today involves an overview of program 03, or the Eligibility Determination program within SRS.

I would first of all like to give you an overview of what is contained in program 03. This particular program contains 80% of the FTE and spending authority for county directors and combined clerical positions and 100% of the FTE's and spending authority for the eligibility technicians, eligibility technician supervisors, and eligibility clerical workers. By combined clerical positions, I mean those clerical workers in predominately small counties who do both economic assistance and social services clerical work. In addition, this program contains the travel and per diem costs for those FTE's which I just mentioned. The appropriation include both state administered counties and non-state administered counties.

The eligibility technicians are the line workers who determine eligibility for the entire range of assistance programs administered by the Economic Assistance Division. These include the programs of Aid to Families with Dependent Children, the Medicaid program, the Food Stamp program, the State General Assistance program and State Medical program, and in non-state administered counties the County General Assistance program and the County Medical Assistance program. In some counties where, prior to state assumption, the county commissioners determined they wanted the county welfare offices to administer the low income energy assistance program, those counties also have eligibility workers that determine eligibility for the LIEAP program. In those cases, however, there is no F.T.E. to cover them, even though there is 100% Federal LIEAP administrative funds available and currently being spent. The Department, out of necessity, continues to contract with county commissioners and they in turn assign them to work in the county welfare office. This amounts to approximately 21 F.T.E.

The current budget for this biennium contains a total of 318.61 FTE's and approximately $6.3 million per year in funding, the predominance of which is

salaries and benefits for those workers. There is approximately $108,000 for travel and per diem for all 318.61 FTE's.

The major concerns I have had during the past biennium is the lack of flexibility and latitude in permitting overtime and the addition of FTE's under, what I would consider, a realistic justification. During the last session, provisions in HB447 contain a clause which had extremely restrictive language in it. The language in the appropriation bill indicated that for purposes of this program, no FTE's or spending authority could be transferred into or out of that program. This extreme limitation caused severe hardship in terms of being able to respond to bona fide requests from even non-state administered counties for increases in the number of staff and the number of overtime hours that may have been required to respond to bona fide workload increases. I will get into a further discussion of this later on in my presentation.

The eligibility technicians are a critical part of the social service delivery system, and as such are the front line workers that determine eligibility and deliver the benefits to clients. If these benefits, whether they be financial, medical or in the form of food stamps or low-income energy assistance payments, are not delivered in a timely manner, the domino affect causes frustration for the client, economic hardships to families, and the potential for having a domino affect into causing even more problems for the social service workers of SRS. It simply means that if economic hardships are such that they cause pressures on families, there is the result of additional potential for child abuse and other negative reactions. It is critical to have adequate staff to address that delivery of service in a timely fashion to those families in need.

Eligibility Technicians on the line and all county workers in general, are caught in a double bind. On the one hand, there is constant pressure to serve clients, determine eligibility and issue benefits in a timely manner, and on the other hand to do that eligibility determination in an accurate fashion to insure that we have a low error rate, thus not resulting in the potential or the very real threat of federal sanctions.

I would like to address, first of all, the things that the department of SRS has done to, what I would call not only work hard, but perhaps, more importantly, to work smart. During the past several years we have been under constant pressure to develop what the federal government calls corrective action plans. A corrective action plan is a formal written document submitted to the Federal Government which outlines specific activities and deadlines aimed at reducing the error rate in the federally funded programs of AFDC, Medicaid, and Food Stamps. During the past several years we have done the following: we have reorganized the division to allow for a Field Services Bureau to improve the communications, and policy development for the field, we have implemented a comprehensive manuals program to give better instructions to counties. We utilize the Field Services Bureau to conduct regular corrective action meetings of county directors and eligibility technician supervisors, at which time various strategies are developed to reduce the error rates in the eligibility determination process, we have developed a unified Eligibility Policy Bureau to insure uniform development of policies. We have developed a formal quality control error siting resolution procedure to insure that any potential error in any case reviewed by quality control is gone over

with a fine-tooth comb to insure that the eligibility was determined properly. We have implemented a monthly reporting and retrospective budgeting system statewide where every single month, for the most part, every AFDC and Food Stamp applicant is required to report on a monthly basis, any changes in their income, resources, or other conditions that would affect their eligibility or amount of benefit. We have implemented a system of supervisory review in the counties where eligibility technician supervisors or county directors, or a peer reviews the work of the county workers to insure proper eligibility determination. We have developed better training programs, including video-tape training to insure uniform implementation of policy. We have developed data processing system for food stamps and just recently brought that on line to insure that there is no duplicate participation in the food stamp program. We have developed word processing systems to enhance the efficiency and effectiveness of the clerical functions within numerous counties including 11 of the 12 state administered counties and 16 of the non-state administered counties. We conduct wage matches of all kinds including unemployment benefits, wages paid, individual Indian accounts with Indian Health Service and we'll be developing more computer matches of wage, income, and resource information in the future. We are under a mandate to do computer matches with Internal Revenue Service by April 1985. We are constantly monitoring and updating our manual instructions, especially in the areas of resources and income where most of the errors in the eligibility determination process occur. We are approximately one month away from issuing a 50-page Food Stamp manual versus the old one of approximately 4 or 5 hundred pages which was extremely cumbersome and awkward to use. We have, several years ago, resolved a federal sex discrimination appeal of the eligibility technicians, an issue that resulted for a long period of time in frustration and preoccupation with that court case of our line workers. As a result of that we have implemented a career ladder for eligibility technicians that involves three levels of career advancement opportunities. We have got a semblance of a performance evaluation system that insures the accountability of eligibility technicians in the proper determination of eligibility and a variety of other ongoing training and management initiatives to enhance and to increase the efficiency and effectiveness of the line worker. There has been much done, but there is still much to do. All the above are constantly under review to assure that we simply don't do things "because we've always done them that way".

All these efforts have resulted in, what I consider to be, a working-smart concept within the county welfare offices and office of human services.

This in turn, leads me to the second part of the bind that eligibility workers find themselves in, and that is the constant pressure to work fast, but at the same time to insure the reduction of errors in all the programs that we administer.

I would like to turn your attention to a chart which shows the result of those management efforts and the successful implementation at the line worker level, that has, in fact, resulted in a significant and substantial reduction in the error rate in all the programs that we administer. In the Medicaid program we have gone from the highest error rate in the nation, to one of the lowest in the nation. In the AFDC program, we have consistently been low and, in fact, at one point Montana had the lowest error rate in the nation. In the Food Stamp program, we have made significant strides to reduce the error rate and, in fact, have received two national awards from the Secretary of Agriculture.

During two periods, the State of Montana has received enhanced funding by increasing the percent of administrative funds available from the Federal Food Stamp program because of our error rate reduction. That's the good news. The bad news is that the recent trend appears to be upward in terms of the number of errors created in the AFDC and Food Stamp programs.

Through my activities as vice-president of the American Association of Food Stamp Directors and in general, the American Public Welfare Association, it has become increasingly apparent that the Federal Government is darn serious about taking sanctions in those states who fail to reduce their error rate to the 3% level in the AFDC and Medicaid program and to 5% in the Food Stamp program. Whether this is perceived by states as an attempt to balance the federal budget, through placing a burden for sanctions on the shoulders of state administrators, state legislators and the backs of poor people, or whether it's an attempt to force states, in utter frustration, to adopt a federal proposal for a block grant in the Food Stamp program, the future is perfectly clear, they are serious about taking sanctions and the tolerances they have established for those error rates are clearly below any obtainable or cost-beneficial level because of the complexity and the constant changes that are thrust upon us by the Federal Government.

This scenario rather reminds me of the position that both you as legislators and the state, as administrators of these programs, find ourselves in. It reminds me of the Fram oil filter which says that you can pay us now or you can pay us later, but sooner or later if we don't administer these programs with an error rate below the federally mandated tolerance, we are going to be faced with sanctions. Although we will be in court on the issue, along with numerous other states, it certainly casts a pall on the public's attitude toward the programs intended to serve the poor.

The whole point of this last discussion was to indicate that during the past two or three years, we have been doing everything we can to reduce that error rate, and we continue to do all those things and more to keep that error rate down. The one thing that is clear to me that to a large extent is causing the recent rise in the error rate, is simply not having the adequate staff to do all the necessary verification and documentation to properly determine eligibility.

I have recently been reading a book, the autobiography of Lee Iacocca of the Chrysler Corporation, and I must admit that I have been somewhat influenced by that book, in terms of the way in which he streamlined the operation and management of the Chrysler Corporation. One of the things that struck me in reading that book, however, is that in streamlining the operation of Chrysler, one of the things he choose not to significantly cut back on are critical elements in the production line process, and critical quality control processes to insure quality products in translating that into the operation of a county welfare office, it rather strikes me that Lee Iacocca would not eliminate three steps in the production process that eliminated the master cylinder brake, the steering wheel and the left front tire. I truly believe that in some ways we are forced into a situation similar to that in county welfare offices, through cutting of staff or on the other hand not making adequate staff available, some of the critical elements in the eligibility determination process are simply not getting done, not because eligibility workers don't want to, but simply because they don't have the time to do it.

With that, I would like to focus your attention on an area of frustration that I think, both you as legislators and I as a manager have had, and that is coming up with a realistic, objective way of determining a staffing pattern for eligibility workers that reflect not what is, but rather an objective way of looking at what ought to be the ideal situation in terms of staffing patterns. Recently the Department of SRS through a 100% federally funded technology transfer grant from the federal office of family assistance brought in a group of managers from Washington State that utilizes an industrial engineering approach to analyzing the work that is done in their office of human services. Utilizing the industrial engineering approach, Washington State actually went out and developed a system for measuring the precise amount of time necessary for doing various aspects of work in the eligibility process.

I have prepared an extensive handout of the analysis that Washington went through and the efforts that we have subsequently done during the last two or three months to apply that industrial engineering approach used in Washington State to the Montana circumstances.

In that study, we attempted to replicate in a very general way the industrial engineering approach that Washington uses and apply that, like I say, to the Montana situation. We gathered extensive data from all counties in the state, dealing with not just strictly caseload, but more importantly, the overall workload of all counties. The result of that effort is outlined in the handout that we have prepared for you. The bottom line of that study would indicate that the ideal staffing pattern for the State of Montana, utilizing the Washington system, would result in the following additional required staffing pattern for Montana over and above current level and over and above the LIEAP technician issue I raised earlier:

	FTE's
Eligibility Technicians	23.47
Eligibility Technician Supervisors	4.69
Clerical Workers	47.79
Clerical Supervisors	9.55
TOTAL	85.50

I have provided the committee with a complete set of the workload indicators and a precise number of minutes and hours that are required for processing various types of applications, and would be more than happy to go into extensive detail about what that staffing pattern study means. In the interest of time, however, I will keep it brief at this point.

The reason I point out the ideal staffing pattern is simply to give you a comparative figure to justify those number of staff requested in the PFP process in tier one. The addition of 18 eligibility workers in the first year of the biennium, and 36 the second year of the biennium for a total 54 over the total biennium. If the total number of FTE's were granted, it would not solve the problem nor arrive at the ideal situation, but would make a significant effort for getting to an ideal staffing pattern increase that would truly reflect, based on the Washington experience, what the staffing pattern ought to be in county welfare offices.

For the last part of my presentation, I would like to present to you another chart in your packet of material which establishes, if you will, a triage or

breakdown of the three separate elements of staffing pattern and funding sources within the eligibility determination program.

It's important to remember state law at 53-2-304 (2) MCA requires "(2) Public assistance staff personnel attached to the county board shall be paid from state public assistance funds both their salaries and their travel expenses as provided for in 2-18-501 through 2-18-503 when away from the county seat in the performance of their duties, but the county board of public welfare shall reimburse the department of social and rehabilitation services from county poor funds the full amount of the salaries and travel expenses not reimbursed to the department by the federal government and the full amount of the department's administrative costs which are allocated by the department to the county for the administration of county welfare programs and not reimbursed to the department by the federal government."

The first branch of the triage are staff in program 03 that are in non-state administered counties. The funding for that set of eligibility workers if 56% county, and 44% federal and these are open-ended federal funds. As a legislator, you could authorize unlimited numbers of FTE's with no general fund impact. In fact, to do anything different, and to continue operation under the current level of authorized FTE's literally puts the State Department of SRS in the situation of telling the Yellowstone County Commissioners who may agree with their county director to the addition of eligibility staff of having to tell them that we simply cannot allow them to do it because SRS doesn't have the authorization from the legislature to do so. Similarly if the Gallatin County Commissioners wanted to add staff in their county, we would be in a similar predicament. To me this is an intolerable situation to be put in; to put increasing demands in terms of workload and caseload on a county and yet not have the tools to respond to an approved request from the county director and county commissioners of those non-state administered counties.

The second part of this triage is the funding for state administered counties, and in this case we are talking of 56% state funds and 44% federal funds. The reason for this, are the requests before you in the PFP initiative , EN-23, to provide the funding for ten additional FTE's in those state administered counties. Previously the department had agreed that we could accommodate the 2% executive level cuts by phasing in these positions in those state administered counties.

The third part of the triage are currently existing positions that existed in counties that came under state assumption, that are currently funded with 56% state or county funds depending on whether it is state administered or not state administered county, and 44% open-ended federal funds. Three examples are 1) county medical personnel that existed in counties, and we continued them because they were funded through either county or state funds; 2) LIEAP or low-income energy assistance program technicians that were hired in a county and assigned to the respective county departments of public welfare and their funding is 100% federal LIEAP dollars; and 3) are situations where the food stamp issuance clerk is hired by the county commissioners, but assigned to the county welfare offices for purposes of food stamp issuance. The Department of SRS is constantly at risk of having a county indicate they are no longer interested in issuing food stamps and asking the state to take over that function, which they can legitimately do. Without the necessary appropriation authority, we are at risk of having that function taken over by the

state with no FTE to accommodate them, and yet the need for issuance of food stamps maintained in those offices.

The point of the above discussion is to impress on you the need to look at the funding in the eligibility determination program as three very distinct parts of that triage with three very distinct funding sources, only one of which would have additional general fund impact, and that is in state administered counties.

With that I will conclude my testimony by asking for your favorable consideration of these PFP requests for 18 additional FTE's during FY86 and 36 additional FTE's during FY87 for a total addition of 54 during the next biennium. I would also request your consideration of the additional FTE's requested that have no general fund impact. And again, although this may not arrive at a totally adequate system, it is certainly a giant step in the right direction. There are several other individuals who, I believe want to testify with regard to the county operations and some of the concerns that they have had during the past two years. Thank you, and if you have any questions, I would be more than glad to answer them.

LEGIS/010

DEPARTMENT OF
SOCIAL AND REHABILITATION SERVICES

TED SCHWINDEN, GOVERNOR

P.O. BOX 4210

STATE OF MONTANA

HELENA, MONTANA 59604

REPORT ON STAFFING

MONTANA COUNTY OFFICES OF HUMAN SERVICES

AND

MONTANA COUNTY DEPARTMENTS OF PUBLIC WELFARE

PREPARED BY

ECONOMIC ASSISTANCE DIVISION
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

FEBRUARY, 1985

AN EQUAL OPPORTUNITY EMPLOYER

INTRODUCTION

The provision of income to persons who would otherwise have no other means of economic support has been a national policy since the mid-1930's. What began as an emergency measure in response to the Depression has become today a variety of programs to meet the economic, medical and nutritional needs of a portion of the United States population.

What has remained fairly constant throughout this transformation process is the fundamental structure of state administration of most of these programs, with the Federal government providing the bulk of the funding and regulating the programs to a certain degree. In response to these requirements, the State of Montana has designated the Department of Social and Rehabilitation Services as responsible for the control, coordination and direction for public assistance programs. The Department develops and coordinates these programs and disseminates policy to local county welfare departments where the financial and clerical staff are responsible for determining need and eligibility for a variety of services including financial grants, food stamps and medical assistance.

Prior to this study, the Economic Assistance Division has not had a means for determining staffing level requirements and alloting staff to county welfare departments.

The State of Washington Department of Social and Health Services system known as Workload Planning and Control (WLPC) was suggested by the Federal

Department of Health and Human Services as the most highly developed and sophisticated system in the nation for achieving these goals.

Using monies from an HHS technology transfer grant, staff met with John Deardorff, Program Manager of WLPC and Ray Church an industrial engineering analyst.

The 1973 Washington Legislature mandated the Department of Social and Health Services to implement an objective means of determining staffing levels. In 1975 , the Consulting Division of Boeing Computer Services developed unique workload standards based upon industrial engineering work measurement principles. Work standards are intended to identify the time it should take to complete the requirements for determining need and eligibility for programs.

The work load standards developed by Washington were compared with the procedures used in Montana and it was found there are no significant difference in tasks performed.

WLPC staff agreed to feed our current caseload numbers into their existing computer program to generate an accurate projection of staffing needs.

After analyzing Montana programs, caseloads and employees, to ensure that the same information was being input from each state, Washington staff came up with the following:

Staff Requirements Based on Workload Standards and Caseload

MONTANA
STAFFING NEEDS CALCULATION

Montana	
Caseload Statewide	28,339
less exempt cases	- 786
	27,553

ELIGIBILITY TECHNICIANS

E.T.'s Statewide	174.25
less exempt FTE	- 9.00
	165.25

146 cases per E.T. based on Washington staffing needs projection.

27,553 ÷ 146 =	188.72	E.T. staff needed
	-165.25	present eligibility staff (adjusted)
	23.47	E.T.'s needed

ELIGIBILITY TECHNICIAN SUPERVISORS

Standard ratio of supervisors to eligibility workers within the Department of SRS is 1-5. Thus, 4.69 E.T. Supervisors are needed.

CLERICAL*

Clerical statewide	104.57
(69.05 E.A.)	
(36.52 S.S.)	
less exempt FTE	- 2.65
	101.92

(* clerical supervisors were included in the total clerical count.)

160 cases per clerical worker based on Washington Staffing needs projection.

27,553 ÷ 160 =	172.20	clerical staff needed
	101.92	present clerical staff
(EA & CSD)	70.28	clerical needed

68% of present clerical staff is Economic Assistance program 03.

70.28	(total clerical needed)
.68	(% EA)
47.79	EA clerical needed

CLERICAL SUPERVISORS

Standard ratio of supervisors to clerical workers within the department is 1-5. Thus - 9.55 EA clerical supervisors.

COUNTIES WITH EXEMPT FTE'S AND CASELOAD

	Total Caseload	Exempt ET's	Exempt Clerical
Carter, Fallon and Wibaux	128		
Daniels and Sheridan	99	1.00	.80
Fallon		1.00	.80
Golden Valley and Wheatland	53	1.00	
Judith Basin	22	.50	
Lewis & Clark		* .50	
Madison	117	1.00	
McCone and Prairie	59	1.00	
Meagher	91	1.00	
Mineral	112	1.00	.25
Musselshell	105	1.00	.80
TOTAL	786	9.00	2.65

Some county offices have a low caseload which may not justify an eligibility technician and/or clerical, but it is necessary to have staff in the office to provide service to recipients. These employees and their caseloads have been exempted from staffing need calculations in order to prevent skewing the statewide averages.

* Lewis & Clark County has one-half time eligibility technician located in Augusta who takes applications for all programs and then the case is maintained in the Lewis & Clark County office. The position has to be excluded from Lewis & Clark County's statistics because the caseload from Augusta is carried by workers in the Helena Office.

COUNTY ELIGIBILITY STAFF

	County Director	ET Supr	Techs by Payroll	ET's by Location	** Exempt ET's	Clerical	** Exempt Clerical	*** Non Measured Staff
Beaverhead	1		1.00	1.00		.80		
Big Horn	1	1	4.00	4.00		1.00		
Blaine			3.00	3.00		1.60		.50
Broadwater	1							
Carbon	1		2.00	2.00		.50		
Carter			.20					
Cascade	1	2	18.00	18.00		8.20		3.40
Chouteau	1		.50	.50		.80		
Custer	* 1		1.60	2.00				1.00
Daniels			.25					
Dawson	* 1		1.00	1.00		.80		.60
Deer Lodge	1	1	4.00	4.00		1.00		
Fallon	* 1		.20	1.00	1.00	.80	.80	
Fergus	* 1	1	2.95	3.00		1.80		
Flathead	1	2	11.00	11.00		4.00		.80
Gallatin	1	1	4.00	4.00		.80		.80
Garfield			.20					
Glacier	1	1	6.00	6.00		.80		
Golden Valley			.20					
Granite			.60	.60				
Hill	* 1	1	5.84	6.00		2.00		
Jefferson	1		1.00	1.00				.80
Judith Basin			.50	.50	.50			
Lake	1	1	5.00	5.00		1.00		1.00
Lewis and Clark	1	2	10.25	10.25	.50	5.75		1.00
Liberty			.16					
Lincoln	1	1	6.00	6.00		2.60		
Madison	1		1.00	1.00	1.00			
McCone								
Meagher			1.00	1.00	1.00			
Mineral	1		1.00	1.00	1.00	.25	.25	
Missoula	1	3	19.00	19.00		8.60		.80
Musselshell			1.00	1.00	1.00	.80	.80	
Park	* 1		3.00	3.00		.80		
Petroleum			.05					
Phillips			1.00	1.00		.80		.40
Pondera	* 1		2.00	2.00				
Powder River			.20			.80		
Powell	* 1		1.60	1.60				
Prairie			1.00	1.00	1.00			
Ravalli	1	1	5.80	5.80		2.30		
Richland	1		2.00	2.00		1.00		1.00
Roosevelt	* 1	1	3.00	3.00				1.00
Rosebud	* 1		2.82	3.00		.80		
Sanders	1		2.00	2.00				
Sheridan			.75	1.00	1.00	.80	.80	
Silver Bow	1	1	10.00	10.00		4.60		4.00
Stillwater			1.00	1.00		1.00		
Sweet Grass	* 1		1.00	1.00				
Teton			1.00	1.00				
Toole			1.00	1.00				.80
Treasure			.18					
Valley	* 1		3.00	3.00		1.80		1.00
Wheatland			.80	1.00	1.00			
Wibaux			.60					
Yellowstone	1	3	18.00	18.00	.	6.80	.	1.60
TOTAL	34	23	174.25	174.25	9.00	65.40	2.65	20.50

* Denotes county director responsible for more than one county.
** E.T.'s and clerical assigned to small offices with less than full caseload, but necessary to staff office.
*** Staff such as receptionists, human service aides, switchboard operators which are not considered as part of caseload workers.

CASELOAD SUMMARY

	Cases Undup Count
SSI With Food Stamps	2,277
Food Stamps Only	9,898
AFDC with Food Stamps	6,484
AFDC Only	997
GA with Food Stamps	1,919
GA Only	130
State/County Medical Only	712
State/County with Food Stamps	145
Medically Needy Incurrment Only	2,310
Medically Needy with Food Stamps	181
Medical Assistance Only with Food Stamps	555
Medical Assistance without Food Stamps	2,731
TOTAL	28,339

CASELOAD SUMMARY (CONT)

	SSI with FS	FS Only	AFDC with FS	AFDC Only	GA with FS	GA Only	State/Co Med Only	State/Co with FS	MN Incurr Only	MN with FS	MAO with FS	MA w/o FS	Total
Sheridan	0	0	0	0	0	0	0	0	0	0	0	0	0
Silver Bow (SAC)	220	582	528	31	430	0	187	0	240	0	29	77	2,324
Stillwater	17	48	17	1	1	0	0	0	47	0	0	16	147
Sweet Grass	10	21	9	1	0	0	0	0	18	0	0	2	61
Teton	18	85	17	4	0	0	1	0	2	0	0	38	165
Toole	31	55	29	4	4	0	0	4	26	1	2	9	165
Treasure	0	0	0	0	0	0	0	0	0	0	0	0	0
Valley	39	62	51	18	8	5	0	3	49	3	4	21	263
Wheatland	6	12	10	3	1	1	0	0	8	0	0	4	45
Wibaux	5	15	10	2	0	0	0	0	0	2	2	14	50
Yellowstone	292	955	741	32	43	29	37	16	316	22	20	210	2,713
TOTAL	2,277	9,898	6,484	997	1,919	130	712	145	2,310	181	555	2,731	28,339

SSI = Supplemental Security Income
FS = Food Stamps
AFDC = Aid to Families with Dependent Children
GA = General Assistance
MN = Medically Needy
MA = Medical Assistance
MAO = Medical Assistance Only

CASELOAD SUMMARY

		SSI with FS	FS Only	AFDC with FS	AFDC Only	GA with FS	GA Only	State/Co Med Only	State/Co with FS	MN Incurr Only	MN with FS	MAO with FS	MA w/o FS	Total
Beaverhead		11	44	56	29	29	0	0	0	61	4	60	103	397
Big Horn		25	316	136	117	0	0	0	0	33	0	0	6	633
Blaine		10	199	140	47	0	1	10	0	39	0	0	14	460
Broadwater		16	44	20	9	7	3	2	1	4	10	12	5	133
Carbon		32	107	34	3	0	3	0	0	9	8	2	56	254
Carter		5	9	3	3	0	0	0	1	0	1	0	9	31
Cascade	(SAC)	401	899	799	20	403	24	56	48	319	33	80	147	3,229
Chouteau		0	56	20	2	0	0	0	1	0	4	0	0	83
Custer		78	123	118	29	0	0	0	0	67	2	11	55	483
Daniels		27	41	4	1	2	0	2	0	2	0	0	47	126
Dawson		21	63	43	7	8	6	2	0	5	5	0	163	323
Deer Lodge	(SAC)	76	164	174	10	142	3	65	0	119	16	12	45	826
Fallon		2	14	6	3	2	0	0	0	1	0	0	19	47
Fergus		51	93	40	10	4	2	2	4	81	3	17	120	427
Flathead	(SAC)	0	1,067	450	7	61	11	25	0	303	0	0	27	1,951
Gallatin		55	413	138	17	1	3	2	1	5	0	0	140	775
Garfield		0	0	0	0	0	0	0	0	0	0	0	0	0
Glacier		2	498	331	74	0	0	0	0	23	1	0	41	970
Golden Valley		0	4	2	2	0	0	0	0	0	0	0	0	8
Granite		10	63	33	0	3	0	0	0	1	2	0	5	117
Hill		16	241	185	78	5	7	17	1	33	3	2	25	613
Jefferson		40	65	33	12	1	0	3	0	48	0	0	249	451
Judith Basin		4	7	6	0	0	1	1	1	0	0	0	2	22
Lake	(SAC)	36	330	247	51	15	0	1	6	7	0	5	122	820
Lewis & Clark	(SAC)	169	389	411	0	229	0	238	0	13	6	33	248	1,736
Liberty		1	9	4	1	0	0	0	0	0	0	0	0	15
Lincoln	(SAC)	0	407	222	21	55	0	5	0	84	0	0	5	799
Madison		2	25	12	5	5	11	1	3	3	0	6	44	117
McCone		4	10	1	0	0	0	0	0	0	0	0	18	33
Meagher		10	24	18	18	1	1	0	0	1	0	0	18	91
Mineral	(SAC)	10	40	33	2	8	0	0	8	1	3	0	6	111
Missoula	(SAC)	205	943	618	42	342	5	20	21	168	38	87	184	2,673
Musselshell		23	31	26	3	2	0	0	0	8	4	1	7	105
Park	(SAC)	65	149	92	13	40	6	4	4	3	4	8	92	480
Petroleum		0	3	0	0	0	0	0	0	0	0	0	2	5
Phillips		18	79	33	5	0	0	0	0	15	0	0	21	171
Pondera		28	110	79	12	1	0	0	0	2	2	8	43	285
Powder River		0	0	0	0	0	0	0	0	0	0	0	0	0
Powell	(SAC)	17	93	56	11	14	5	11	1	44	1	9	6	268
Prairie		3	4	1	0	0	0	0	1	1	1	1	14	26
Ravalli	(SAC)	56	308	160	14	28	2	8	9	98	2	18	32	735
Richland		42	158	72	6	22	1	1	10	0	0	12	48	372
Roosevelt		5	50	93	103	0	0	0	0	3	0	12	88	354
Rosebud		63	215	123	34	2	0	0	1	0	0	1	64	503
Sanders		0	156	0	80	0	0	11	0	0	0	101	0	348

TOTAL CASELOAD BY COUNTY

Beaverhead	397
Big Horn	633
Blaine	460
Broadwater	133
Carbon	254
Carter	31
Cascade	3,229
Chouteau	83
Custer	483
Daniels	126
Dawson	323
Deer Lodge	826
Fallon	47
Fergus	427
Flathead	1,951
Gallatin	775
Garfield	
Glacier	970
Golden Valley	8
Granite	117
Hill	613
Jefferson	451
Judith Basin	22
Lake	820
Lewis and Clark	1,736
Liberty	15
Lincoln	799
Madison	117
McCone	33
Meagher	91
Mineral	111
Missoula	2,673
Musselshell	105
Park	480
Petroleum	5
Phillips	171
Pondera	285
Powder River	
Powell	268
Prairie	26
Ravalli	735
Richland	372
Roosevelt	354
Rosebud	503
Sanders	348
Sheridan	
Silver Bow	2,324
Stillwater	147
Sweet Grass	61
Teton	165
Toole	165
Treasure	
Valley	263
Wheatland	45
Wibaux	50
Yellowstone	2,713
TOTAL	28,339

workers would then reflect more accurately the existing workload for the entire state. The 33% will increase when the exempt (dedicated) staff and respective caseloads are removed from totals.

Non-Measured Staff:

Adjustments must also be made for exempt staff, i.e. telephone operators, receptionists, human services aides, etc. (all staff not directly involved in caseload work or caseload support in clerical or eligibility units), as these types of workers were not used in Washington staffing ratio.

The Washington system establishes a ratio of supervisors to line workers, thus excluding supervisory staff from total staff in computing staffing needs. Montana should do the same and in projecting supervisor staffing needs, use the Department's standard ratio for supervisors to line workers.

By using the caseload/worker ratio which has been validated by the Washington system i.e. 146/E.T, 160/clerical, and 76/combined, the E.A. staff needed presently in Montana is:

Eligibility Technicians	- 23.47
Eligibility Technician Supervisors	- 4.69
E.A. Clerical	- 47.79
E.A. Clerical Supervisors	- 9.55

Actual Staff/Washington:

FST	949
Clerical (CSD & EA)	865
Combined	1814

Actual Staff/Montana:

ET	175
Clerical (CSD & EA)	105
	280

Average Caseload/Worker:

	Washington	Montana
FST/ET	146	162
Clerical	160	270
Combined	76	101

Notes and Observations:

Based on the ratio of caseload to workers as found in Montana, the ET/clerical combination would need to complete 33% more workload standards a day (equal to spending 2.64 hours more a day at work) than the Washington Industrial engineering staff's study showed could be done by average workers.

Exempt Staff:

Montana shall make an adjustment for dedicated staff - staff that is assigned to less than a full caseload (small counties - rural area) and is restricted from working any other caseload - should be removed from total staff and total caseload should be reduced by the assigned caseload. The ratio of cases to

Based on information provided by your office concerning your current staffing and caseload levels, we have developed a model to compare your staffing requirements as measured by work standards developed by our industrial engineering staff.

Terms:

Washington State	Montana
Department of Social and Health Services (DSHS)	Department of Social and Rehabilitation Services (SRS)
*Financial Service Technician (FST)	*Eligibility Technician (ET)

*These positions are essentially the same.

Washington Allotted Staff - Staff requirements, as determined by caseload analysis, allotted staff and actual staff in the State of Washington are equal.

Staffing Pattern:

	Washington D.S.H.S. FY84	Montana S.R.S. as of 12-84
Caseload Total	138,563	28,339

SUMMARY: Required Staffing for Montana

	FTE
Eligibility Technicians	23.47
Eligibility Technician Supervisors	4.69
Clerical	47.79
Clerical Supervisors	9.55
Total	85.50

LEGIS/111

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

W.L.P.C. PROGRAM
STANDARD SUMMARY

ORGN.	OPERATION	STANDARD NO.
DSHS	Financial Grant Application	A01
ORGN. NO.	(Eligibility Determination	**EFFECTIVE DATE**
Statewide		December 1, 1983
W.L.P.C. NO.	and Paper Processing)	**PREVIOUS EFFECTIVE DATE**
1.		February 1, 1982
ANALYST		**PRODUCTION UNIT** Each Financial
MSL (D)		Application Approved, Denied,

or Withdrawn (when medical assistance is not approved or conditionally denied for spend-down)

1 ELEMENT NUMBER	2 ELEMENT DESCRIPTION	3 NORMAL MINUTES	4 FREQUENCY OF OCCURENCE	5 NORMAL MINUTES PER PRODUCTION UNIT
1	Organize desk and supplies; obtain case record			
	and application forms from central area for			
	appointments and from RFIS pending for return			
	interviews; obtain forms and supplies from			
	desk or central supply; complete Internal			
	Requisition, DSHS 2-317, to request forms,			
	supplies; includes cleanup and put away			
	activities throughout application process and			
	at beginning and end of day.	1.11	175 / 100	1.94
2	Pre-screen of the application and supplements;			
	review the case record and any information			
	and verification available. Includes the			
	initial annotation of the Verification (CONT.)			

APPROVAL		
	6 TOTAL NORMAL MINUTES PER PRODUCTION UNIT	108.28
	7 NORMAL ALLOWANCE 10% + SPECIAL ALLOWANCE 2 %= 12 %	12.99
	8 TOTAL STANDARD MINUTES PER PRODUCTION UNIT (6 + 7)	121.27
	9 PRODUCTION UNITS PER HOUR (60 ÷ LINE 8)	.49
	10 STANDARD HOURS PER PRODUCTION UNIT (LINE 8 ÷ 60)	2.02

SKILL SUMMARY	CLASSIFICATION	HRS.	%	CLASSIFICATION	HRS.	%

1 ELEMENT NUMBER	2 ELEMENT DESCRIPTION	3 NORMAL MINUTES	4 FREQUENCY OF OCCURENCE	5 NORMAL MINUTES PER PRODUCTION UNIT
2 CONT.	Document, DSHS 14-109.	9.02	100/100	9.02
3A	Initial Intake Interview: Includes all forms			
	completed in client's presence. Gather			
	application, record, forms used, travel to			
	waiting room, call client, go to interview			
	booth (includes wait for booth). Read/Review			
	Financial and Food Stamp Rights and Responsi-			
	bilities and give client a copy of the DSHS			
	14-113 and the DSHS 12-27A. Review items on			
	back of application with client, checking off			
	each item as explained/discussed; sign and date.			
	Annotate the Verification Record, DSHS 14-109.			
	Have client complete omitted questions on DSHS			
	14-01 and supplements. Discuss OSE collection			
	function and explain "Good Cause" for non-			
	cooperation with OSE; obtain client signature			
	on DSHS 18-334, return original after photo-			
	copied: put case number, date on front of DSHS			
	18-334 and case number on DSHS 14-119. Complete			
	OSE Referral, DSHS 14-57a, for telephone			
	referrals, call OSE and relate information.			
	Calculate and tell client opening and ongoing			
	grant and food stamp amounts, if eligible;			
	discuss delivery of benefits. Complete a			
	Release of Authorization, DSHS 14-174, for			
	over-the-counter releases. Complete referral			
	documents; e.g., AFDC Enumeration, DSHS 14-167,			
	Employment Security, DSHS 14-27, as necessary.			

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
W.I.P.C. PROGRAM
STANDARD SUMMARY

ORGN.	CONTINUATION SHEET	STANDARD NO.
DSHS - Statewide		A01 - Financial Apps.

1. ELEMENT NUMBER	2 ELEMENT DESCRIPTION	3 NORMAL MINUTES	4 FREQUENCY OF OCCURRENCE	5 NORMAL MINUTES PER PRODUCTION UNIT
3A CONT.	Note verification needed. Complete and			
	explain Ten Day Letter, DSHS 14-81, as			
	necessary. Explain earned income computations			
	and requirements to report. Explain service			
	referral procedures; referrals for AFDC,			
	refugee, plus those for IRT decision. Discuss			
	WIN and E & T and give brochure. Discuss Health Maintenance Organization/Medicaid			
	alternatives. Have client complete Group			
	Health Enrollment card, if necessary. Discuss			
	possible retroactive medical benefits, nursing			
	home admit dates, etc. If client is ineligible,			
	explain reason, Fair Hearing rights. Includes			
	some research, e.g., NADA Book, obtaining			
	telephone numbers for client, Food Stamp			
	tables. Includes obtaining ashtrays, extra			
	chairs, waiting while client gets verification			
	from waiting room, car. Includes brief			
	contacts with clients in waiting room. Return			
	to desk following interview.	30.40	100 / 100	30.40
3B	Return interview: as for 3A above.	13.64	102 / 100	13.91
4A	Case coordination with DSHS staff; includes			
	consulting supervisor and other financial			
	workers; contacts with other CSO's; discussion			
	with clerical and social service staff, OSE, (CONT.)			

1 ELEMENT NUMBER	2 ELEMENT DESCRIPTION	3 NORMAL MINUTES	4 FREQUENCY OF OCCURRENCE	5 NORMAL MINUTES PER PRODUCTION UN
4A CONT.	etc.; includes unsuccessful attempts at			
	telephone contacts.	1.76	263/100	4.63
4B	Case coordination with non-DSHS staff;			
	includes telephone calls from clients and/or			
	client representatives; community agencies;			
	collateral contacts; other state agencies;			
	public assistance agencies in other states,			
	etc.; (includes unsuccessful attempts).	2.50	232/100	5.80
5	Forms completion outside the interview. Time			
	for forms completed either entirely or			
	partially during the interviews or during			
	phone conversations is included in the inter-			
	view and case coordination elements. This			
	will affect both normal time and frequency			
	for some forms.			
	A. DSHS 1-01, Record Transfer Notice	2.25	1/100	.02
	B. DSHS 2-54, Tickler File	1.13	4/100	.05
	C. DSHS 2-109, Memo	2.16	2/100	.04
	D. DSHS 2-128, Registration and Control	3.89	100/100	3.89
	E. DSHS 2-132, VOCS Referral	.97	10/100	.10
	F. DSHS 2-236, Client Change of Status	2.07	2/100	.04
	G. DSHS 2-392, M-Form Special Action Request	1.13	4/100	.05
	H. DSHS 3-149, E & T Registration Record	1.04	17/100	.18
	I. DSHS 7-01, Certification and Computation			
	of Grant	4.41	93/100	4.10
	J. DSHS 7-03, DPA Payment Authorization	1.00	1/100	.01
	K. DSHS 7-13, One-Time Grant Authorization	2.42	41/100	.99
	L. DSHS 7-28, Notice of Warrant Redirect and Proposed Termination	3.25	1/100	.03

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

W.L.P.C. PROGRAM STANDARD SUMMARY

ORGN. DSHS - Statewide | CONTINUATION SHEET | STANDARD NO. A01 - Financial Apps.

1 ELEMENT NUMBER	2 ELEMENT DESCRIPTION	3 NORMAL MINUTES	4 FREQUENCY OF OCCURRENCE	5 NORMAL MINUTES PER PRODUCTION UNIT
5 CONT.	M. DSHS 7-42, Earned Income Report	2.00	1/100	.02
	N. DSHS 12-05, Authorization to Issue	3.96	84/100	3.33
	O. DSHS 12-86, Food Stamp Verification Record	1.87	1/100	.02
	P. DSHS 12.90, Notice of Action Taken Required on Your Food Stamp Case	1.99	44/100	.88
	Q. DSHS 12-93, FS Earned Income Report	.83	1/100	.01
	R. DSHS 14-01, Application for Assistance	.94	18/100	.17
	S. DSHS 14-08, Financial Summary	1.19	16/100	.19
	T. DSHS 14-14, Letter of Denial	2.14	23/100	.49
	U. DSHS 14-27, Employment Security Referral	1.69	2/100	.03
	V. DSHS 14-30, Medical Care Award Letter	2.85	3/100	.09
	W. DSHS 14-32X, Medical Eligibility Income Computation	2.86	2/100	.06
	X. DSHS 14-36, Notice to Recipients in Institutions	3.38	2/100	.07
	Y. DSHS 14-57, Support Enforcement Referral	.38	42/100	.16
	Z. DSHS 15-57A, Support Enforcement Referral Part A	2.13	50/100	1.07
	AA. DSHS 14-81, Ten Day Letter	2.69	83/100	2.23
	BB. DSHS 14-84, Financial/Social Services Communication	1.54	26/100	.40
	CC. DSHS 14-90, WIN Program Volunteer Letter	.60	3/100	.02
	DD. DSHS 14-109, Financial Verification Document (Completion time for the majority of this form is contained in element 3A-Interview.)	1.56	97/100	1.51

1 ELEMENT NUMBER	2 ELEMENT DESCRIPTION	3 NORMAL MINUTES	4 FREQUENCY OF OCCURRENCE	5 NORMAL MINUTES PER PRODUCTION UNIT
5 CONT.	EE. DSHS 14-119 & 18-334, Assignment & Notice			
	Concerning Support Cooperation	.52	54/100	.28
	FF. DSHS 14-163, Income Control Card	.25	1/100	.01
	GG. DSHS 14-165, Financial Assistance Award	2.95	75/100	2.21
	HH. DSHS 14-167, AFDC Enumeration Referral	2.25	1/100	.02
	II. DSHS 14-174, Release Authorization	1.50	1/100	.02
	JJ. DSHS 14-194, Health Insurance Coverage			
	Information	.81	4/100	.03
	KK. DSHS 14-196, Applicant Liability Letter	3.67	1/100	.04
	LL. DSHS 14-204, Spend-Down Computation -			
	Partial Day Eligibility	7.85	1/100	.08
	MM. DSHS 14-222, Statement of Collateral			
	Information	.97	68/100	.66
	NN. DSHS 14-223, Statement from School	.76	13/100	.10
	OO. DSHS 14-224, Statement from Landlord	.70	32/100	.22
	PP. DSHS 15-83, Letter of Award - Congregate			
	Care	3.55	1/100	.04
	QQ. DSHS 18-255, Labor and Industries			
	Claim Information	4.20	1/100	.04
	RR. EMS 511, Application Card	1.00	15/100	.15
	SS. EMS 587, WIN Registration	1.75	9/100	.16
	TT. 150% Computation Form	1.33	3/100	.04
	UU. HMO (or Group Health) Cards	1.57	12/100	.19
	VV. CEAP Computation Forms	2.20	5/100	.11
	WW. Notes to Self	.67	20/100	.13
	XX. Notes to Staff	1.15	10/100	.12
	YY. Verification Forms (Other Agencies)	.50	1/100	.01

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

W.L.P.C. PROGRAM
STANDARD SUMMARY

ORGN.	CONTINUATION SHEET	STANDARD NO.
DSHS - Statewide		A01-Financial Apps.

1. ELEMENT NUMBER	2 ELEMENT DESCRIPTION	3 NORMAL MINUTES	4 FREQUENCY OF OCCURRENCE	5 NORMAL MINUTES PER PRODUCTION UNIT
6	Research manuals, terminal, microfiche, directories, case records, resource materials, etc.	1.66	264/100	4.38
7	Pull/Request case files from active files, closed files, or pending files (includes completing DSHS 2-02)	1.09	82/100	.89
8	File case records in pending files	.54	68/100	.37
9	Photocopy verification documents and forms	.38	877/100	3.33
10	Review of documents and case records (includes review of Ten Day Letter and previous activity preceding return interview).	1.02	139/100	1.42
11	Distribute pended and completed applications; collate and staple OSE papers in sets; hole-punch and attach verification documents and DSHS 14-109, deliver/route referrals to services; assemble documents; put DSHS14-81 on outside of record, band, place in RFIS pending file; deliver/route DSHS 12-05 to typist, DSHS 7-13 to approving authority, DSHS 7-01 to input operator, etc,; count for WLPC as necessary.	1.93	377/100	7.28

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
W.L.P.C. PROGRAM
STANDARD SUMMARY

ORGN.	OPERATION	STANDARD NO.
DSHS	Medical Applications	A04
ORGN. NO.	(Eligibility Determination	**EFFECTIVE DATE**
Statewide		December 1, 1983
W.L.P.C. NO.	and Paper Processing)	**PREVIOUS EFFECTIVE DATE**
		July 1, 1983
ANALYST		**PRODUCTION UNIT** Each medical application approved, denied, withdrawn, or conditionally denied for spenddown.
MSL (C)		

1 ELEMENT NUMBER	2 ELEMENT DESCRIPTION	3 NORMAL MINUTES	4 FREQUENCY OF OCCURENCE	5 NORMAL MINUTES PER PRODUCTION UNIT
1	Organize desk and supplies; obtain forms and supplies from desk or central supply; complete Internal Requisition DSHS 2-317 to request forms and supplies; includes cleanup and put away activities throughout application process and at beginning and end of day.	1.11	105/100	1.17
2	Travel to distribution box (pickup point), get case record and/or documents, return to work station.	.91	113/100	1.03
3	Prescreen of the application and supplements; review the case record and any information and			

APPROVAL		
	6 TOTAL NORMAL MINUTES PER PRODUCTION UNIT	65.54
	7 NORMAL ALLOWANCE 10% + SPECIAL ALLOWANCE 2% = 12%	7.86
	8 TOTAL STANDARD MINUTES PER PRODUCTION UNIT (6 + 7)	73.40
	9 PRODUCTION UNITS PER HOUR (60 ÷ LINE 8)	.82
	10 STANDARD HOURS PER PRODUCTION UNIT (LINE 8 ÷ 60)	1.22

SKILL SUMMARY	CLASSIFICATION	HRS.	%	CLASSIFICATION	HRS.	%

1 ELEMENT NUMBER	2 ELEMENT DESCRIPTION	3 NORMAL MINUTES	4 FREQUENCY OF OCCURENCE	5 NORMAL MINUTES PER PROJECTION
	verification available; includes the initial			
	annotation of the Verification Record, DSHS			
	14-109.	3.70	100/100	3.70
4	Initial Interview:			
	Gather application, case record, and forms			
	used (as appropriate); travel to waiting room;			
	call client; escort client to interview booth			
	(includes wait, as necessary). Review Rights			
	and Responsibilities on back of application			
	with client, checking off each item as explain-			
	ed/ discussed; sign and date. Annotate the			
	Verification Record, DSHS 14-109. Have client			
	complete omitted questions on DSHS 14-01 and			
	supplements. Explain the various medical			
	programs and limitations of each. If client			
	is eligible, explain how to use medical cou-			
	pons and reporting requirements. If client			
	is to be conditionally denied for spenddown,			
	explain how to report medical expenses for			
	consideration. If MI is being considered,			
	explain the deductible. Give the client the			
	necessary forms. Note verification needed.			
	Explain Ten Day Letter, DSHS 14-81, as necess-			
	ary. Explain income computations and require-			
	ment to report. Explain service referral pro-			
	cedures. Discuss Group Health/Medicaid			

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

W.I.P.C. PROGRAM
STANDARD SUMMARY

ORGN.

CONTINUATION SHEET

STANDARD NO. A04

1. ELEMENT NUMBER	2 ELEMENT DESCRIPTION	3 NORMAL MINUTES	4 FREQUENCY OF OCCURRENCE	5 NORMAL MINUTES PER PRODUCTION UNIT
	alternatives. Have client complete Group Health Enrollment card, if necessary. Discuss possible retroactive medical benefits. If client is ineligible, explain reason, Fair Hearing rights. Includes some research, e.g., NADA Book, obtaining telephone numbers for client. Includes obtaining ashtrays, extra chairs, waiting while client gets verification from waiting room or car, and getting interpreter. Escort client to waiting room; return to work station.	27.95	100/100	27.95
5	Return Interview: Same as element 4.	11.53	16/100	1.84
6	Forms completion during and after interview(s).			
	A. DSHS 1-01, Record Transfer Notice.	1.50	3/100	.05
	B. DSHS 1-32, Routing Slip.	1.50	5/100	.08
	C. DSHS 2-02, Out Slip	.41	21/100	.09
	D. DSHS 2-128, Application, Registration and Control.	1.84	111/100	2.04

DSHS 6-116A (10-78)

1 ELEMENT NUMBER	2 ELEMENT DESCRIPTION	3 NORMAL MINUTES	4 FREQUENCY OF OCCURRENCE	5 NORMAL MINUTES PER PRODUCTION UNIT
	E. DSHS 2-392, Terminal Input Special Action Request.	.95	5/100	.05
	F. DSHS 7-01, Certification and Computation of Grant.	2.22	63/100	1.40
	G. DSHS 7-02, Registration and Control of Negotiables.	.75	3/100	.02
	H. DSHS 7-28, Notice of Warrant Redirect and Proposed Termination.	2.50	3/100	.08
	I. DSHS 12-05, Food Stamp Computation Form.	2.48	29/100	.72
	J. DSHS 12-05, Authorization to Issue Identification and Authorization Cards.	2.09	39/100	.82
	K. DSHS 12-86, Food Stamp Verification/Documentation Record.	2.25	3/100	.07
	L. DSHS 12-90, Notice of Action Taken/Required on Your Food Stamp Case.	1.51	42/100	.63
	M. DSHS 14-08, Financial Summary.	1.80	3/100	.05
	N. DSHS 14-08A, Termination/Transfer Financial Summary.	1.50	3/100	.05

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
W.L.P.C. PROGRAM
STANDARD SUMMARY

ORGN.

CONTINUATION SHEET

STANDARD NO. A04

1. ELEMENT NUMBER	2 ELEMENT DESCRIPTION	3 NORMAL MINUTES	4 FREQUENCY OF OCCURRENCE	5 NORMAL MINUTES PER PRODUCTION UNIT
	O. DSHS 14-12, Authorization to Release Information.	1.75	3/100	.05
	P. DSHS 14-14, Letter of Denial or Application Withdrawal.	2.73	45/100	1.23
	Q. DSHS 14-27, Employment Security Referral.	2.00	3/100	.06
	R. DSHS 14-30, Notice of Eligibility for Medical Care.	1.83	29/100	.53
	S. DSHS 14-32, Medical Eligibility--Income Computation for Medically Needy Related to AFDC, R, Under 21, Grandfathered P and Medically Indigent.	4.77	63/100	3.01
	T. DSHS 14-32A, Medical Eligibility--Income Computation for Categorically and Medically Needy Related to Title XVI (Aged, Blind, and Disabled).	4.00	11/100	.44
	U. DSHS 14-31, Ten Day Letter.	2.55	37/100	.94

1 ELEMENT NUMBER	2 ELEMENT DESCRIPTION	3 NORMAL MINUTES	4 FREQUENCY OF OCCURRENCE	5 NORMAL MINUTES PER PRODUCTION UNIT
	V. DSHS 14-194, Health Insurance Coverage Information.	.63	100/100	.63
	W. DSHS 14-196, Applicant Liability (LCP-MN/MI).	2.48	32/100	.79
	X. DSHS 14-204, Spend-Down/Deductible Computation-Partial Day Eligibility.	3.70	8/100	.30
	Y. DSHS 14-214, Medical Consultant Referral.	1.65	13/100	.21
	Z. DSHS 14-224, Statement from Landlord.	.50	3/100	.02
	AA. Notes to staff.	1.00	5/100	.05
	BB. Notes to self.	.25	3/100	.01
7	Review documents and case records (Includes review of Ten Day Letter and previous activity prior to return interview).	1.24	53/100	.66
8	Photocopy verification documents and forms.	.31	592/100	1.84
9	Research manuals, terminal, microfiche, directories, case records, resource materials etc.	3.79	24/100	.91

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

W.L.P.C. PROGRAM
STANDARD SUMMARY

ORGN.

CONTINUATION SHEET

STANDARD NO. A04

1. ELEMENT NUMBER	2 ELEMENT DESCRIPTION	3 NORMAL MINUTES	4 FREQUENCY OF OCCURRENCE	5 NORMAL MINUTES PER PRODUCTION UNIT
10	Case coordination with DSHS staff--includes consulting supervisor and other financial workers; contacts wtih other CSO's; discussion with clerical and social service staff, OSE, etc. (includes unsuccessful attempts at telephone contacts).	1.68	84/100	1.41
11	Case coordination with non-DSHS staff--includes telephone calls from clients and/or client's representatives; community agencies, collateral contacts; other state agencies, public assistance departments in other states, etc. (includes unsuccessful attempts at telephone contacts).	2.03	203/100	4.12
12	Pull/request case files from active files, closed files, or pending files.	1.10	29/100	.32
13	Travel to pending file, file case records; return to work station.	.35	82/100	.29
14	Work distribution: Hole punch and attach verification documents and DSHS 14-109.			

1 ELEMENT NUMBER	2 ELEMENT DESCRIPTION	3 NORMAL MINUTES	4 FREQUENCY OF OCCURRENCE	5 NORMAL MINUTES PER PRODUCTION UNIT
	deliver/route referrals to services; assemble			
	documents; put DSHS 14-81 on outside of re-			
	cord, band; deliver/route DSHS 12-05 to typist,			
	DSHS 7-01 to input operator, letters to mail,			
	etc. Annotate log and count for WLPC as			
	necessary.	5.77	100/100	5.77
15	Make M-Form corrections.	1.23	9/100	.11

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
W.L.P.C. PROGRAM
STANDARD SUMMARY

ORGN. DSHS	OPERATION Determine eligibility for	STANDARD NO. B01
ORGN. NO. Statewide	food stamps	EFFECTIVE DATE 9/1/82
W.L.P.C. NO.		PREVIOUS EFFECTIVE DATE 9/1/80
ANALYST MSL (DC)		PRODUCTION UNIT Each application, DSHS 12-27 approved, denied or withdrawn when noted on DSHS 2-128.

1 ELEMENT NUMBER	2 ELEMENT DESCRIPTION	3 NORMAL MINUTES	4 FREQUENCY OF OCCURENCE	5 NORMAL MINUTES PER PRODUCTION UNIT
1	Make ready. Receive and review case record, application (part 2 only, or both parts together) and/or other documents (mailed in or dropped off for pended applications) prior to conducting initial or follow-up interviews, or completing a pended application. Obtain forms and supplies.	5.55	100/100	5.55
2A	Conduct initial interview in CSO or outstation with or without interpretor. Travel to and from reception/interview area; call applicant (includes calling "no shows"); verify household composition, living expenses, income and resources as required by Food Stamp Manual;			

APPROVAL		
	6 TOTAL NORMAL MINUTES PER PRODUCTION UNIT	40.00
	7 NORMAL ALLOWANCE 10% + SPECIAL ALLOWANCE 2 %* 12%	4.80
	8 TOTAL STANDARD MINUTES PER PRODUCTION UNIT (6 + 7)	44.80
	9 PRODUCTION UNITS PER HOUR (60 ÷ LINE 8)	1.34
	10 STANDARD HOURS PER PRODUCTION UNIT (LINE 8 ÷ 60)	.75

SKILL SUMMARY	CLASSIFICATION	HRS.	%	CLASSIFICATION	HRS.	%

1 ELEMENT NUMBER	2 ELEMENT DESCRIPTION	3 NORMAL MINUTES	4 FREQUENCY OF OCCURENCE	5 NORMAL MINUTES PER PRODUCTION UNIT
	explain rights and responsibilities and fair			
	hearing procedures; check tables of issuance,			
	propration tables, and utility standards as			
	necessary; make necessary calculations, initiate,			
	annotate and/or comlete forms during the			
	interview (DSHS 2-128, DSHS 2-132, DSHS 7-01,			
	DSHS 7-52, DSHS 12-05, DSHS 12-27, DSHS 12-86,			
	DSHS 12-90, DSHS 14-174, EMS 511 and 511-C.			
	Make referrals to other agencies as appropriate			
	(WIC, Food Bank, etc.)	16.02	100/100	16.02
2B	Conduct return interviews as above. Includes			
	forms initiated, annotated or completed during			
	interview.	8.86	13/100	1.15
3A	Initiate, annotate and/or complete forms after			
	the initial interview as required to approve or			
	deny an application, (DSHS 2-128, DSHS 2-132,			
	DSHS 7-01, DSHS 7-52, DSHS 12-27, DSHS 12-86,			
	DSHS 12-90, DSHS 14-174, EMS 511 and 511-C).	4.73	73/100	3.45
3B	Initiate, annotate and/or complete forms after			
	the initial interview to pend an application,			
	(DSHS 2-128, DSHS 2-132, DSHS 7-01, DSHS 7-52,			
	DSHS 12-27, DSHS 12-86, DSHS 12-90, DSHS 14-174,			
	EMS 511 and 511-C).	2.05	27/100	.55
4	Initiate, annotate and/or complete forms, not			
	done during initial or return interviews, to			
	complete a pended application.	8.22	27/100	2.22

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

W.L.P.C. PROGRAM
STANDARD SUMMARY

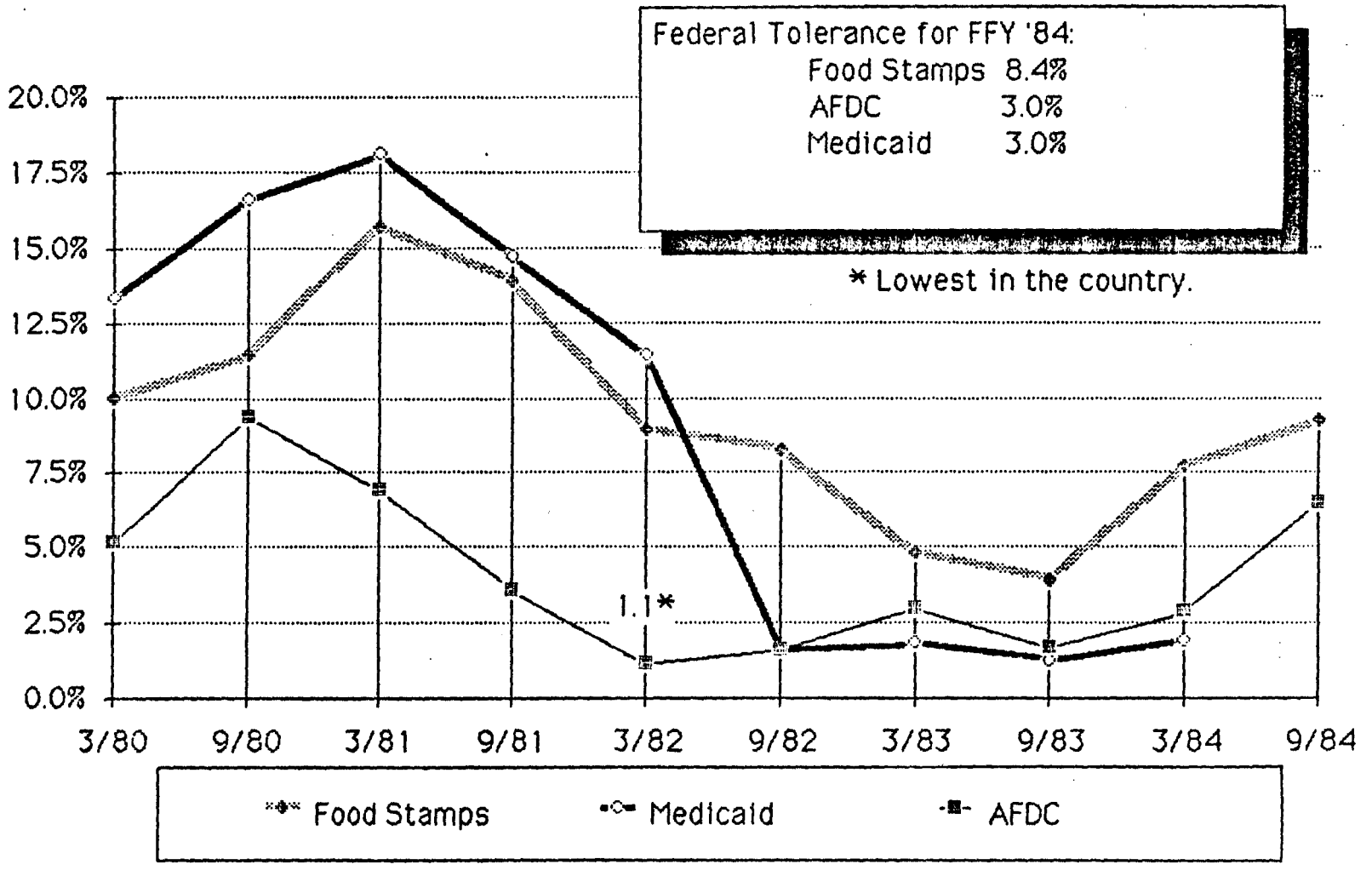
ORGN.	CONTINUATION SHEET	STANDARD NO.
DSHS		B01

1 ELEMENT NUMBER	2 ELEMENT DESCRIPTION	3 NORMAL MINUTES	4 FREQUENCY OF OCCURRENCE	5 NORMAL MINUTES PER PRODUCTION UNIT
5	Case coordination in person, by telephone or in writing with other than CSO staff regarding processing of an application.	1.90	37/100	.70
6	Case coordination in person, by telephone, or in writing with CSO staff regarding processing of an application.	1.58	126/100	1.99
7	Photocopy: includes waiting for machine, adding paper, and repairing machine as required.	.65	142/100	.92
8	Research manuals, micro fiche, terminal.	2.19	31/100	.68
9	Distribute work to typist, transmittal desk, mail, pending, and permanent files. Includes sorting, punching and bradding, clearing and cleaning of work area, annotating WLPC.	2.89	100/100	2.89
10	Screen DSHS 12-27, part 1, for eligibility for expedited services. Includes receiving case record and part one of DSHS 12-27, reviewing part one with applicant, explaining the expedited process to the applicant, issuing a DSHS 14-05, detailing what to bring to the interview, and coordinating with other CSO staff as necessary.	7.75	50/100	3.88

1. ELEMENT NUMBER	2 ELEMENT DESCRIPTION	3 NORMAL MINUTES	4 FREQUENCY OF OCCURRENCE	5 NORMAL MINUTES PER PRODUCTION UNIT

DSHS 5-116A (10-76)

Error Rates


Federal Tolerance for FFY '84:
Food Stamps 8.4%
AFDC 3.0%
Medicaid 3.0%
* Lowest in the country.
20.0%
17.5%
15.0%
12.5%
10.0%
7.5%
5.0%
2.5%
0.0%
1.1*
3/80
9/80
3/81
9/81
3/82
9/82
3/83
9/83
3/84
9/84
Food Stamps
Medicaid
AFDC

LJT

#03 ELIGIBILITY DETERMINATION PROGRAM 1/23/85

TRIAGE

NON-SAC	SAC	CURRENTLY EXISTING
Funding: 54% County 46% Federal	Funding: 54% State 46% Federal	Funding: 54% County State 46% Federal 19 FTE LIEAP 2.5 Medical Personnel 4.0 F. Stamps

Priorities for People (PFP) EN-23 Request:

STAFF (FTE) REQUEST

FY86	18	Non-SAC	10	SAC	8
FY87	36	Non-SAC	20	SAC	16
		Non-SAC	30	SAC	24

Staff Ratio - SAC - to Non-SAC:

	ET		Clerical	
	Number	Percentage	Number	Percentage
SAC	94.65	54.32%	39.1	59.78
Non-SAC	79.60	45.68%	26.3	40.21

*FUNDING FOR IDEAL STAFFING PATTERN

POSITION	GRADE	STEP	SALARY	F.T.E	46% FEDERAL	54% STATE	54% COUNTY	TOTAL
ET	G-10	2	$15,073	15.47	$ 107,262	$ 68,398	$ 57,519	$ 233,179
ET	G-11	5	17,323	8.00	63,749	40,650	34,185	138,584
ETS	G-12	5	18,711	4.69	40,367	25,741	21,647	87,755
Clerical	G-8	5	13,847	47.79	304,997	214,037	144,004	663,038
Clerical Supervisor	G-10	5	16,069	9.55	70,591	49,538	33,330	153,459
SUB-TOTAL					$ 586,966	$ 398,364	$290,685	$1,276,015
BENEFITS(22%)					129,133	87,640	63,951	280,723
TOTAL					$ 716,099	$ 486,004	$354,636	$1,556,738
TOTAL FY86 +2%					$ 730,421	$ 495,724	$361,729	$1,587,873
TOTAL FY87 +2%					745,029	505,638	368,964	1,619,630
TOTAL BIENNIUM					$1,475,450	$1,001,362	$730,693	$3,207,503
EXECUTIVE BUDGET REQUEST						292,900		
DIFFERENCE (GENERAL FUND)						$ 708,462		

*May not crossfoot due to rounding.

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

TED SCHWINDEN, GOVERNOR

STATE OF MONTANA

P.O. BOX 4210

HELENA, MONTANA 59604

RECEIVED
FEB -5
EXCHANGE

January 16, 1985

TO: Dave Lewis, Director

FROM: Pat Godbout, Administrator
Audit and Program Compliance Division

RE: Latest Quality Control Error Rates

The Quality Control reports for Food Stamps and AFDC were submitted to the federal agencies on January 4, 1985, as required. A summary of the reports follows:

Food Stamps

Report Period 10/83 through 9/84

	Cases		Percentage of Total	
Cases Reviewed	755	(727)*	100%	
Ineligible Cases	32	(24)	4.2%	(3.3%)
Eligible Cases with Overissuances	105	(68)	13.9%	(9.4%)
Eligible Cases with Underissuances	52	(45)	6.9%	(6.2%)
Correct Cases	566	(590)	75%	(81%)
Total Issuance All Cases	$86,440	($84,306)		
Total Overissuance	$ 7,325	($ 3,715)	8.5%	(4.4%)
Federal Tolerance (Based on dollar error rate rather than case error rate)			8.4%	(12%)
Amount in Excess of Tolerance			0.1%	(N/A)

* (The numbers in parentheses are for the prior year.)

Responsibility for Errors		
Agency Errors	118	62%
Client Errors	71	38%
Type of Errors		
Excess Resources	10	5%
Income	127	67%
Income Deductions	27	14%
Other	25	13%

Agency Errors		
Policy Misapplied	45	38%
Reported Information Not Used	20	17%
Failure to Followup on information	24	20%
Failure to Verify Information	17	14%
Arithmetic Errors	8	7%
Client Errors		
Information Not Reported	48	68%
Information Not Correct	23	32%

See attached for error rate by region

Federal Differences:

It is important to note that the Federal Quality Control Reviewers disagreed with the state findings in two cases. The state is heavily penalized for differences. Given that the differences amount to additional issuance errors of $46.00, the federally determined error rate will be approximately 8.6 percent.

Sanction:

The sanction will be approximately $59,000.00 and is determined by multiplying the total amount of stamps issued during the year by the difference between the actual error rate and federal tolerance rate ($29,229,118 times .002). Note: There are two methods of determining the amount of sanction. This method applies because it results in the lower sanction. Federal regulations do not appear to allow for a waiver of the sanction in our case.

AFDC

Report Period 4/84 through 9/84

	Cases		Percentage of Total	
Cases Reviewed	153	(158)*		100%
Ineligible Cases	5	(1)	3.3%	(0.6%)
Eligible with Overpayment	10	(7)	6.5%	(4.4%)
Eligible with Underpayment	3	(5)	1.9%	(3.2%)
Correct Cases	135	(145)	88%	(92%)
Total Payment All Cases Reviewed	$46,745	($45,973)		
Total Overpayments	$ 3,060	($ 1,365)	6.5%	(2.9%)
Federal Tolerance			3.0%	(4%)
Amount in Excess of Tolerance			3.5%	(N/A)

* (The number in parentheses are for the period 10/83 - 3/84.)

Federal Variances:

Federal Quality Control cited differences in one case. The additional overpayments of $332.00 will increase the federally determined error rate to approximately 8 percent.

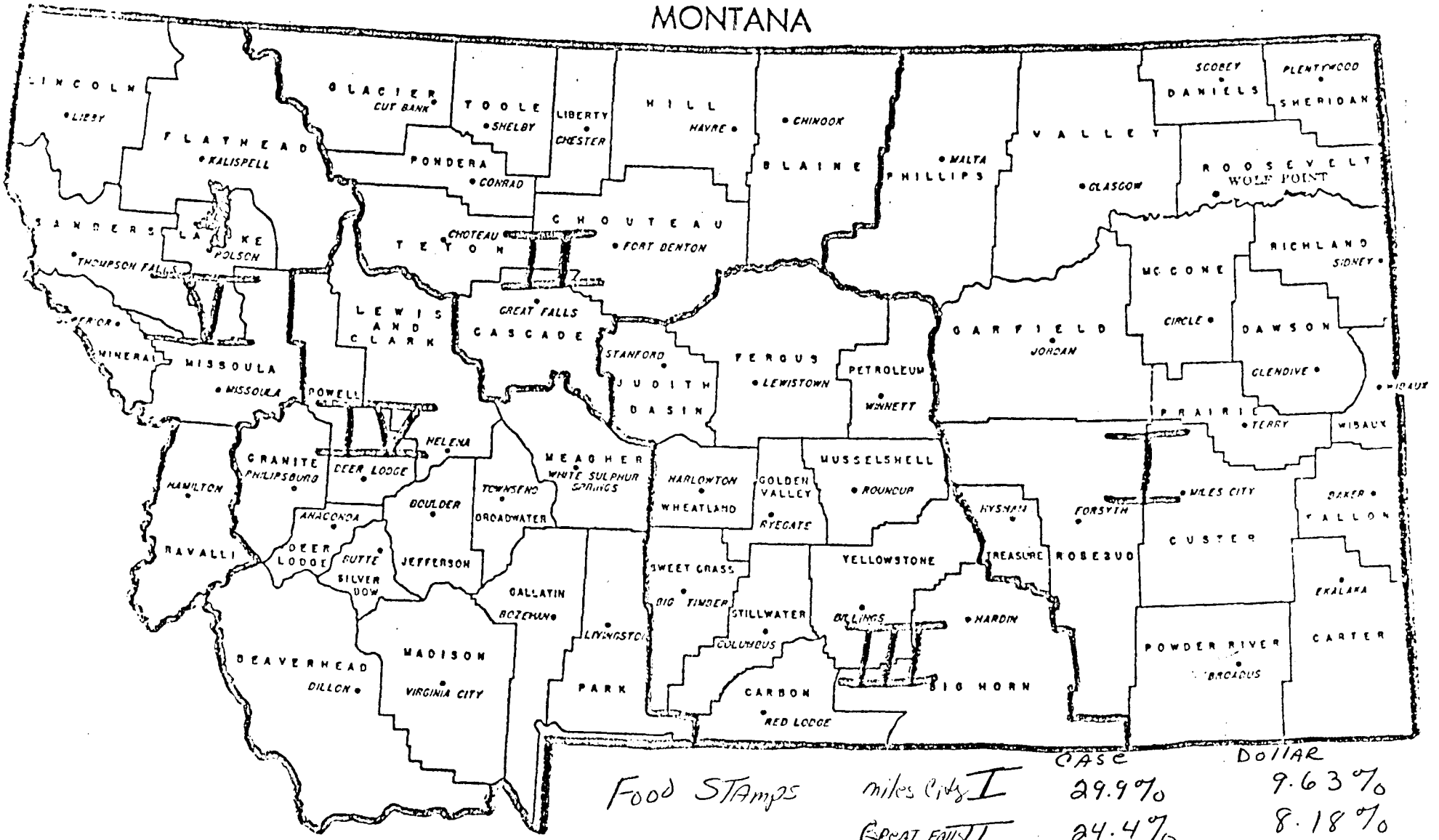
Sanction:

The sanction will be approximately $395,000.00 and is determined by multiplying the federal share of AFDC payments during the period by the difference between the actual and the federal tolerance error rates. There is no basis for a waiver of the sanction in our situation in the current federal regulations.

In Fiscal Year 1985 the federal tolerance for Food Stamps drops to 5 percent and the sanction is a 10 percent reduction of the federal share of administrative costs, for every one percent (or part thereof) the error exceeds 5 percent. If there is no reduction in the error rate, the sanction would be in excess of $800,000.00. The AFDC tolerance remains the same.

cjc

cc: Lee Tickell
Jack Ellery



Food STAMPS		CASE	DOLLAR
	Miles City I	29.9%	9.63%
	Great Falls II	24.4%	8.18%
	Billings III	24.2%	9.1%
	Helena IV	23.6%	14.2%

REGIONS

SOCIAL & REHABILITATION SERVICES/DEVELOPMENTAL DISABILITIES DIVISION

	Missoula V	25.6%	10.3%

QC: Abbreviation for Failure

IT STARTED AS A GOOD IDEA.

BY JOHN WRAFTER

Faced with skyrocketing ineligibility and overpayment rates in aid to families with dependent children (AFDC), the federal government in 1970 introduced quality control (QC). Based on the statistical sampling of case records, the program initially was sold to and embraced by state and local governments as a useful management tool. It was intended to identify causes of errors so that agencies could take appropriate corrective action. The program turned out to be something quite different, however; and its change to a fiscal sanctioning device represented an apparent shift in concern for the needy to a means of combating the rising costs of public assistance.

The use of the QC process as a means of fiscal sanctioning has caused considerable controversy. In this article I raise a number of questions that I hope will stimulate discussion of the QC sanctions:

- Does the federal QC program constitute a valid measure of AFDC program performance?
- Is the QC program a fair measure of relative error rates from state to state?
- What unidentified costs have been incurred in program implementation?
- Why are other federal programs not subject to comparable processes?
- Has the QC program undermined the federal, state, local partnership in the AFDC program?

The AFDC program, authorized by Title IV of the Social Security Act (42 U.S.C. 601-676), provides for direct cash assistance and social services to needy dependent children and their parents or other relatives. The program is intended to encourage the care of children in their own homes or in relatives' homes, to maintain and strengthen family life, and to help parents and relatives gain or retain the capacity for self-support.

Amounts of AFDC grants vary depending on need based on such factors as family size, income, and resources. AFDC is one of the largest federally aided, public assistance

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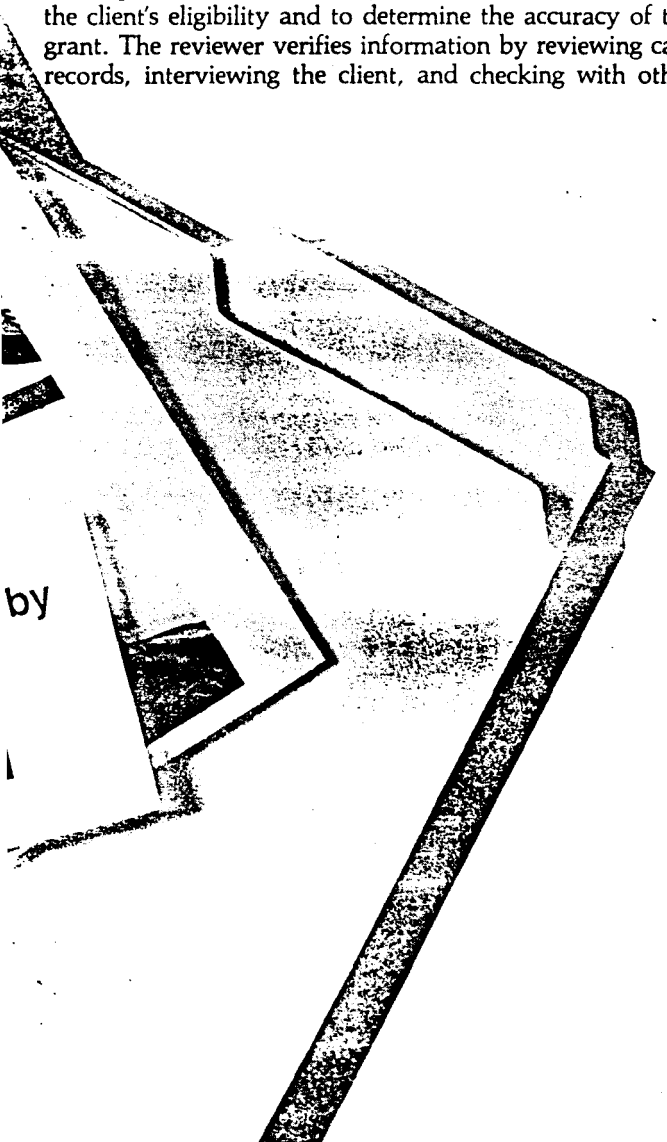
programs providing help to about 3.6 million families in fiscal year 1983. Program payments amounted to about $13.4 billion in that same year with the federal share being about $7.3 billion.

Any program with such vitality obviously would have a point at which the error rate is irreducible.

The QC system is operated primarily by state QC staffs with review by the Department of Health and Human Services (HHS) regional QC staffs. HHS oversees the program and compiles national error-rate statistics. Each state is required to select and review a statistically valid sample of its cases every six months. The size of the samples varies from about 150 cases in states with fewer than 10,000 cases to approximately 1,200 in states with more than 60,000 cases.

Sample cases are checked by state QC reviewers to verify the client's eligibility and to determine the accuracy of the grant. The reviewer verifies information by reviewing case records, interviewing the client, and checking with other (collateral) sources such as neighbors, landlords, banks, and employers.



Each state compiles the results of its review and computes both case and payment error rates in three categories: payments to ineligible families, overpayments to eligible families, and underpayments to families who are eligible. A sample of denials and terminations of grants also is reviewed but not in such depth as are active cases.

HHS checks a subsample of cases, and the results are combined with those of the state to determine the official error rate for that state.

Each state is required to develop a plan to correct the causes of the identified errors. The plans may include appropriate training for eligibility staff, revisions in program procedures, or changes in program requirements.

The 1970 regulations set error-rate limits at 3 percent for ineligibility, 5 percent for overpayments, and 5 percent for underpayments. The penalty for failure to meet the tolerances was to be termination of federal funding.

Eighteen states were cited during 1971 and 1972 for noncompliance with the new regulations, that is, for failing to complete the required sampling. The recalcitrant states apparently felt the ultimate penalty, program termination, would not be imposed and their assumptions proved to be valid. No punitive action was taken.

Then the emphasis of the program shifted. In 1973, the federal government quickly changed the QC focus from that of a management tool for corrective action to one of imposing fiscal sanctions on state and local governments for overpayments to clients. States that failed to reduce case error rates to 3 percent for ineligibility and 5 percent for overpayments were to be penalized based on error rates in the July through December 1975 sample period.

In 1975, fourteen states challenged the legality of the sanctions regulation in court. The court ruled that HHS could impose sanctions, but that the 3 percent and 5 percent error tolerances were arbitrary and capricious and, therefore, unenforceable.

In 1979, HHS proposed a new sanctions regulation. Federal funds were to be withheld for erroneous payments, and states were to be sanctioned if they were above the median error rate for all states and had not reduced their payment error rate from the previous QC period by 6.4 percent. The 6.4 percent figure represented the national error-rate reduction that had been achieved between the January-June 1976 and July-December 1979 sample periods. The new regulation committed HHS to conducting a study to determine the ultimate error-rate goal. To date, the study has not been completed.

In its report on a fiscal year 1979 supplemental appropriations bill, the House-Senate conferees directed that HHS issue regulations requiring states to reduce the AFDC payment error rate to 4 percent by September 1982 or lose federal matching funds associated with erroneous payments in excess of the target. In January 1980, HHS issued final rules to implement the sanctions directive. After intensive lobbying by the states in late 1983, House and Senate conferees met to discuss a delay of the sanctions until fiscal year 1986. In June 1984, the conference panel decided against the delay.

The New York Experience

The number of cases and their dollar amounts of underpayments in New York State have been relatively insignificant. Overpayments, both totally ineligible and incorrectly budgeted cases, have been significantly higher and the dollar amounts have been at least four times those of underpayments. (See Table 1.)

From July through December 1973, the first QC period, the overpayment error rate in the state was 26 percent. New York steadily reduced its rate until the October 1982 through March 1983 period when it had dipped to an all-time low of 6.1 percent. For the last two years, the error rate has hovered between 6 and 8 percent. The error-rate declines attest to the apparent phenomenal success New York State and its local districts have achieved as a result of vigorous efforts to reduce errors.

The cost to make any system error-free moves toward a point of diminishing returns when its cost exceeds that of the benefit to be derived.

Persons with basic understanding of the AFDC program know well the complexities of regulations, which are subject to constant change. They know, too, of the attendant reliance on the human factor (client and worker alike), of the key relationship to the swiftly changing political and economic scene, and of the vigorous demands imposed by the QC process itself. They understand that any program with such vitality obviously would have, even under perfect conditions, a point at which the error rate is irreducible. Reasonable persons also know that any program is subject to error and that the cost to make any system error-free moves toward a point of diminishing returns when its cost exceeds that of the benefit to be derived. The AFDC program is no different. The sanctions formula, however, does not take into account the added administrative costs incurred in reducing errors.

Whether the phenomenon of the last two years, in which the error rate in New York State remained in the 6 to 8 percent range, represents either the irreducible minimum or the point of diminishing returns is a subject for debate. But it *is* a subject for debate.

The current administration equates QC overpayment rates with administrative efficiency. Its position is that it does not want to participate in the cost of those benefits erroneously paid because of administrative inefficiency. In assessing this posture, it may be helpful to remember that the AFDC program, just as other similar benefit programs, relies heavily upon information provided by clients. In fact, an estimated two-thirds of the payment error rate is attributed to client error and the balance attributed to the agency. (See Table 2.)

While the QC program hardly qualifies as a measure of agency administrative efficiency, how does it stack up as a measure for evaluating the effective and efficient delivery of the AFDC program?

A respected Broadway critic would be reluctant to write a critique of a three-act play based only on the first scene of the first act. Similarly, QC cannot be viewed as a system that evaluates the effective and efficient delivery of a family assistance program such as AFDC. QC does provide data on misspent money, and congressional and White House interest in QC focuses almost exclusively on this factor – a fiscal consideration on which social programs can never be solely judged. Federal emphasis on QC and state and local preoccupation with the related sanctions appear to stifle the development and/or use of appropriate measures to improve program effectiveness. QC in no way helps answer these questions relating to AFDC goals: Does the program encourage the care of children in their own homes or in the homes of relatives?

Table 1. New York State AFDC Overpayment and Underpayment Dollar Error Rates by Quality Control Period

Period		Rates	
		Overpayments	Underpayments
July-December	1973	26.0	1.7
January-June	1974	23.6	1.7
July-December	1974	21.7	2.6
January-June	1975	15.4	2.7
July-December	1975	15.7	1.9
January-June	1976	13.2	2.1
July-December	1976	12.4	1.2
January-June	1977	10.6	1.7
July-December	1977	10.9	1.6
January-June	1978[a]	11.5	1.2
April-September	1978[a]	9.0	1.3
October 1978-March	1979	8.8	1.7
April-September	1979	9.0	1.7
October 1979-March	1980	6.4	1.5
April-September	1980	8.8	1.6
October 1980-March	1981	8.7	1.7
April-September	1981	8.6	1.4
October 1981-March	1982	7.2	1.5
April-September	1982	6.6	1.1
October 1982-March	1983[b]	6.1	0.6
April-September	1983[b]	7.8	0.8

[a] Overlapping period during which quality control cycle changed to coincide with federal fiscal years.

[b] Preliminary

Source: New York State Department of Social Services.

Does the program maintain and strengthen family life? To what extent does the program help parents and relatives gain or retain the capacity for self-support? Does it reduce the cycle of poverty?

In a program such as AFDC, social and organizational costs cannot be excluded from consideration. The social cost of underpayments should be of major concern in AFDC, a program designed to help needy families. QC emphasizes overpayments but pays scant attention to applicants who are denied assistance or to clients whose grants are decreased.

Because of the apparent lack of data on effective performance, a panel convened by the National Research Council has urged HHS to develop, collect, and disseminate measures of performance in the delivery of family assistance (*Family Assistance and Poverty: An Assessment of Statistical Needs*, National Academy Press, 1983). The panel recommended that particular attention be paid to comparability across states of *positive* measures of program effectiveness and services delivered.

But what of the comparability of the *negative* measures of QC results as a valid measure of efficiency from state to state?

A State by Any Other Name . . .

Because HHS sanctions state and local governments for the value of federal funds erroneously paid, those with high error rates must pay a relatively larger penalty than those with low rates. The most recently published error rates range from 1.1 percent in Montana and 1.3 percent in North Dakota to 17.6 percent in the District of Columbia. (See Table 3.) Such disparate results, however, may not necessarily suggest inefficient administration.

Several theories have been advanced to account for the wide variance in error rates.

- States that use flat grants are likely to have lower error rates than those that tailor grants to special needs.
- A General Accounting Office (GAO) study of QC in six states (California, Hawaii, Indiana, Maine, Maryland, and New York) found that the client's word was accepted in most cases in California; but in Indiana and New York, reviewers verified the client's word with from one to eleven collateral sources.[1]
- GAO found similar variations in the federal reexamination of states' reviews from region to region.
- The statistical validity of the results varies depending on the size of the sample and universe of cases. In New York, with an 8.8 percent error rate, using a 95 percent confidence level, the actual rate of error would be somewhere between 5.8 percent and 11.8 percent. In Wisconsin, with a 10.4 error rate, using the same confidence level, the rate could range from 5.5 to 15.2 percent.

HHS's own nationwide analysis presents a mind-boggling array of data showing the complexities and varieties of error causes. For example, the most recent analysis for the October 1980 through March 1981 period suggests that *perhaps* AFDC error rates in urban areas within which the program operates have a more than casual effect on state error rates. A special analysis shows that, with the exception of California's Los Angeles County, overpayment error rates in each of the other nine of the ten largest urban welfare locations increase the statewide rates significantly.

New York City is a case in point. Its AFDC caseload, concentrated in 301 square miles, exceeds the combined caseload of 19 other states comprising 1,743,000 square miles. This comparison raises questions about the effect of caseload on error rates.

But if the QC process is a valid measure neither of program effectiveness nor of relative efficiency from state to state, just what kind of program administration does the federal government seek to foster with its sanctions mechanism?

Table 2. Percentage of Case Errors Attributed to Agency or Client

	Agency Errors	Client Errors
April-September 1973	48.6	51.4
January-June 1974	49.4	50.9
July-December 1974	49.4	50.6
January-June 1975	Not available	
July-December 1975	51.3	48.7
January-June 1976	50.9	49.1
July-December 1976	51.1	48.9
January-June 1977	52.8	47.2
July-December 1977	51.3	48.6
January-June 1978	54.3	45.7
April-September 1978	61.2	38.8
October 1978-March 1979	Not available	
April-September 1979	Not available	
October 1979-March 1980	54.5	45.4
April-September 1980	53.0	47.0
October 1980-March 1981	51.7	48.3
April-September 1981	52.3	47.7

Percentage of Payment Error Rate Attributed to Agency or Client

	Agency Errors	Client Errors
April-September 1973	33.3	66.7
July-September 1975	34.1	65.9
January-June 1976	31.3	68.8

NOTE: The Department of Health and Human Services ordinarily does not report the percentage of *payment* error attributed to the agency and client. As these data show, during the periods in which case errors were about 50 percent for both clients and the agency, the payment errors were attributed one-third to the agency and two-thirds to the client. Quality control workers report that the average values of individual case payment errors attributed to clients are ordinarily higher than those attributed to the agency.

Source: Department of Health and Human Services, nationwide data.

All Field, No Hit

The Minnesota Twins ended up in first place in the American League in 1965, seven games in front of second-place Chicago and twenty-five games ahead of the sixth-place Yankees. The pennant was the first for the team, transplanted from Washington, in thirty-three years – and the first ever for Minnesota fans. Everyone was elated, and it did not seem to matter that the team had more errors than any of the twenty teams of both leagues and the worst fielding average. Among the ten American League teams the Twins had amassed the most runs and had the best team batting average. They were first in the most telling statistic of all, percentage of wins.

In a startling reversal of form, the Twins made fewer errors in the World Series than the National League Dodgers. Some baseball buffs theorized that the manager, in preparing the team for the series, emphasized fielding proficiency rather than the strong points that had led the team to success. This would have been alright. The Twins did have fewer errors than the Dodgers in the series, but the Dodgers had more hits and captured the series in seven games.

Baseball's key measure of success is indisputable. But the measures in programs such as AFDC are not so well-defined. Because of intangible goals spelled out in authorizing legislation, agencies are hard-pressed to devise appropriate ways to gauge successful performance. Unlike baseball managers with their win percentages, government managers are unable to claim success because they lack appropriate measures. (See "Measuring Up" by Reginald Carter in this issue of PUBLIC WELFARE.)

Detrimental Effects

While the threat of QC sanctions motivates states to reduce overpayments, scant attention is paid to detrimental effects in other areas. A study of the QC process and administrative strategies employed by Massachusetts to reduce its payment error rate from 1978 to 1980 shows that, under the pressure of productivity quotas and stringent quality assurances reviews, workers made excessive demands on clients to document their eligibility; but management made no effort to monitor the reasonableness of worker demands.[2]

The study reports a substantial increase during the period in

- fair hearing decisions that sustained client challenges of denials for procedural noncompliance, and
- "churning" of clients (the termination from and rapid reinstatement to assistance rolls) until they could complete procedural requirements.

A reported "churning" phenomenon was investigated in New York City by the New York State Department of Social Services. In 1984 the department found that the New York City Human Resources Administration had significant problems in some of its efforts to cut ineligibles from the welfare rolls. There was an "unacceptably high" rate of erroneous administrative closings – 25 percent in the March 1983 test month – made contrary to regulation and despite the fact that clients had met the requirements for which their cases were closed. Another 30 percent of the closings were made in accordance with regulations but reopened quickly, suggesting that clients remained needy while their cases were closed.

Explaining how he thought these closings had come about, New York State Commissioner Cesar Perales said

> In light of phenomenal public assistance caseload growth during the 1970s, the federal government imposed numerous requirements for verification of need by welfare recipients and Congress enacted fiscal penalties for states who erred in paying benefits to ineligibles. In order to avoid sanctions and make sure only those in need receive help, states ordered face-to-face certifications, periodic mail surveys, and prompt closing procedures. Although these actions were effective in New York State in decreasing the payment error rate from a high in 1973 of 26 percent to eight percent in 1983, they too often result in the interruption of benefits for individuals who obviously need assistance.

Providing benefits to individuals who need help is, after all, one of the key goals of the AFDC programs. The commissioner promised to review the city's performance within a year to assure that such errors have been minimized.

The federal government quickly changed the QC focus from that of a management tool for corrective action to one of imposing fiscal sanctions on state and local governments for overpayments to clients.

All would agree that reduction of overpayments is a worthwhile goal of the AFDC program, just as all would agree that fielding proficiency is a desirable goal in baseball. To the extent that QC keeps program managers aware of their performance in relation to that one aspect of the program, it serves a valuable purpose. As in baseball, though, overemphasis of errors tends to diminish other important, and sometimes more critical, considerations.

Few can deny that the QC process is not a valid measure of program effectiveness, and its value is limited as a relative measure of efficiency from state to state, or that its emphasis and sanctions can be detrimental to program success. The process does provide, however, some measure of accountability of state and locally administered programs. But what of comparable measures of programs that the federal government itself administers?

If It's Good for the States. . . .

In contrast to the strictly enforced QC process and relatively stringent sanctions brought against the states in the AFDC program, Congress sets no quality control standards for federally administered programs such as social security, veterans benefits, and railroad retirement benefits. These programs obviously have a more favored constituency and their clients – and, therefore, their administration – are not as socially stigmatized. The National Research Council panel reported that error rates often are not published for these programs – and perhaps not even estimated.

One notable exception is the quality assurance (QA) process under the federally administered supplemental security income (SSI) program. SSI, similar to AFDC, involves grants of federal and state monies to elderly, blind, and disabled persons in need. Since SSI's inception in 1974, and after the states insisted that the federal government be held liable for errors it caused just as the states were for AFDC errors, the federal government has measured its payment error rates. Federal regulations – not legislation – published in 1979 set out rules governing federal fiscal liability (FFL) to states above certain tolerance levels.

Table 3. AFDC Quality Control October 1981 – March 1982 Payment Error Rates

State	Rate	State	Rate
U.S. Average[a]	7.3		
Alabama	5.5	Montana	1.1
Alaska	12.9	Nebraska	5.9
Arizona	11.6	Nevada	1.5
Arkansas	8.8	New Hampshire	5.8
California	7.4	New Jersey	9.4
Colorado	5.2	New Mexico	11.9
Connecticut	5.3	New York	6.8
Delaware	10.6	North Carolina	3.7
District of Columbia	17.6	North Dakota	1.3
Florida	6.3	Ohio	7.9
Georgia	4.8	Oklahoma	4.7
Hawaii	8.7	Oregon	7.3
Idaho	4.7	Pennsylvania	9.4
Illinois	7.7	Puerto Rico	9.7
Indiana	3.5	Rhode Island	6.2
Iowa	4.1	South Carolina	9.4
Kansas	5.6	South Dakota	3.8
Kentucky	3.4	Tennessee	5.6
Louisiana	6.4	Texas	8.8
Maine	5.3	Utah	5.4
Maryland	9.1	Vermont	5.7
Massachusetts	5.5	Virgin Islands	[b]
Michigan	9.0	Virginia	3.3
Minnesota	3.1	Washington	7.4
Mississippi	5.0	West Virginia	8.1
Missouri	6.1	Wisconsin	8.0[c]
		Wyoming	3.8

[a] Weighted average
[b] Incomplete data
[c] Weighted average based on previous three quality control periods

Source: Department of Health and Human Services, Office of Family Assistance. (Release dated November 17, 1983.)

Fiscal sanctions create an adversary relationship between the federal government and the states when a cooperative effort is needed to reduce error.

In April 1984, however, HHS proposed in the *Federal Register* to terminate the determination and payment of FFL after October 1, 1984. HHS cited, among other reasons for stopping the process, its success in administering the program. The department stated that, as it gained experience, it made fewer errors with the payment error rate declining from a high of 11.5 percent in January through June 1975 period to 5.2 percent in April through September 1977 and holding at about the 5 percent mark since that time. HHS reasoned further that the termination would "promote more efficient and economical administration" because the cost of program administration, added to the cost of the QA process, far exceeded the amount of FFL payments to states. While admitting to a nationwide error rate of 5 percent, HHS concluded that it had demonstrated its "successful efforts to administer state funds in a proper and responsible manner." Cannot the same judgements be made about the states' administration of AFDC, a program whose nationwide error rate declined from 16.5 percent in 1973 to about 7 percent today, whose clients are so much more mobile and subject to greater changes in living circumstances?

An interesting analogy can likewise be drawn between the AFDC program and a program operated by the Internal Revenue Service (IRS). In response to a request from the author, IRS advised that it randomly selects returns to determine the potential tax liability if it examined all returns. Called the taxpayers compliance measurement program (TCMP), it is used to ascertain the "tax gap," which refers to all revenue lost to the U.S. Treasury because potential taxpayers do not comply with the tax laws.

IRS relies heavily upon data provided by the client (taxpayer) as do the states for AFDC. Almost identical to QC, TCMP uses sampling techniques to measure taxes not paid. Again, similar to QC, the major part of the TCMP error rate is attributed to incorrect client (taxpayer) reporting.

Zorro Makes His Mark

Zoilo ("Zorro") Versalles, shortstop for the Twins, had more errors in the 1965 season than any other player in both leagues. When discussing his salary for 1966, did the general manager (GM) attempt to penalize him for the errors he made? If he did, it probably went something like this.

GM: Zorro, you're gonna hafta take a salary cut. You had more errors this season than any player in the majors. You bobbled one out of every twenty chances.

Zorro: I know how you feel about those errors, but. . .

GM: I've told you over and over again, Zorro. And it's not just me. The owners are on me all the time about errors. I'm under the gun.

Zorro: But why are you picking on me? What about the other players?

GM: They're gonna hafta take their cuts, too — Killebrew and Rollins and Olivia and practically all the rest. The new men might escape the cuts. They didn't have many errors.

Zorro: Yeah, but you understand this game. Those guys being cut are heavy hitters like me. We're starters. Shortstop is a tough position and Rollins is in the hot corner. Sure, the new guys didn't have errors; but they're not regulars like us — in there every day.

GM: Listen, Zorro. We're in bad shape financially. In the red. Twenty percent of the season ticket holders haven't paid their bills, and salaries hafta be cut.

Zorro: Yeah, but why just us? What about the guys in charge of collections? Can't they get the ticket holders to pay what they owe? Us players — we have our families to think about, and prices are going up all the time.

GM: We gotta take chances to get a strong defense. The Yanks had a bad year, but they still have Mantle and Maris. They could annihilate us next year. And we can't pressure season ticket holders. There are other considerations.

Zorro: But I had more home runs and runs batted in than Mantle and Maris. They're not as strong as they used to be.

GM: Stick to the point, Zorro. The errors.

Zorro: Okay. But errors are only part of this game. We gave you and the owners and the fans what you wanted. A winner! We won the pennant! And I sure did my part. I led the league in double plays and the majors in doubles and most runs scored. Those should be considerations.

GM: But the errors.

Zorro: Yeah, but I also led the league in total bases. I had a lot more home runs and runs batted in than any other shortstop in the majors. Those should be considera —

GM: Now wait a minute, Zorro. I know all that. The thing is we have to do something about the errors. . . .

In 1982 testimony before the Senate Subcommittee on Oversight of the Internal Revenue Service, IRS Commissioner Roscoe L. Egger, Jr. testified that most taxpayers were conscientious and the system was basically sound and reliable. He stated that income tax reported voluntarily, without enforcement efforts, was 80 percent of the amount owed. He further reported that in recent years revenue lost to the U.S. Treasury through noncompliance with the tax laws, the "tax gap," had "reached alarming levels" from $31.5 billion in 1973 to $95 billion in 1981. The commissioner estimated that by 1985, if no changes are made, the tax gap would reach $133 billion.

The "administrative inefficiency" of the IRS, hovering around the 20 percent mark, is almost three times the most recently published 7 percent of AFDC estimated overpayments experienced nationwide. (See Table 3.) With a 7 percent AFDC overpayment rate in the six months beginning October 1981, the federal share of AFDC benefits erroneously paid would amount to about $574 million annually ($8.2 billion × 7 percent), a far cry from the estimated 20 percent or $95 billion tax gap for 1981. Coincidentally, the third-ranking category in unpaid taxes for 1981 was $8.2 billion due for unreported and underreported dividends and interests. That item alone would have paid the entire federal share of AFDC program costs during the same period. State and local "administrative inefficiency" begins to pale when compared with federal "administrative inefficiency."

Society's commitment to collect taxes appropriately due and obviously needed to operate essential government programs should be no less than its commitment to provide resources to those families most in need. The support given to the appropriate level of government should not be based only on efficiency.

The questionable value of QC as a measure of program effectiveness or as a measure of program efficiency from state to state, its overemphasis on but one aspect of the program to the possible detriment of other more important aspects, and the apparent reluctance of the federal government to submit its programs to similar measurements lead one to ask: what about the federal, state, and local government partnership in the AFDC program?

The Jury Is Still Out

Some view the federal budget as signaling incremental changes in fiscal and social policy. Such has not seemed to be the case with the first three budgets of the Reagan administration. Rather, the Reagan budgets have been skillfully constructed to bring about fundamental changes in public policy. One of those changes is a none-too-subtle withdrawal of federal support of social ser-

vices programs with a shifting of the financial burden from the federal to state and local governments. The QC sanctions simply represent a part of that shift.

As previously discussed, accountability based strictly on fiscal considerations can limit an organization's ability to meet the valid objectives of the program it administers. Such accountability heightens political struggles and can limit organizational discretion, cooperation, and flexibility.

In a 1980 report to the Senate Finance Committee, the GAO recommended that the federal government discontinue fiscal sanctions against states based on AFDC error rates. To support its position, GAO made two important points.

- Fiscal sanctions create an adversary relationship between the federal government and the states at a time when a cooperative effort is needed to reduce error. Using the QC system as the basis for sanctions limits the system's value as a means of improving payment processes.

- Because a high error rate will result in sanctions, there is an incentive to identify fewer errors. To be most effective, the QC system should identify as many errors as possible. This will give management more information to develop corrective action plans.

Echoing a similar theme, at 1979 hearings before the Senate Subcommittee on Public Assistance, Barbara Blum, then commissioner of the New York State Department of Social Services, stated:

> Under threat of sanction, it would not be surprising if states reduced the rigor of quality control procedures. While this approach could protect us from penalties, it would subvert the very purpose of the quality control program. Imposition of sanctions for payment errors above arbitrarily defined standards could have serious financial consequences for New York State.
>
> Of equal importance is the potential damage to programs designed to provide essential services to low income persons.

The QC process alone is not a viable measure of the effectiveness of the AFDC program. Its value as a fiscal sanctioning device is highly suspect, and it is likely to divert attention from other important aspects of the AFDC program involving as yet unidentified costs to clients and to society as a whole.

The federal government has experience in administering comparable programs of its own and is unlikely to want to be held to similarly rigorous tolerances.

With today's fiscal troubles, states can no more afford the costs of high overpayment rates than they can afford loss of federal funds due to sanctions. In order for the partnership to remain intact, the Congress should take the GAO recommendations to heart and make the necessary changes. PW

John Wrafter is the director of audit operations in the Office of Audit and Quality Control, New York State Department of Social Services.

For "Notes and References," see back of magazine.

Exhibit 2
2-6-85

DEPARTMENT OF SOCIAL & REHABILITATION SERVICES

RAVALLI COUNTY OFFICE OF HUMAN SERVICES

TED SCHWINDEN, GOVERNOR

310 NORTH THIRD STREET

STATE OF MONTANA

(406) 363-1944

HAMILTON, MONTANA 59840

AFDC & AFDC-MEDICAL

_____ has an appointment on _____ at _____ am/pm
The application should be completed before your interview. If you are late it is possible that you will not be seen that day, but will have to have your appointment rescheduled.

To determine eligiblity for assistance, we MUST have the following documents as they apply to your case.

1. IDENTIFICATION
   - -Drivers License
   - -Birth Certificates
   - -Social Security Cards (For all family members)

II. INCOME:
   - -Child Support Verification
   - -VA Benefits Verification
   - -SS Benefits Verification
   - -Any Other Determined Benefits Verification
   - -Wage Slips or Statement from Employer
   - -UC Verification Unemployment Benefits
   - -Closure Letter from Other State or County
   - -Escrow Payments
   - -Family Contribution

III. RESOURCE:
   - -Equity value on vehicles
   - -Checking Account Statement-Current
   - -Savings Account Statement-Current
   - -Life Insurance Policies
   - -CD Numbers, Face Value, Interest accumulated
   - -Vehicle Registrations
   - -Stocks, Bonds, Mutual Funds
   - -Mineral Rights
   - -Contract for Deed & Real Estate Other than Home

IV. MARITAL STATUS:
   - -Separation Statements
   - -Marriage Licenses
   - -Divorce Decrees
   - -Other

V. EXPENSES:
   - -Rent Receipts or Statement
   - -Mortgage Payments
   - -Child Care Receipts

VI. MEDICAL:
   - -Proof of Disability or Doctor Referral
   - -Pregnancy Verification
   - -Hospital/Medical Insurance

If verification and documentation is not readily available by your appointment date, bring in what you have and additional time will be given to you to obtain the items still needed. If you fail to keep your appointment without notifying our office (363-1944/45), we will consider that you are not interested at this time, but will reapply at a later date.

SRS–PA–1(e)
(rev. 9/78)

MONTANA DEPARTMENT OF SOCIAL & REHABILITATION SERVICES
Economic Assistance Division

FACE SHEET

County: _____
H. H. No: _____
Date: _____
Phone: _____

SURNAME: _____ FIRST NAME: _____

CROSS REFERENCES: _____

MEMBERS OF HOUSEHOLD

NAME	BIRTH–DATE	BIRTHPLACE	RELAT.	RACE	RELIGION	EDUC.	SOC. SEC. NO.	VETER. STATUS	CENSUS NUMBER
Man									
Woman									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
Deceased Spouse									

CURRENT ADDRESS

STREET & NUMBER	CITY	COUNTY	STATE	FROM	TO

FAMILY STATUS

☐ Single ☐ Divorced ☐ Married ☐ Deserted ☐ Widowed ☐ Separated ☐ Other

MAIDEN NAME	MARRIAGE			TERMINATION		
	DATE	TOWN	STATE	DATE	TOWN	STATE
Present Marriage:						
Former Husband (name)						
Former Wife (name)						

Court Stipulations (support orders, custody, etc.) _____

Other agencies or persons interested: _____

RELATIVES

NAME	ADDRESS	RELATION.	NAME	ADDRESS	RELATION.

SRS—EA—1A
(Rev. 8/83)

APPLICATION
REDETERMINATION FOR ASSISTANCE

▶ *PLEASE PRINT CLEARLY* ◀ H. H. No. ____

COLUMNS: A	B	C	D	E	F	G
Print the names of all persons who live in your present household: First / Middle Initial / Last	Birthdate Mo./Day/Yr. and Birthplace	Sex M/F	Relationship to Applicant	Social Security Number and Indian Enrollment Number	Full Time Student? Yes or No	Child Support Code See Item 22 Below
1. (Man)	/ /			SSN / IE		
2. (Woman) (Maiden)	/ /			SSN / IE		
3.	/ /			SSN / IE		
4.	/ /			SSN / IE		
5.	/ /			SSN / IE		
6.	/ /			SSN / IE		
7.	/ /			SSN / IE		
8.	/ /			SSN / IE		
9.	/ /			SSN / IE		

TO LIST ANY ADDITIONAL PERSONS WHO LIVE IN YOUR HOUSEHOLD, ASK FOR PAGE 2A, FORM **EA—1A**

22. COLUMN G ENTRY: Print one of the following code letters that shows the reason why the parent cannot support each Child that is listed above. If both Parents are in the home, pick the code that applies to the Father. If there is an absent parent, choose the code letter that applies to the absent parent.

CODE:
1. Separation (SP)
2. Unemployed Parent (UP)
3. Divorce (DV)
4. Unmarried—Paternity (PE) Established

CODE:
5. Desertion (DS)
6. Incapacity (IC)
7. Medical Institution (MI)
8. Unmarried—Paternity (NE) Not Established

CODE:
9. Jail, or Prison (JP)
10. Death (DE)
11. Armed Forces (AF)
12. Deported (DP)

23. If the parent is absent from the home, how long has he been gone? ..... months

24. Are there any members of your household that do NOT need assistance? ☐ Yes ☐ No
If "YES," list their names here: .....

.....

25. Have you received any money from any other Welfare Agency in the last 4 months? ☐ Yes ☐ No
When: Mo. ..... Day ..... Yr. ..... Where .....

26. Do you intend to make your home in Montana? ☐ Yes ☐ No How long in present county ..... Months
County of Legal Residence ..... Current Address .....

27. MONTHLY EXPENSES:

RENT:	$	**MORTGAGE PAYMENT:**	$	**WATER:**	$
LIGHTS:	$	**TAXES:**	$	**SEWER:**	$
HEATING FUEL:	$	**TELEPHONE:**	$	**OTHER:**	$
MEDICAL PAYMENT	$	SUPPORT and ALIMONY	$		

40. Are you currently registered for work at the local employment office? ☐Yes ☐No

41. Have you filed for unemployment, or workmen's compensation? ☐Yes ☐No

42. Have you been out of work for 30 days, or more? ☐Yes ☐No

43. Have you refused a job in the last thirty days? ☐Yes ☐No

44. Are you currently working 100 hours, or more, in a month? ☐Yes ☐No

45. If your answer to 44 was YES, list the details here: .....

46. *EMPLOYMENT HISTORY FOR THE LAST 3 YEARS. (List the most recent employer first.)*

DATA FOR APPLICANT					DATA FOR SPOUSE OF APPLICANT				
Employer's Name	City	State	From	To	Employer's Name	City	State	From	To

50. **LISTING OF ASSETS.** Print the estimated dollar ($) value of the assets listed below that YOU, OR YOUR SPOUSE, OR ANY OTHER MEMBER OF YOUR HOUSEHOLD possess. If YOU, or any member of your household DO NOT HAVE the asset listed below, then place a ✓ in the column marked "NONE." Personal clothing and household furniture should not be listed below. An entry is required for each asset line.

ASSETS	✓NONE	Yours	Spouse	Others	ASSETS	✓NONE	Yours	Spouse	Others
Checking Account(s)		$	$	$	Automobile No. 1		$	$	$
Savings Account(s)		$	$	$	Automobile No. 2		$	$	$
Money NOT in a Bank		$	$	$	Truck		$	$	$
Credit Union Shares		$	$	$	Trailer or Camper		$	$	$
Savings Bond(s)		$	$	$	Boat or Snowmobile		$	$	$
Retirement Fund		$	$	$	Motorcycle		$	$	$
Stocks or Bonds		$	$	$	Tools, hand & powered		$	$	$
Burial Funds		$	$	$	Farm/Business Equipmt.		$	$	$
Real Estate Used as Home		$	$	$	Livestock or Poultry		$	$	$
Other Real Estate		$	$	$	Safety DP, CD, etc.		$	$	$

51. Do you, or your spouse, have any life insurance? ☐Yes ☐ No Company .....

Face Value $..... Cash Value $..... Policy No.....

52. In the last 2 years, have you, or any member of your household, sold or given away, a house, building, real estate, or other property to another person(s)? ☐ Yes ☐ No

If your answer is "YES" list the details in item 80, supplemental page.

60. INCOME LISTING. Print the amount of money received by YOU, YOUR SPOUSE, or any other member of your household in the correct column, below. If you DO NOT RECEIVE income from the sources listed below, make a ✓ in the "NONE" column. For any income that you receive but is not listed in column A, below, print the amount in the line marked "ANY OTHER INCOME."

A	B	C	D	E	F
TYPES OF INCOME	✓NONE	YOURS	SPOUSE	OTHERS	How Often Received
UNEMPLOYMENT COMPENSATION		$.	$.	$.	
WORKMEN'S COMPENSATION (IA)		$.	$.	$.	
SOCIAL SECURITY BENEFITS		$.	$.	$.	
RAILROAD RETIREMENT		$.	$.	$.	
VETERANS ADMINISTRATION BENEFITS		$.	$.	$.	
RETIREMENT OR PENSION INCOME		$.	$.	$.	
ARMED FORCES ALLOTMENT		$.	$.	$.	
ALIMONY AND CHILD SUPPORT		$.	$.	$.	
RELATIVE CONTRIBUTIONS		$.	$.	$.	
INCOME FROM MORTGAGE, or Sales Contract		$.	$.	$.	
RENT FROM REAL ESTATE PROPERTY		$.	$.	$.	
INCOME FROM ROOMERS, or Boarders		$.	$.	$.	
INTEREST FROM SAVINGS ACCOUNT		$.	$.	$.	
MONEY FROM INDIAN TRIBAL FUNDS B.I.A., and/or I.I.M.		$.	$.	$.	
OIL OR MINERAL BENEFITS		$.	$.	$.	
ANY OTHER INCOME		$.	$.	$.	

If you expect to receive income from any of the above sources, explain in Block 80.

COMPLETE THIS SECTION IF ANY MEMBER OF HOUSEHOLD IS EMPLOYED

61. GROSS PAY (Before Deductions)		$.	$.	$.	
62. List your **REQUIRED DEDUCTIONS,** but only if you entered Gross Pay above.					
a. Income Taxes (Federal)					
b. State of Montana Taxes					
c. Social Security					
d. Other required deductions; Union Dues, Medical, etc.					
e. Transportation to and from work					
f. Other work deductions, uniforms, etc.					
g. Retirement					

63. If you are self-employed, we will need a copy of your last income tax return.

70. If the Applicant, or Spouse, is *unable* to work, list the reason(s) here: .....

.....

71. If any member of your household is pregnant, list the name of the person: .....
and expected date of birth: .....

72. Is any member of household currently covered by Health, Accident, or Hospital Insurance? If "YES" enter the company name here: ..... ☐ Yes ☐ No

73. Is another person, or company, responsible for medical care that you or any member of your family is receiving, or has received? ☐ Yes ☐ No

74. Do you owe money for medical care that you, or any family member received in the last three months? ☐ Yes ☐ No

75. Do you make regular payments on medical bills, or medical insurance premiums? ☐ Yes ☐ No

If "YES", provide payment information below:

	AMOUNT PAID	PAID HOW OFTEN
a. Medical Bills (Doctor or Hospital)		
b. Health, Accident or Hospital Insurance		
c. Prescribed Medication		
d. Any other medical expense(s)		

76. Responsible relative

NAME	ADDRESS	RELATION

80. Use this block for additional details, or explanation of previous blocks: .....

.....

.....

.....

.....

.....

90. BE SURE THAT YOU HAVE ANSWERED ALL QUESTIONS ON FORM EA-1, AND PAGES 2 TO 5, FORM EA-1A. READ CAREFULLY THE FOLLOWING STATEMENT BEFORE YOU SIGN:

I declare that this statement has been examined and filled out by me, and to the best of my knowledge and belief is true, accurate and complete. I understand that any misstatement will be investigated and prosecuted. I further declare that I will promptly report to the Welfare Department all facts concerning any income or sources received by me and/or my dependents and any change of circumstances whatever of myself and/or dependents for whom I have applied for assistance.

I understand I can appeal for a fair hearing to the State Department of Social Rehabilitation Services if I am not satisfied with the promptness of the action on my application, with the decision, or with the amount of assistance which I receive.

I have been informed of the availability of Family Planning and early screening and may have these services by contacting the County Welfare Office.

I understand that this Declaration of Facts may be investigated by the Department of Public Welfare and I agree to cooperate by signing EA-4 and EA-29 and help in such an investigation by presenting proof of the statements I have made in this Declaration.

I hereby authorize all medical providers to provide and release any medical information pertaining to myself, or any other person for whom I am applying for assistance, to the State Department of Social and Rehabilitation Services, the State Department of Revenue, and their agents, upon their request, and hereby release said medical providers from any liability based on such release.

Benefits and services must be provided without regard to race, color, national origin, religion, political belief, age, handicap, sex or marital status. I understand I may file a complaint with the State Department of Social and Rehabilitation Services if I feel that I have been discriminated against.

(APPLICANT OR GUARDIAN – SIGN HERE)	Date	(SPOUSE OF THE APPLICANT – Sign Name Here)	Date

91. If the applicant CANNOT write, or sign his name above, a Mark will be used instead of a signature; one witness is then required to verify the applicant's Mark and complete 92 below.

92. Witness's Signature (When Required)	Date	Witness Address & Zip Code

Date _____ Worker's Signature _____

SRS—EA—4A
(Rev. 11/83)

STATE OF MONTANA
DEPARTMENT OF SOCIAL & REHABILITATION SERVICES
Economic Assistance Division

RELEASE OF CONFIDENTIAL INFORMATION

AUTHORIZATION TO MONTANA SOCIAL & REHABILITATION SERVICES TO OBTAIN PERSONAL INFORMATION

Client's Name:_____ SSN:_____

Address:_____
(STREET) (CITY) (STATE) (ZIP CODE)

I authorize the individual, company or agency shown below to disclose to the _____ County Department of Welfare of the Montana Social and Rehabilitation Services, the information specified below, which relates to my eligiblity to receive Public Assistance benefits. I understand any information obtained will be kept confidential and will be used only for purposes directly connected with the administration of benefits or services. I further understand that any information obtained may be released to a proper governmental agency or court of law enforcement agency for purposes of legal and investigative actions concerning fraud, collection of support or establishment of third party liability.

INFORMATION SOURCE: Landlords, Neighbors, Employers, Social Security Administration, Doctors, Hospitals, Veterans Administration, Bureau of Indian Affairs, Department of Labor and Industry, Assessors, Treasurers, County Clerks of Court, Banks, Credit Unions, Savings and Loans, Buyers of Contracts for Deed/Negotiable Instruments.

INFORMATION TO BE REQUESTED: Family Composition, Earned Wages, Unearned Wages, Checking Accounts, Savings Accounts, Stocks, Bonds, Time Certificates, BIA-IIM Funds, Veterans Benefits, Unemployment Compensation, Workmens Compensation, Loans, Personal Property, Mortgages, Contracts for Deed/Negotiable Instruments, Real Estate, etc. Also, Medical Reports or conditions to exempt participation in employment or County Work Program.

DISCLOSURE: Please provide information requested in space below or on back of sheet.

Signature of applicant or authorized representative:

X_____ Date:_____

SRS-EA-32(a)
(rev. 2/80)

MONTANA DEPT. OF SOCIAL & REHABILITATION SERVICES

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

ASSIGNMENT OF RIGHTS TO SUPPORT

As a condition of eligibility, any rights to support are assigned to the Child Support Enforcement Agency, Department of Revenue, as provided in Chapter 612 of Montana Law.

BENEFITS OF CHILD SUPPORT ENFORCEMENT

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

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

WHAT IS MEANT BY COOPERATION?

The law requires you to cooperate with the welfare and child support agencies to get any support owed to you and any of the children for whom you want AFDC, unless you have good cause for not cooperating.

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

- Name the parent of any child applying for or receiving AFDC, and give information you have to help find the parent;
- Help determine legally who the father is if your child was born out of wedlock;
- Give help to obtain money owed to you or the children receiving AFDC; and
- Pay to the State any money which is given directly to you by the absent parent (you will continue to get your full AFDC grant
- from the State).

You may be required to come to the welfare office, child support office, or court to sign papers or give necessary information.

WHAT IS MEANT BY GOOD CAUSE?

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

IF YOU DO NOT COOPERATE AND DO NOT HAVE GOOD CAUSE

- You will be ineligible for AFDC.
- Your children will still be eligible for AFDC for their own needs. Your children's grant will go to another person, called a "protective payee".

HOW & WHEN YOU MAY CLAIM GOOD CAUSE

If you want to claim good cause, you must tell your Eligibility Technician that you think you have good cause. You can do this at any time you believe you have good cause not to cooperate.

GOOD CAUSE CIRCUMSTANCES

You may claim to have good cause for refusing to cooperate if you believe that such cooperation would not be in the best interest of your child. The following are circumstances under which the Welfare Agency may determine that you have good cause for refusing to cooperate:

- Cooperation is anticipated to result in serious physical or emotional harm to the child;
- Cooperation is anticipated to result in physical or emotional harm to you which is so serious it reduces your ability to care for the child adequately;
- The child was born after forcible rape or incest;
- Court proceedings are going on for adoption of the child; or
- You are working with an agency helping you to decide whether to place the child for adoption.

PROVING GOOD CAUSE

It is your responsibility to:

- Provide the Welfare Agency with the evidence needed to determine whether you have good cause for refusing to cooperate. (If the reason for claiming good cause is your fear of physical harm and it is impossible to obtain evidence, the Welfare Agency may still be able to make a good cause determination after an investigation of your claim.)

- Give the necessary evidence to the agency within 20 days after claiming good cause. The Welfare Agency will give you more time only if it determines that more than 20 days are required because of the difficulty in obtaining the evidence.

The Welfare Agency may:

- Decide your claim based on the evidence which you give to the agency, or
- Decide to conduct an investigation to further verify your claim. If the Welfare Agency decides an investigation is needed, you may be required to give information such as the absent parent's name and address to help the investigation. The agency will not contact the absent parent without first telling you.

NOTE: If you are an applicant for assistance, you will not receive your share of the grant until you have given the agency the evidence needed to support your claim and, if requested, the information needed to permit an investigation of your claim.

EXAMPLES OF ACCEPTABLE EVIDENCE

The following are examples of acceptable kinds of evidence the Welfare Agency can use in determining if good cause exists.

If you need help in getting a copy of any of the documents, ask the Welfare Agency. The Welfare Agency will give you reasonable assistance which is needed to help you obtain the necessary documents to support your claim.

- Birth certificates, or medical or law enforcement records, which indicate that the child was conceived as the result of incest or forcible rape;
- Court documents or other records which indicate that legal proceedings for adoption are pending in court;
- Court, medical, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the alleged or absent father might inflict physical or emotional harm on you or the child;
- Medical records which indicate emotional health history and present health status of you or the child for whom support would be sought; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of you or the child;
- A written statement from a public or private agency confirming that you are being assisted in resolving the issue of whether to keep or give up the child for adoption; and
- Sworn statements from individuals, including friends, neighbors, clergymen, social workers, and medical professionals who might have knowledge of the circumstances providing the basis of your good cause claim.

CHILD SUPPORT AGENCY PARTICIPATION AND ENFORCEMENT

The Child Support Enforcement Agency may review the Welfare Agency's findings and the basis for a good cause determination in your case. If you request a hearing regarding this issue of good cause for refusing to cooperate, the Child Support Enforcement Agency may participate in that hearing.

If you are found to have good cause for not cooperating, the Child Support Enforcement Agency may attempt to establish paternity or collect support only if the Welfare Agency determines that this can be done without risk to you or your child. This will not be done without first telling you.

WHAT IF AN ABSENT PARENT IS LOCATED AND REFUSES TO PAY CHILD SUPPORT?

Your AFDC payment will continue. The Child Support Agency, which is the Department of Revenue in Montana, will seek court or other legal remedies that could result in withholding of the absent parent's property or wages to pay for child support.

I have read this notice concerning my right to claim good cause for refusing to cooperate.

_____

(Signature of applicant/recipient) **(Date)**

I have provided the applicant/recipient with a copy of this notice.

_____

(Signature of Eligibility Technician) **(Date)**

STATE OF MONTANA

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

SRS-EA-32
(New 3/81)

CHILD SUPPORT ENFORCEMENT REFERRAL

INSTRUCTIONS TO APPLICANT/RECIPIENT:
As a condition of eligibility for AFDC, you must cooperate in obtaining support for each child for whom aid is requested by completing and returning this form. Failure to do this without good cause (as outlined on the EA-32A, Right to Claim Good Cause) may result in your ineligibility for assistance. Please read each question carefully. You must answer all questions except for those to be answered by the county director (in the section headed "Good Cause") and the questions under the section headed "Grant Award." If a question does not apply to your situation, mark N/A in the blank. If you do not know the answer to a question, write – DO NOT KNOW – in the blank. *THIS FORM MUST BE RETURNED TO YOUR COUNTY WELFARE OFFICE. UNDER MONTANA LAW, APPLICATION FOR AFDC AUTOMATICALLY ASSIGNS TO THE STATE, THE RIGHT TO COLLECT SUPPORT IN YOUR BEHALF.*

FULL NAME (First, Middle, Last)	PHONE NUMBER	DATE OF BIRTH

OTHER NAMES USED (Maiden, married, etc.)	SOCIAL SECURITY NO. and INDIAN ENROLLMENT NO.

STREET ADDRESS/BOX NUMBER

CITY	COUNTY	STATE	ZIP CODE

EMPLOYER NAME AND ADDRESS

WORK PHONE NUMBER	WORK HOURS	MAY WE CONTACT YOU AT WORK?
		☐ YES ☐ NO

GOOD CAUSE

1. I have read and understand the pamphlet explaining "good cause" for not cooperating in obtaining child support.
2. I understand that my AFDC grant will be reduced if I refuse to cooperate in obtaining child support without "good cause".
3. I ☐ do ☐ do not have "good cause" for refusing to cooperate in obtaining child support.

SIGNATURE OF APPLICANT/RECIPIENT: _____ DATE: _____

As an authorized representative of the Department of Social & Rehabilitation Services, I have determined that:

☐ Good cause to refuse to cooperate exists in this case and support should not be pursued.
☐ Good cause to refuse to cooperate exists in this case. Please pursue support without cooperation.
☐ Good cause to refuse to cooperate may exist. Please do not pursue support until I can make a determination.
☐ Please pursue support.

COUNTY DIRECTOR'S SIGNATURE: _____ DATE: _____

GRANT AWARD

Date of Eligibility: _____

Opening grant amount: $_____ (1st month) Grant amount: $_____ (2nd month)

Has applicant/recipient ever received AFDC? ☐ Yes ☐ No

If yes, where: when:

SEPARATE FORM TO BE FILLED OUT ON EACH ABSENT PARENT

☐ ACTUAL
☐ ALLEGED

RELATIONSHIP BETWEEN APPLICANT AND ABSENT PARENT: **(Please check appropriate box)**

☐ MARRIED Date of marriage: _____
Married in: (city, county, court, state) _____

☐ DIVORCED OR LEGALLY SEPARATED: Date of order: _____ Court Order No. _____
Decree issued in: (city, co., court, state) _____
Attach a copy of the divorce decree and any modifications thereto.

☐ SEPARATED (No legal document of separation.)
Legal separation begun? ☐ Yes ☐ No If yes, date: _____
Divorce begun? ☐ Yes ☐ No If yes, date: _____

☐ NEVER MARRIED
☐ COMMON LAW

CHILDREN INCLUDED ON GRANT: *CODES:* Separation (SP) Unemp. Parent (UP) Divorce (DV) Unmarr.-Pater. Estab. (PE) Desertion (DS) Incapacity (IC) Med. Inst. (MI) Unmarr.-Pater. not Estab. (NE) Jail or prison (JP) Death (DE) Armed Forces (AF) Deported (DP)

Name (First, Middle, Last)	DOB/Exp. DOB	Social Security No. & IEN	Sex	Deprivation (cds. above)

TYPE OF SUPPORT ORDER: (Please check one)

Amount per month

☐ Court Order $_____
☐ Administrative Order $_____
☐ No Order Established $_____
☐ Voluntarily Agreed $_____
☐ Other (explain) $_____

STATUS OF SUPPORT PAYMENTS (Please check one)

☐ Being received regularly and in the amount ordered/agreed to.
☐ Being received regularly, but in a lesser amount than ordered/agreed to. $_____ being received.
☐ Being received irregularly: $_____.
☐ Payments not being made by absent parent.
Date of last payment _____

SUPPORT PAYMENTS MADE TO:

☐ Clerk of Court: (city, county & state) _____
☐ Recipient
☐ Department of Revenue
☐ Other (explain): _____

FULL NAME OF ABSENT PARENT (First, Middle, Last)

LAST KNOWN OR CURRENT ADDRESS (Street, City, State, Zip)

DATE LAST RESIDED THERE:	PHONE NUMBER	SOCIAL SECURITY NUMBER	AGE
DATE OF BIRTH (Month, Day, Year)	PLACE OF BIRTH (City, State)		

PHYSICAL DESCRIPTION:

Height _____ Weight _____ Color Eyes _____ Race _____
Complexion _____ Color Hair _____ Scars or Marks _____

NAME OF ABSENT PARENT'S FATHER (First, Middle, Last)

MAIDEN NAME OF ABSENT PARENT'S MOTHER (First, Middle, Last)

LIST NAMES AND ADDRESS OF HIS/HER OTHER RELATIVES/FRIENDS THAT MIGHT KNOW OF THE ABSENT PARENT'S WHEREABOUTS.

Name *Relationship*
Street or P.O. Box
City *State* *Zip*

Name *Relationship*
Street or P.O. Box
City *State* *Zip*

WHAT IS THE NAME AND ADDRESS AND POLICY NO. OF THE COMPANY WITH WHICH THE ABSENT PARENT HAS MEDICAL INSURANCE COVERAGE? (LIST NAME(S) OF CHILD(REN) COVERED.)

LIST NAMES, ADDRESSES, PHONE NUMBERS, AND APPROXIMATE DATES OF EMPLOYMENT OF LAST THREE EMPLOYERS OF ABSENT PARENT. (most recent first) Indicate with (✓) Montana employers.

NAME	*ADDRESS*	*PHONE NO.*	*DATES WORKED*

PRESENT SALARY

DID YOU FILE ANY JOINT INCOME TAX RETURNS WITH THE ABSENT PARENT? IF YES, WHAT YEAR(S) AND WERE THE RETURNS STATE OF FEDERAL? ALSO NAME THE STATE WHERE THEY WERE FILED.

DOES THE ABSENT PARENT HAVE AN ARREST RECORD? If yes, name where, when and the charge.

DOES THE ABSENT PARENT HAVE VETERAN STATUS? If yes, which? Navy, Army, Air Force, or Marine Corps.

DOES THE ABSENT PARENT HAVE THE FOLLOWING?

	YES	*NO*	
OWN ANY PROPERTY?			*Give location and description.*
DRIVER'S LICENSE?			*If so, what state and number?*
OWN VEHICLES?			*Makes, colors, states where registered, year and license number.*
BANK ACCOUNT?			*List name of bank, city and state, and type of account.*
CREDIT CARDS?			*List companies, account numbers, etc.*
OUTSTANDING LOANS?			*List bank, financial institution, account number, city and state of lending institution.*
UNEMPLOYMENT COMPENSATION?			*If yes, what state and amount?*
INDUSTRIAL COMPENSATION?			*If yes, what state and amount?*
DISABILITY INCOME?			*If yes, give details.*
RETIREMENT INCOME?			*If yes, give details.*
VETERAN'S ADMINISTRATION BENEFITS?			*If yes, ☐ school, ☐ disability state and amount?*

APPLICANT/RECIPIENT CERTIFICATION:

I UNDERSTAND THAT I MUST TURN OVER ANY CHILD SUPPORT RECEIVED BY ME TO THE DEPARTMENT OF REVENUE, CHILD SUPPORT ENFORCEMENT BUREAU, AS LONG AS I AM RECEIVING AFDC ASSISTANCE.

Signature of Applicant/Recipient _____ *Date:* _____

CRC Ⓟ M

STATE OF MONTANA

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

SRS-EA-32
(New 3/81)

ACKNOWLEDGEMENT OF AUTOMATIC ASSIGNMENT OF RIGHTS TO SUPPORT

NOTICE TO CLERK OF COURT

I, _____ acknowledge I have automatically assigned and
(Full name of Applicant/Recipient as it appears on Court Order)

transferred to the Montana Department of Social & Rehabilitation Services and the Department of Revenue, Child Support Enforcement Bureau, all support rights which I or my child(ren), for whom I am applying for or receiving Aid to Families with Dependent Children (AFDC) Assistance, have against

_____.
(Name of Absent Parent with Duty to Support as it appears on Court Order)

This assignment is made under the terms and conditions of Section 502 (a) (26) of Title IV of the Social Security Act, as amended and pursuant to 53-2-613 MCA.

This assignment shall terminate when our child(ren) cease to receive Aid to Families with Dependent Children (AFDC) Assistance, except with respect to the amount of any unpaid support obligation that has accrued under this assignment.

This signed form authorizes the Clerk of Court to send any support monies received under

_____ to:
(Court Order Number)

DEPARTMENT OF REVENUE
CHILD SUPPORT ENFORCEMENT BUREAU
P. O. BOX 5955
HELENA, MT 59604

Signature of Applicant/Recipient: _____

Date: _____

SOCIAL SECURITY NUMBER CONSENT STATEMENT

"I understand that providing my Social Security Number to the State agency of the State Government lawfully charged with administering Title XIX (Medicaid) of the Social Services Act is voluntary. The only use of the Social Security Number to be made by the State agency is in the administration of Title XIX programs, with no disclosure of such Social Security Number for any other purpose."

"I hereby consent to be issued a Social Security Number by the Social Security Administration and to have my Social Security Number released for the aforementioned purposes only."

(Signature) (Date)

79
/81

STATE OF MONTANA
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Economic Assistance Division

DECLARATION OF RESOURCES

(To be completed by applicant/recipient)

In addition to the resources I have identified on my application form or my eligibility redetermination form, other assets belonging to me or members of my household and their values are listed below. I understand that I do not have to list one refrigerator, one stove, one washer, one dryer, one television (or radio), or household furnishings essential for day-today living (specifically, bedroom, kitchen, and living room furniture; and cooking utensils, dishes, and flatware).

ITEM	IN WHOSE NAME	VALUE

I am aware that the laws of Montana provide for a fine and/or imprisonment of any person who attempts to receive or receives assistance to which he/she is not entitled.

Signature _____ Date _____

EVALUATION OF COUNTABLE RESOURCES

(To be completed by county welfare)

The County Director has evaluated the applicant/recipient's itemization of assets and declares that the items listed below are to be counted as resources against the $1,000 resource limit in accordance with AFDC manual instructions.

ITEM	COUNTY CERTIFIED VALUE

County Eligibility Technician Signature _____ Date _____

County Director Approval _____ Date _____

FS-74A (Rev. 12/83)
MONTANA DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Report Month:_____

Due Date:_____

MONTHLY ELIGIBILITY AND INCOME REPORT

Sign and return this form to your local county welfare department by the the 8th of this month. If this report is not received, your food stamps, AFDC grant and /or Medicaid may be closed as of the last date of this month.

The information that you put on this report will be used by your eligibility technician to decide if you continue to be eligible for food stamp benefits, AFDC and/or Medicaid. If you have any questions about completing this form, please contact your local County Welfare Office.

THE INFORMATION PROVIDED ON THIS FORM WILL BE SUBJECT TO VERIFICATION BY FEDERAL, STATE AND LOCAL OFFICIALS. IF INACCURATE OR INCOMPLETE, YOU MAY BE DENIED FOOD STAMPS AND/OR BE SUBJECT TO CRIMINAL PROSECUTION FOR KNOWINGLY PROVIDING FALSE INFORMATION.

IF YOUR HOUSEHOLD RECEIVES FOOD STAMPS, IT MUST FOLLOW THE RULES LISTED BELOW. ANY MEMBER OF YOUR HOUSEHOLD WHO INTENTIONALLY BREAKS ANY OF THE FOLLOWING RULES CAN BE BARRED FROM THE FOOD STAMP PROGRAM FOR 6 MONTHS AFTER THE FIRST VIOLATION, 12 MONTHS AFTER THE SECOND VIOLATION, AND PERMANENTLY AFTER THE THIRD VIOLATION. THE INDIVIDUAL WOULD ALSO BE SUBJECT TO A FINE OF UP TO $10,000, IMPRISONMENT OF UP TO FIVE YEARS, OR BOTH, IN ADDITION TO SUSPENSION FROM THE FOOD STAMP PROGRAM OF UP TO 18 MONTHS CONSECUTIVE TO THE ORIGINAL SUSPENSION, AS WELL AS FURTHER PROSECUTION UNDER OTHER APPLICABLE STATE AND FEDERAL LAWS.

DO NOT give false information, or hide information, to receive or continue to receive food stamps.
DO NOT trade or sell food stamps or authorization cards.
DO NOT alter authorization to participate (ATP) cards to receive food stamps to which you're not entitled.
DO NOT use food stamps to buy ineligible items, such as alcoholic drinks and tobacco.
DO NOT use someone else's food stamps or ATP cards for your household.

1. Please print your name_____
(Head of Household)

Social Security Number_____

2. ADDRESS CHANGE

Has your address changed since your last report? ☐ **YES** ☐ **NO**
If yes, give your new address below:

_____

_____

3. PEOPLE IN YOUR HOME

Instructions: List the names and relationship to you, of the people who live and eat with you at this time. (include yourself)

Name	Relation	Name	Relation
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

4. CHANGES IN YOUR HOUSEHOLD LAST MONTH

Did anyone move into or out of your household last month? ☐ YES ☐ NO

If 'yes', write the change below. If you answered 'no', go on to 5.

Name	Date Moved Out	Date Moved In	Birthdate	Social Security Number
	___/___/___	___/___/___		
	___/___/___	___/___/___		
	___/___/___	___/___/___		
	___/___/___	___/___/___		

The Social Security card of a new member(s) must be provided to your Eligibility Technician. Always include any new member's resources and income in this report.

5. EXPECTED CHANGES

Do you expect any changes in your circumstances in the next month, such as:

- someone starting a job, starting to receive unemployment compensation or other income or receiving a lease or royalty payment; or
- someone moving into or out of your household?

☐ YES (If Yes, Explain) ☐ NO

6. WAGES

Did anyone in your household receive wages last month? ☐ YES ☐ NO

Instructions: 1. Report the earning of anyone who received wages LAST MONTH;
2. Attach verification of earnings (paystubs) or loss of earnings (lay-off slip).

Wage Earner's Name			Did This Person's Income ☐ Start ☐ Continue ☐ Stop		Will Income Continue Next Month: ☐ Yes ☐ No
Employer's Name & Address					
Date Paid	**Earned Before Tax**	**Tips**	**Date Paid**	**Earned Before Tax**	**Tips**
1st payday			4th payday		
2nd payday			5th payday		
3rd payday					

Wage Earner's Name			Did This Person's Income ☐ Start ☐ Continue ☐ Stop		Will Income Continue Next Month? ☐ Yes ☐ No
Employer's Name & Address					
Date Paid	**Earned Before Tax**	**Tips**	**Date Paid**	**Earned Before Tax**	**Tips**
1st payday			4th payday		
2nd payday			5th payday		
3rd payday					

(If you have earned income and your report is turned in late you will not be allowed the $30 + ⅓, child care or work expenses. If you receive AFDC the Department must add an amount for advance Earned Income Tax Credit (EITC) payments to earnings.)

7. SELF-EMPLOYMENT

Did your household have income from self-employment last month? ☐ YES ☐ NO

Instructions: If you answered yes, enter the gross self-employment income below and list your operating expenses on a separate sheet. Attach verification of income and expenses or bring in your books.

$_____

Gross Income

8. OTHER INCOME

Did your household have income other than from work last month? ☐ YES ☐ NO

Instructions: 1. Report **any other money** your household received last month. 2. Examples of income which MUST be reported are: Social Security benefits, Veteran's benefits, unemployment benefits, strike pay, worker's compensation, disability insurance, pensions, military allotments, income from property and rental property; lump sum payments, such as past social security, an insurance or court settlement, income tax refunds, general assistance, ADC and INDIAN INCOME including BIA General Assistance, Per Capita Payments, sale of land, or mineral right payments; educational grants/loans; 3. Attach verification of income if it has changed.

Person Receiving Income	Amount	Date Received	Type of Income	Did Person's Income Start, Change, or Stop			Will Income Continue Next Month (Mark X)	
	$			☐	☐	☐	☐ Yes	☐ No
	$			☐	☐	☐	☐ Yes	☐ No
	$			☐	☐	☐	☐ Yes	☐ No
	$			☐	☐	☐	☐ Yes	☐ No

9. CHECKING OR SAVINGS ACCOUNTS (If zero, please enter zero.)

For all household members: $_____ Savings $_____ Checking
Amount (current) Amount (current)

Name of Bank(s) _____ Address _____

10. RESOURCES AND ASSETS

Did anyone in your household buy, sell, or receive a resource or asset last month? ☐ YES ☐ NO

Resources or assets could include:

- Cash
- Car, truck, camper, boat, snowmobile, motorcycle
- Stocks, bonds, securities, trust fund or deed
- Recreation property, cottages, buildings
- Land contract, house, or property
- Life insurance (cash value)

Instructions: If anyone in your household has bought sold or received resources/assets, please list them and contact your eligibility technician. Verification may be required.

Resource/Asset	(Bought, Sold or Received)	Date	Price/Value
			$
			$

11. COST OF CARE FOR CHILDREN, ILL OR DISABLED PERSONS:

Did your household have a child care, ill or disabled person care expense last month? ☐ YES ☐ NO

Instructions: 1. Attach verification of your costs.
2. If reason for care is education or training, send verification of the number of hours spent in the classroom or in training.

Name of Person Receiving Care	Monthly Cost	Who Provides Care? (Name and Address)	How Many Hours Per Month Was Care Provided	Reason For Care
	$			
	$			
	$			

12. HOUSING COSTS

Was there a change in housing costs? ☐ YES ☐ NO Examples of housing cost changes would be:

• House Payment • House Rent •House Insurance • Property Taxes • Utilities (lights, water, sewage, etc.)

Instructions: If yes, explain the change and attach verification of the change.

What Was the Change(s)?_____

13. MEDICAL COSTS

Did anyone in your household over 60 years of age or older, receiving SSI, social security disability or Veteran's benefits because of a total disability have a medical expense last month? ☐ YES ☐ NO

Instructions: If yes, list expense below and attach verification of medical expense.

Person's Name	Type of Medical Cost	Amount

14. RIGHTS

If you fail to complete this report correctly and/or verify needed information your case may be closed. If that happens, you would not receive any benefits for the month this report covers. You have the right, however, to furnish a completed report and reapply for benefits.

This is an equal opportunity program. If you believe you have been discriminated against because of race, color, national origin, age, sex, handicap, political beliefs or religion, write immediately to: Eligibility Policy Bureau Chief, Dept. of S.R.S., P.O. Box 4210, Helena, Montana 59604.

AUTHORITY TO REQUIRE SOCIAL SECURITY NUMBERS

The submission of the Social Security Number (SSN) for all household members is mandatory under the Food Stamp Act of 1977 as amended by PL 97-98. Your SSN will be used in the administration of the food stamp program to check the identity of household members, prevent duplicate participation and to facilitate making mass changes. Your SSN will also be used in computer matching and program reviews or audits to make sure your household is eligible for food stamps. This may result in criminal or civil action to administrative claims against persons fraudulently participating in the Food Stamp Program.

HEARING RIGHTS

If you disagree with any action taken as a result of this notice (subject to an additional notification), you have the right to request a fair hearing. If a fair hearing is requested within 10 days of the mailing dates of the additional notice of adverse action, and if the State Department of Social and Rehabilitation Services determines that the issues concern facts of judgements relating to your individual case rather than State policy, the action will not be effective until the fair hearing decision is rendered. Unless you request a fair hearing within 60 days of having your benefits reduced, suspended, terminated or denied, you will not usually be granted a hearing.

Fair hearings are conducted by the Department's Hearing Officer. Decisions by the Hearing Officer are binding on the Department and must conform to Federal and State law, regulation or policy and must be based exclusively on evidence and material introduced at the hearing.

This information is given to advise you of your right to a fair hearing in the event that your grant is reduced or terminated as a result of noncooperation in returning this monthly reporting form or because of information that you have reported on this form. A HEARING NEED NOT BE GRANTED WHEN EITHER STATE OR FEDERAL LAW REQUIRES AUTOMATIC GRANT ADJUSTMENTS FOR CLASSES OF RECIPIENTS UNLESS THE REASON FOR AN INDIVIDUAL APPEAL IS INCORRECT GRANT COMPUTATION.

I understand that the information I provide on this report may result in changes in my assistance, including reducing the amount of my checks, food stamps, and medicaid, or closing my case. I understand that such changes may be made without advance notice. I **AM AWARE THAT THE LAWS OF MONTANA PROVIDE FOR A FINE AND/OR IMPRISONMENT OF ANY PERSON WHO ATTEMPTS TO RECEIVE, OR RECEIVES, ASSISTANCE TO WHICH HE/SHE IS NOT ENTITLED. I HAVE ALSO READ THE PENALTY WARNING FOR FOOD STAMPS.**

SIGNATURE:_____ **DATE:**_____

Before you mail this form, have you:

( ) Signed the form. ( ) Enclosed wage stubs or other information to verify your income.

( ) Enclosed bills for day care, shelter expenses and so on.

If you have questions about this report call 1-800-332-2272, Toll Free.

AFDC____ MA____ GA____ FS____

INITIAL INTERVIEW

Date_____ Phone_____

Applicant's name _____

Have we had prior contacts?_____

The applicant:_____

_____

Household composition: _____

_____

Date entered county:_____Where from?_____

Ever received assistance?_____ When_____ Where_____

Address and living expenses: _____

_____

Landlord _____

Deprivation: _____

_____

_____

Applicant's income: _____

_____

_____

Child Support income. Yes_____ No_____

_____

Property:_____

_____

_____

Vehicles: _____

_____

_____

Savings Account:_____

Checking Account: _____

_____

Life Insurance:_____

Health Insurance:_____

Company_____ Policy # _____

Contract for deed?_____

School Attendance:_____

Child Support Forms:_____

Registered with Job Service? _____

Children living with you at present time?_____

Comments:

INTAKE AND PROBLEM (DATE) _____

HOUSEHOLD COMPOSITION:

THIRD PARTY LIABILITY:

RESIDENCE:

DEPRIVATION:

INCOME:

RESOURCES:

CHILD SUPPORT:

RECOMMENDATIONS:

SRS-EA-WS-2
(Rev. 11/82)

CHECKLIST OF HIGH RISK AREAS AND BUDGET COMPUTATION

CLIENT'S NAME: _____ S.S. Number: _____

Date Applied for S.S. Number: _____ SS5 Sent In: _____

AID TO DEPENDENT CHILDREN

1. Deprivation—reason: _____

2. Support Court and Order Number: _____ EA 32 Support Assignment Date Signed: _____
   Work Registration: FNS 284: _____ WIN 8: _____
   Employment: _____ Hours Worked: _____
   Where Employed: _____

3. Earnings: Gross Amount: _____ How Verified: _____
   Other Income (unearned): _____

4. Proper Persons in Budget (children living in home): _____

5. Children Between 16–21 Years of Age Name: _____ Age: _____
   Name: _____ Age: _____
   Name: _____ Age: _____
   In School: Yes ☐ No ☐ Registered WIN: _____ Not in School: _____
   Mandatory: _____ EA 22 Medical: _____
   Exempt Reason: _____

6. Correct Shelter and Change of Address: _____

7. Real Estate: Home: _____ Market Value: _____
   Rental Property: _____ Market Value: _____
   Other: _____ Market Value: _____

8. Property Transfer: Date: _____ Fair Market Value: _____
   Sale Price: _____

9. Savings and Checking Accounts: Where: _____ Amount: _____
   Where: _____ Amount: _____

10. Safe Deposit Boxes: Where: _____ Amount: _____

11. C–D's – Credit Union – Bonds: Where: _____ Amount: _____
    Where: _____ Amount: _____

12. Insurance (cash value): Type & Company _____
    _____ Amount: _____
    Cash Loan Value: _____

13. Other: ET Comments: _____

Worker's Name _____ Date: _____

BUDGET COMPUTATION

I. Computation of Earned Income Date:					
1. Gross Earnings					Directions to Home:
2. Earned Income Disregard					
3. Mandatory Deductions					
4. Personal Employment Expense.					
5. Child Care Expense					
6. Total Deductions.					
7. Net Earned Income . . . . . (Subtract Line 6 from Line 1 to Determine Line 7)					
II. Other Income **Social Security, Veterans, i.a., UC Compensation, etc. (Specify)**					
1.					
2.					
3.					
4.					
5.					
6.					
III. Special Living Arrangement					ET – Notes:
Skilled Nursing Care.					
Intermediate Care					
Personal Care					
Adult Foster Care					
Child Only					
IV. Basic Requirement					
Shelter Included					
Shelter Not Included					
Less Income to Budget					
Deficit.					
V. Grant Recommendation . .					
ET's Signature:					

SRS—EA—WS1
(Rev. 9/83)

ELIGIBLITY INTAKE CHECKLIST

CLIENTS NAME: **S.S. NUMBER:**

REASON APPLYING FOR ASSISTANCE: AFDC ☐ MED. ☐ G.A. ☐ F.S. ☐

CLIENTS RIGHTS AND RESPONSIBILITIES:

A. RIGHTS:

☐ 1. The nature of a confidential relationship.
☐ 2. The right to a prompt determination of eligibility (30 days for AFDC or Medicaid determination, 90 days for Medically Needy.)
☐ 3. The right to an unrestricted money payment.
☐ 4. The right to a Fair Hearing.
☐ 5. The right to tell his story in his own words.
☐ 6. The right to continue to be responsible for himself and his own affairs.
☐ 7. Civil Rights.
☐ 8. The right to inquire and be informed.
☐ 9. The right to know that wage match and benefit reports are being submitted.
☐ 10. Effect on eligibility if employment and income is gained.
☐ 11. Notification of penalties (EA-85).

B. RESPONSIBILITIES:

☐ 1. To report changes in: ADDRESS, RENT, INCOME, SCHOOL GRANTS/LOANS, LUMP SUM PAYMENTS, RESOURCES, EMPLOYMENT **within 10 days of having knowledge of these changes.** (EA-4 & EA-79)
☐ 2. To report changes in household (number of children, anyone entering or leaving the household, return of absent parent or death of a member) **within 10 days.**
☐ 3. Child support and paternity assignment, along with cooperation with the Child Support Bureau. Child Support received after application must be turned over to C. S. B. (EA-32 & 32A).
☐ 4. Enumeration (securing S. S. Numbers and cards for all persons included in the assistance grant) and to submit necessary verification. (SS-5)
☐ 5. Work registration WIN 2 _____ WIN 8 _____ (manditory or voluntary registration).
☐ 6. Return Monthly Report by the **8th of each month**, completed, and return Six Month redetermination form by the **5th of the redetermination month**, completed.
☐ 7. Report any and all Third Party liability.

FORMS: EA-1a EA-4 EA-79 EA-1(h)
EA-32's WIN EA-85
(Not. of Pen.)

BEFORE YOUR APPLICATION CAN BE COMPLETED, YOU MUST PROVIDE THE FOLLOWING INFORMATION. IF THESE ITEMS ARE NOT SENT TO US BY, _____, YOUR APPLICATION WILL BE DENIED.

INFORMATION AND REFERRALS:

SOCIAL SERVICES FAMILY PLANNING QUALITY CONTROL/ASSURANCE
MEDICAL COVERAGE LIMITATIONS LEGAL SERVICES EARLY SCREENING

WORKERS COMMENTS: (to be used by technician)

WORKERS NAME: _____ **DATE:** _____

CLIENTS SIGNATURE: _____ **DATE:** _____

SRS-EA-85
(New 4/82)

State of Montana
Department of Social and Rehabilitation Services
Economic Assistance

NOTIFICATION OF PENALTIES

Sec. 1909, (a) Whoever-

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b) (1) Whoever solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind-

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchases, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined to not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person-

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to-

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully-

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or received, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)-

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

HOUSEHOLD SIZE		A___ C___		A___ C___		A___ C___		A___ C___		VERIFICATION – NOTES
SHELTER		☐Y ☐N		☐Y ☐N		☐Y ☐N		☐Y ☐N		
		PROS		RETRO		PROS		RETRO		
GROSS MONTHLY INCOME (GMI)										
1	GROSS EARNED	A								
		B								
		C								
2	TOTAL EARNED	=								
3	GROSS UNEARNED (including child support)	A								
		B								
		C								
4	TOTAL UNEARNED	=								
5	TOTAL GMI (2 + 4)	=								
	GMI STANDARD	=								
	GMI ELIGIBLE		☐Y ☐N		☐Y ☐N		☐Y ☐N		☐Y ☐N	
NET MONTHLY INCOME (NMI)										
6	TOTAL EARNED (line 2)	=								
7	LESS EXCLUSIONS	–								
8	ADD EIC	+								
9	LESS $ 75 (pro-rate)	–								
10	LESS DAY CARE	–								
11	**Sub Total**	=								
12	LESS 30 & 1/3 DISREGARD (if eligible under AFDC 404-2B)	–								
13	**BALANCE**	=								
14	ADD TOTAL UNEARNED INCOME (line4)	+								
15	TOTAL NMI	=								
	NMI STANDARD									
	NMI ELIGIBLE		☐Y ☐N		☐Y ☐N		☐Y ☐N		☐Y ☐N	
BENEFIT COMPUTATION										
16	BENEFIT STANDARD	=								
17	LESS TOTAL NMI (minus 30 & 1/3 if eligible under AFDC 404-2B and not deducted above in line 11)	–								
18	GRANT AMOUNT	=								
19	Less Recovery	–								
20	CHECK AMOUNT	=								
21	Effective Date									
	Worker									
	Date Of Action									
	Reviewer									
	Date Of Review									
	Board Approval									

State Of Montana
DEPARTMENT OF SOCIAL & REHABILITATION SERVICES
Economic Assistance Division

NAME _____

SRS
EA-WS3

AFDC BUDGET COMPUTATION WORKSHEET

HOUSEHOLD SIZE	A___ C___	A___ C___	A___ C___	A___ C___	VERIFICATION – NOTES
SHELTER	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
	PROS	RETRO	PROS	RETRO	
GROSS MONTHLY INCOME (GMI)					
1 GROSS EARNED A					
B					
C					
2 TOTAL EARNED =					
3 GROSS UNEARNED A (including child support)					
B					
C					
4 TOTAL UNEARNED =					
5 TOTAL GMI (2 + 4) =					
GMI STANDARD =					
GMI ELIGIBLE	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
NET MONTHLY INCOME (NMI)					
6 TOTAL EARNED (line 2) =					
7 LESS EXCLUSIONS –					
8 ADD EIC +					
9 LESS $ 75 (pro-rate) –					
10 LESS DAY CARE –					
11 **Sub Total** =					
12 LESS 30 & 1/3 DISREGARD– (if eligible under AFDC 404-2B)					
13 **BALANCE** =					
14 ADD TOTAL + UNEARNED INCOME (line4)					
15 TOTAL NMI =					
NMI STANDARD					
NMI ELIGIBLE	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
BENEFIT COMPUTATION					
16 BENEFIT STANDARD =					
17 LESS TOTAL NMI – (minus 30 & 1/3 if eligible under AFDC 404-2B and not deducted above in line 11)					
18 GRANT AMOUNT =					
19 Less Recovery –					
20 CHECK AMOUNT =					
21 Effective Date					
Worker					
Date Of Action					
Reviewer					
Date Of Review					
Board Approval					

SRS-EA-27
(Rev. 8/83)

MONTANA DEPARTMENT OF SOCIAL & REHABILITATION SERVICES

LETTER OF NOTIFICATION

TO:		FROM:	
Name of Applicant or Recipient:		Organizational Unit:	
Street Address:		Street Address:	
City and Zip Code:		City and Zip Code:	Phone:

1. **PROGRAM:** ☐ AFDC ☐ MED. ASSIST. ☐ GEN. ASSIST. ☐ CO. MED. ☐ FOOD STAMPS
☐ OTHER:_____

2. **ACTION:**

Legal Basis for Action:

ARM_____

_____ **CFR**_____

_____ **MCA**

If you have any questions regarding this action or if there are additional facts relating to your circumstances which you have not reported to us, please write or telephone. We will answer your questions or make an appointment to see you in person. Please remember that this action pertains only to the circumstances you reported to us. **(PLEASE READ THE REVERSE SIDE OF THIS NOTICE FOR YOUR FAIR HEARING RIGHTS).**

_____
(NAME & TITLE)

_____
(DATE)

REQUEST FOR FAIR HEARING

This is to request a fair hearing. I am making this request because:_____

_____

I understand that the right to a fair hearing includes an administrative review and a pre-hearing conference. If my reasons for a fair hearing have not been resolved during the administrative review and/or pre-hearing conference, I understand that a fair hearing will be scheduled.

I have an attorney: ☐ **Yes** ☐ **No.** My attorney's name is:_____

His/her address is:_____. His/her phone number is:_____.

_____ _____ _____
(CLAIMANT OR AUTHORIZED REPRESENTATIVE) **(PHONE)** **(DATE)**

***TO REQUEST A FAIR HEARING COMPLETE, SIGN AND MAIL THE WHITE COPY OF THIS NOTICE TO: HEARINGS OFFICER, BOX 4210, HELENA, MT 59604.**

Distribution: White — Household; Yellow — Household; Pink — County File

"Benefits and services must be provided without regard to race, color, national origin, religion, political belief, age, handicap, sex or marital status.

You may file a complaint with the State Department of Social and Rehabilitation Services if you feel that you have been discriminated against."

IMPORTANT

If you disagree with the action taken by the County Welfare Office, request a fair hearing immediately. If a fair hearing is requested within 10 days of the mailing date of this notice, and if the State Department of Social and Rehabilitation Services determines that the issues concern facts or judgments relating to your individual case, rather than State policy, the action will not be effective until the fair hearing decision is rendered.

Unless you ask for a fair hearing within 90 days of having your benefits reduced, suspended, terminated or denied, you will not usually be granted a hearing.

Fair hearings are conducted by the Department's Hearing Officer. Decisions by the Hearing Officer are binding on the Department and must conform to Federal and State law, regulation or policy and must be based exclusively on evidence and other material introduced at the hearing.

The right to a fair hearing on the county's action includes an administrative review of the action and a pre-hearing conference on the action.

The purpose of the administrative review is to permit you to discuss the proposed action with representatives of the Department; to present additional information to the Department concerning the action; and to obtain additional explanations from the Department of the reasons for the action.

The purpose of the pre-hearing conference is to consider simplification of the legal and factual issues in preparation for the fair hearing; to obtain admissions of fact and documents which will avoid unnecessary proof in the fair hearing; to explore any possiblity of settlement of the parties' differences; to establish what evidence and witnesses will be presented in the fair hearing; and to discuss any other matters which may aid in the disposition of the fair hearing.

The opportunity for you to have an administrative review or pre-hearing conference may not be used by the Department to diminish, delay or avoid a fair hearing.

You may be represented by an attorney, or by a relative, friend or other spokesman, or you may represent yourself. The Eligibility Technician at your County Welfare Office can tell you where and how to obtain free legal help.

You may request a hearing orally or in writing. However, if you make an oral request, you will be asked to complete the written request on the front section of this notice. If you need help completing the written request, the county office can assist you.

Hearing Officer — Box 4210 — Helena, MT 59601

FOR AFDC RECIPIENTS ONLY

Family Planning Services — As an AFDC recipient, you may be eligible for family planning services. Please ask about them at your County Welfare Office.

EPSDT — All Medicaid recipients under 21 years of age are eligible for Early, Periodic Screening, Diagnosis and Treatment (EPSDT). Emphasizing pevention, this program offers a comprehensive mental health and physical examiniation to determine whether you have any health problems. This examination includes height and weight measurement, a blood pressure test, a hematocrit (blood) test, urinalysis, a hearing test, a speech/language test, growth assessment, a Denver Developmental Test (for children under 6), an immunization survey, a dental assessment and a vision test. The EPSDT program also offers follow-up diagnosis and treatment for any problems found. If you want to participate in this program, ask at your County Welfare Office.

SRS–EA–36
(rev. 4/80)

MONTANA DEPT. OF SOCIAL & REHABILITATION SERVICES
Medical Assistance Bureau

LIST OF MEDICAL EXPENSES

(Please See Reverse Side for Instructions)

This form is for you to keep track of your medical expenses incurred from: _____ .
(Date)

When your medical expenses equal or exceed $ _____ , bring the bills
(Amount of Required Incurment)

for the listed expenses to this office.

DATE OF CARE	PERSON RECEIVING CARE	NAME OF DOCTOR, DENTIST, ETC.	CHARGES

The above is an accurate and complete listing of medical care charges for the dates shown above. I understand that I will need to submit proof of the claimed charges.

_____
(APPLICANT'S SIGNATURE) (DATE)

RECIPIENT INSTRUCTIONS

Your doctor bills may qualify you for help in paying for some past and future medical care. Bills incurred may be counted whether they have been paid or not, if the services have been provided by a licensed practitioner.

All expenses for any of the following services will be counted.

Ambulance charges
Anesthesiologists
Chiropractors
Dentists
Doctors (of all specialties)
Drugs
Eyeglasses, hearing aids, dentures, wheelchairs, braces, etc.
Hospital Care
Medical or Hospital Insurance premiums
Nursing care in home or hospital
Nursing Home Care
Radiologists
Tests and X-rays
Therapy - Occupational, Speech, etc.
Transportation costs to get medical care
Other expenses associated

It is important that you list all of the medical care you and your family have received in the past three months, the date the care was given, and by whom. The charge for the care must also be known.

The best sources of information are the bills you have received for the month the care was received. Drugstores often provide slips for prescription drugs that may be used for tax purposes.

You may list all of the charges on the reverse side of this page or bring all of the information to the County Welfare Office for help in organizing the information.

Be sure that you have <u>all</u> of the information about your expenses to date. If you have not received a bill for some care, get a slip from the doctor's office showing the date of visit and the charge.

SRS-EA-35
(rev. 5/80)

MONTANA DEPT. OF SOCIAL & REHABILITATION SERVICES
Medical Assistance Bureau

MEDICALLY NEEDY ONLY

Name: _____ Case Number: _____

Date of Application: _____ Certification Period: _____ to: _____

Number of Eligibles in Household: _____

Advise Client of Availability of 3 Month Retroactive Coverage, if Applicable.

INCOME CALCULATION

MONTHLY EARNED INCOME		MONTHLY UNEARNED INCOME	
Gross Earnings:		Child Support:	
Disregard:		RSDI:	
Mandatory Deductions:		Income in Kind:	
Earnings Expenses:		Other:	
Net Earnings:		Disregard:	
		Net Unearned Income:	

MONTHLY

Net Earnings: _____

Plus: + _____

Net Unearned: _____

Total		x		=		
Less	–	x		=		
MNIL		x		=		
Spenddown		x		=		

Date spenddown met satisfaction date: _____

Dates of medical eligibility: _____ (one day after satisfaction date)

INCURRED MEDICAL EXPENSES AND MEDICAL INSURANCE PREMIUMS

(Current liabilities and/or medical bills paid for within the Certification Period)

DATE	SERVICES FOR	PROVIDER / OR INSURANCE COMPANY	COST	THIRD PARTY	NET	CUMUL. TOTAL

AFDC RELATED EARNED INCOME COMPUTATION		SSI RELATED EARNED INCOME COMPUTATION	
Gross Income:		Gross Income:	
Mandatory Deductions:			– 65.00
Work Expense:		½ Remainder:	
Child Care Expense:		Countable Income:	
Transportation:			
Other:			
Countable Income:			

AFDC RELATED EARNED INCOME COMPUTATION		SSI RELATED EARNED INCOME COMPUTATION	
Gross Income:		Gross Income:	
Mandatory Deductions:			– 65.00
Work Expense:		½ Remainder:	
Child Care Expense:		Countable Income:	
Transportation:			
Other:			
Countable Income:			

AFDC RELATED EARNED INCOME COMPUTATION		SSI RELATED EARNED INCOME COMPUTATION	
Gross Income:		Gross Income:	
Mandatory Deductions:			– 65.00
Work Expense:		½ Remainder:	
Child Care Expense:		Countable Income:	
Transportation:			
Other:			
Countable Income:			

AFDC RELATED EARNED INCOME COMPUTATION		SSI RELATED EARNED INCOME COMPUTATION	
Gross Income:		Gross Income:	
Mandatory Deductions:			– 65.00
Work Expense:		½ Remainder:	
Child Care Expense:		Countable Income:	
Transportation:			
Other:			
Countable Income:			

ONE–DAY SPECIAL AUTHORIZATIONS TO:

DATE	PROVIDER	AMOUNT

SIGNATURE OF ELIG. TECH: DATE:

SRS–EA–37
(rev. 4/80)

MONTANA DEPT. OF SOCIAL & REHABILITATION SERVICES
Medical Assistance Bureau

ONE DAY SPECIAL MEDICAID AUTHORIZATION

THE MEDICAID PROGRAM IS NOT RESPONSIBLE FOR ANY AMOUNT IN EXCESS OF THAT MENTIONED BELOW

TO: _____

_____

_____

This will authorize Medicaid to pay you for services rendered by you on _____
except for $ _____ , which is the client's liability.

Name: _____ Birthdate: _____ Client ID: _____
(to be taken from attached claim) (Mo. / Day / Year)

This client will be eligible during the period: _____ to _____ .
(Mo. / Day / Year) (Mo. / Day / Year)

TYPE OF ASSISTANCE BENEFIT	CATEGORY (Circle One)	
3 – State	1 – Aged	2 – ADC - Adult
4 – Medically Needy	3 – Blind	4 – ADC - Child
☐ Male	4 – Medically Needy Child	9 – Foster Care Regular
☐ Female		

ATTACH THIS FORM TO YOUR MEDICAID CLAIM BEFORE SUBMITTING IT FOR PAYMENT. THE CLIENT MAY BE BILLED FOR ANY AMOUNT DUE YOU FOR SERVICES ON THE ABOVE MENTIONED DATE IN EXCESS OF THE AMOUNT LISTED.

_____
(COUNTY) (SIGNED) (DATE)

Original: For use of provider named above

Copy retained in case record

DEPARTMENT OF SOCIAL & REHABILITATION SERVICES

RAVALLI COUNTY OFFICE OF HUMAN SERVICES

TED SCHWINDEN, GOVERNOR

310 NORTH THIRD STREET

STATE OF MONTANA

(406) 363-1944

HAMILTON, MONTANA 59840

FOOD STAMPS & GENERAL ASSISTANCE

_____ has an appointment on _____ at _____ am/pm

The application should be completed before your interview. If you are late it is possible that you will not be seen that day, but will have to have your appointment rescheduled.

To determine eligibility for assistance, we MUST have the following documents as they apply to your case.

1. IDENTIFICATION:
   - -Drivers License
   - -Birth Certificates
   - -Social Security Cards (for all family members)
   - -Alien

2. INCOME:
   - -Child Support Verification
   - -VA Benefits Verification
   - -SS Benefits Verification
   - -Any other determined benefits verification
   - -Wage Slips or Statements from employer
   - -UC Verification-Unemployment Benefits
   - -Closure letter from Other State or County
   - -Escrow Income
   - -Family Contribution

III. RESOURCES:
   - -Equity Value on vehicles
   - -Checking Account Statement-Current
   - -Current Savings Account Statement
   - -Life Insurance Policies
   - -CD Numbers, Face Value, Interest accumulated
   - -Vehicle Registrations
   - -Stocks, Bonds, Mutual Funds
   - -Mineral Rights
   - -Lease Agreements
   - -Escrow & Trust Funds-locations of

IV. EXPENSES:
   - -Rent Receipts or Statement
   - -Utilities Receipts
   - -Telephone Bill
   - -Mortgage Payments
   - -Taxes-Property
   - -Insurance-Property
   - -Child Care Receipts

V. OTHER:
   - -Job Service Registration Card
   - -Lay off statement

If Verification and documentation is not readily available by your appointment date, bring in what you have and additional time will be given to you to obtain the items still needed.

If you fail to keep your appointment without notifying our office (363-1944/45), we will consider that you are not interested at this time, but will reapply at later date.

SRS–FS–1 (Rev. 10/83)

FORM APP. OMB NO. 40-R4055

MONTANA DEPT. OF SOCIAL & REHABILITATION SERVICES
Economic Assistance Division - Food & Nutrition Services

For Office Use Only:

Case Number: _____

Date received: _____

APPLICATION FOR FOOD STAMPS – PART 1

STEP 1. Complete Page 1

To begin to apply for food stamps, you can complete this first page, tear it off and give it to us. We are required to take action on your application within 30 days from the date you give us this first page. So, the sooner you give us the first page, the quicker you will know whether you will receive food stamps. Now go to **Step 2.**

STEP 2. Complete Pages 2 - 6

PAGES 2 - 6 MUST BE COMPLETED BEFORE WE CAN SEE IF YOU'RE ELIGIBLE FOR FOOD STAMPS. You can return pages 2 - 6 to us along with the first page or at the time of the interview we will schedule for you. Try to fill out as much as possible now. Your Eligibility Technician will help you with the rest during the interview.

Your Name: _____ Phone no. where you can be reached: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

If you don't have a street address, tell us how to get to your home: _____

_____

_____

Sign here: _____

IF YOU NEED FOOD STAMPS RIGHT AWAY:

If your household (you and the people who live and eat with you) has little or no income right now, you may be able to receive food stamps within a few days. Answer the following questions only if your household has little or no income and needs food stamps right away.

INCLUDE AS HOUSEHOLD MEMBERS, THE FOLLOWING PEOPLE WHO LIVE TOGETHER:

Parents and children, or brothers/sisters, under age 60.

Parents, or brothers/sisters, age 60 or older, if they live and eat meals with the other household members.

Other people who live and eat with you (except roomers and boarders).

Have you ever applied for food stamps before? ☐ **Yes** ☐ **No**

If yes, where did you apply for them last? _____

And, when did you get food stamps last? _____

Has anyone in your household received any money so far this month? ☐ **Yes** ☐ **No**

If yes, how much? $ _____

Did your household's only income recently stop? ☐ **Yes** ☐ **No**

If yes, when? _____

Does anyone in your household expect to receive income later this month? ☐ **Yes** ☐ **No** ☐ **Don't Know**

If yes, how much? $ _____ When? _____

If you are not employed at this time, when did your last job end? _____ ☐ **Quit** ☐ **Fired or laid off**

How many people live in your home and eat with you? (include yourself) _____

Is anyone in your household 60 years or older? ☐ **Yes** ☐ **No**

Is anyone in your household receiving Supplemental Security Income (SSI) benefits or Social Security Disability Payments?

☐ **Yes** ☐ **No**

How much do the members of your household have in cash and savings? (give your best estimate of the total)

$ _____

APPLICATION FOR FOOD STAMPS – PART 2

Answer the following questions honestly and completely. If you know but refuse on purpose to give any needed information, your household (you and the people who live and eat with you) won't be eligible for food stamps.

You may complete this form at home and mail it or bring it to the food stamp office. Or, another member of your household, or an adult who knows you, may complete and return it to us.

IMPORTANT: *When you are interviewed, please bring proof of all household income - for example, pay stubs and award letters for government benefits (such as SSI or Social Security). You will also need Social Security cards for the people in your household. We may also need the following items: statements of all household savings and checking accounts; vehicle registration slips; rent or mortgage receipts; & utility bills. If someone in your household is age 60, receives Social Security Disab. Benefits or Supple. Security Income benefits, you may need to bring in your medical bills.*

Having these items with you could speed up your application.

Your Name: _____

Mailing address: _____

City: _____ State: _____ Zip code: _____

HOUSEHOLD MEMBERS:

Fill in all blanks for each household member, including yourself. For each person who is not a citizen, you will need to show the food stamp office an alien registration card, such as INS Forms I-151, I-551, I-94, or a Re-entry Permit.

INCLUDE AS HOUSEHOLD MEMBERS, THE FOLLOWING PEOPLE WHO LIVE TOGETHER:

Parents and children, or brothers/sisters, under age 60.

Parents, or brothers/sisters, age 60 or older, if they live and eat meals with the other household members.

Other people who live and eat with you (except roomers and boarders).

The submission of the Social Security Number (SSN) for all household members is mandatory under the Food Stamp Act of 1977 as amended by PL 97-98. Your SSN will be used in the administration of the food stamp program to check the identity of household members, prevent duplicate participation and to facilitate making mass changes. Your SSN will also be used in computer matching and program reviews or audits to make sure your household is eligible for food stamps. This may result in criminal or civil action or administrative claims against persons fraudulently participating in the Food Stamp Program.

Name	Birthdate	SSN	Is this person a U.S. citizen? (Yes or No)

(Attach a separate sheet if you need more room.)

RESOURCES:

Check either "Yes" or "No" about things you or anyone in your household owns or are buying. If you check "Yes", give value.

a. Checking account ☐ Yes ☐ No Value $ _____

b. Savings account ☐ Yes ☐ No Value $ _____

c. Cash on hand ☐ Yes ☐ No Value $ _____

d. Stocks or bonds, other ☐ Yes ☐ No Value $ _____

e. Oil, mineral rights ☐ Yes ☐ No Value $ _____

f. Livestock ☐ Yes ☐ No Value $ _____

g. Boats and/or campers ☐ Yes ☐ No Value $ _____

h. Cars, trucks, motorcycles, and other vehicles ☐ Yes ☐ No Value $ _____

If "Yes", list the year, make and model of each vehicle:

Year	Make	Model	Year	Make	Model

i. Real estate, **other than your home** (for example, land or buildings you rent to others) ☐ Yes ☐ No Value $ _____

If yes, you may need to bring information about the value of the property, any amount owed, and how the property is used.

j. Do you or anyone in your household own or are you (they) buying anything not listed in this section? ☐ Yes ☐ No Value $ _____

If yes, list the things owned or being purchased. Do not list household items or personal effects.

_____

_____

Have you transferred, sold, deeded or given away any houses, lots, land, money, etc., within the last 3 months? ☐ **Yes** ☐ **No**

If yes, give date and explain. _____

_____

INCOME FROM WORK:

Fill in **all** blanks for each household member with a full or part-time job. If a member has more than one job, list each job separately. Include members who receive income from JTPA or WIN. Do not include self-employed household members.

Household Member	Name of Employer	Amount of each paycheck before deductions such as taxes, retirement or union dues are taken out	How often paid

Is anyone in your household self-employed? ☐ **Yes** ☐ **No** *If yes, give their names:*

_____

Please bring last year's Federal Tax forms for **self-employed** members of your household. Or, if no such tax forms were filed last year, bring proof of self-employment costs and income.

Has anyone in your household quit a job in the last 60 days? ☐ **Yes** ☐ **No**

If yes, what was the date they quit? _____

OTHER INCOME AMOUNTS:

Source of Income	Household members who receive this income	Amount of each check or payment	How often received
AFDC (Aid to Families with Dependent Children)			
Social Security – Blue/green checks			
SSI (Supplemental Security Income) – Gold checks			
GA (General Assistance)			
VA (Veterans Benefits)			
Pensions/retirement income			
Unemployment or Workers' Compensation			
Child support & alimony			
Money from friends or relatives (other than loans)			
Other (specify) - such as per capita, lease or rental income			

ROOMERS AND BOARDERS: *(Do not include people listed as household members.)*

Does anyone pay you for meals, a room, or both? ☐ Yes ☐ No *If yes, complete the following:*

Name	How much do they pay you?	How often

MEDICAL:

Please list medical expenses for any household member who is age 60 or over, or who receives Supplemental Security Income (SSI) benefits, Social Security Disability payments or Veteran's benefits because of a total disability.

	Amount	How often is each payment due?
Medical & dental services		
Hospital or nursing care		
Health insurance & Medicare payments		
Drugs prescribed by a doctor		
Dentures, hearing aids & eyeglasses		
Transportation costs to get medical care		
Services of an attendant or nurse		
Other (explain)		

Please list the names of household members who have these expenses: _____

DEPENDENT CARE:

Does anyone in your household pay for someone to babysit or care for a child or a disabled adult, so that a member can get work or training or look for a job? ☐ Yes ☐ No

If yes, how much do you pay $ _____ How often? _____

Who provides this care? Name: _____

Address: _____ Telephone number: _____

SHELTER:

Please list the amount your household is billed for each of the following items:

	Amount	How often is each payment due?
Rent or mortgage payment		
Property taxes (if not included in mortgage)		
Insurance on home (if not included in mortgage)		

UTILITIES:

Check the box next to the utility costs you pay and list the amount you are billed. We must see your utility bills in order to use them as deductions. If you have an expense for heating separate from your rent or mortgage payment you may be able to use a standard utility allowance.

	Amount	How often do you get a bill?
☐ Telephone (basic rate)		
☐ Electricity		
☐ Gas for heating & cooking		
☐ Oil		
☐ Water & sewer service		
☐ Garbage & trash		
☐ Installation of utilities		
☐ Other (coal, wood)		

Does anyone outside your household pay or help you pay any of the medical or shelter costs you've listed above, such as, the Energy Assistance program for your fuel, the Department of Housing and Urban Development (HUD) or the Bureau of Indian Affairs (BIA) for your rent or house payment, and so on? ☐ Yes ☐ No

If yes, which bills do they pay? How much do they pay? _____

STUDENTS:

If there are students in your household who are (1) between the ages of 18 and 60 and (2) not in high school, complete the following:

Name of Student	School or Program	Hours of Class per week
1.		
2.		
3.		

If any of the students listed above receive educational grants, scholarships or loans, complete the following:

Name of Student	Total amount of grants, scholarships or loans	Mos. covered by grants, scholarships or loans	Tuition and mandatory fees
1.			
2.			
3.			

YOUR RACIAL / ETHNIC HERITAGE:

Although you are not required to provide this information, your cooperation will help determine compliance with Federal Civil Rights Law. In no instance will this information be used in considering your application.

If you decline to provide this information, it will in no way affect consideration of your application. We are authorized to ask for this information under Title VI of the Civil Rights Act of 1964.

☐ Black, not of Hispanic origin
☐ American Indian or Alaskan Native
☐ Hispanic
☐ White, not of Hispanic origin
☐ Asian or Pacific Islander

AUTHORIZED REPRESENTATIVE:

You can authorize someone outside your household to get your food stamps for you or to use them to buy food for you. If you would like to authorize someone, write the person's name below:

Name: _____ Phone no: _____

Address: _____

PENALTY WARNING:

THE INFORMATION PROVIDED ON THIS FORM WILL BE SUBJECT TO VERIFICATION BY FEDERAL, STATE AND LOCAL OFFICIALS. IF ANY IS FOUND INACCURATE OR INCOMPLETE, YOU MAY BE DENIED FOOD STAMPS AND/OR BE SUBJECT TO CRIMINAL PROSECUTION FOR KNOWINGLY PROVIDING FALSE INFORMATION.

ANY MEMBER OF YOUR HOUSEHOLD WHO INTENTIONALLY BREAKS ANY OF THE FOLLOWING RULES CAN BE BARRED FROM THE FOOD STAMP PROGRAM FOR SIX (6) MONTHS AFTER THE FIRST VIOLATION, TWELVE (12) MONTHS AFTER THE SECOND VIOLATION, AND PERMANENTLY AFTER THE THIRD VIOLATION. THE INDIVIDUAL WOULD ALSO BE SUBJECT TO A FINE OF UP TO $10,000, IMPRISONMENT OF UP TO FIVE YEARS, OR BOTH, IN ADDITION TO SUSPENSION FROM THE FOOD STAMP PROGRAM OF UP TO EIGHTEEN (18) MONTHS CONSECUTIVE TO THE ORIGINAL SUSPENSION, AS WELL AS FURTHER PROSECUTION UNDER OTHER APPLICABLE STATE AND FEDERAL LAWS.

- **DO NOT** give false information, or hide information, to get or continue to get food stamps.
- **DO NOT** trade or sell food stamps or authorization cards.
- **DO NOT** alter authorization cards to get food stamps you're not entitled to receive.
- **DO NOT** use food stamps to buy ineligible items, such as alcoholic drinks and tobacco.
- **DO NOT** use someone else's food stamps or authorization cards for your household.

YOUR SIGNATURE:

I understand the questions on this application and the penalty for hiding or giving false information or breaking any of the rules listed in the Penalty Warning. My answers are correct and complete to the best of my knowledge.

I understand that I may have to provide documents to prove what I've said. I agree to do this. If documents are not available, I agree to give the name of a person or organization the food stamp office may contact to obtain the necessary proof.

I ALSO UNDERSTAND THAT I AM REQUIRED BY STATE AND FEDERAL LAW TO REPORT TO THE COUNTY FOOD STAMP OFFICE ANY CHANGES IN INCOME AND MEDICAL COSTS OF MORE THAN $25 PER MONTH; ANY CHANGES IN THE SOURCE OF INCOME; CHANGES IN RESOURCES IF THEY REACH OR EXCEED $1,500; CHANGES IN HOUSEHOLD SIZE; CHANGES IN THE NUMBER OF VEHICLES; ANY CHANGES IN ADDRESS AND ANY RESULTING CHANGE IN SHELTER COSTS. I FURTHER UNDERSTAND THAT I MUST REPORT THESE CHANGES WITHIN 10 DAYS AND THAT THE FAILURE TO DO SO MAY RESULT IN A LOSS OF PROGRAM BENEFITS AND IN POSSIBLE CRIMINAL PROSECUTION OR PENALTIES AS PROVIDED BY LAW.

Your Signature: _____ Today's Date: _____

Witness: (if you signed with an X) _____

You or your representative may request a fair hearing either orally or in writing if you disagree with any action taken on your case. Your case may be represented at the hearing by any person you choose.

This is an equal opportunity program. If you believe you have been discriminated against because of race, color, national origin, age, sex, handicap, political beliefs, or religion, write immediately to the Secretary of Agriculture, Washington, D.C. 20250.

SRS–FS–3
(rev. 6/79)

MONTANA DEPT. OF SOCIAL & REHABILITATION SERVICES
Economic Assistance Division – Food & Nutrition Bureau

EXPLANATION OF FOOD STAMP PROGRAM

Rights/Responsibility Sheet

FOOD STAMPS are coupons that are used like cash to buy food and garden seeds at participating stores. They cannot be used to buy tobacco, alcoholic beverages, or things you cannot eat.

You have the right to request an application to receive food stamps by coming to the office, sending a request letter to the office, or by telephoning the office. You may file the application by mail or by returning it personally to the office. You may put your name, address and signature on **PART 1,** turn it in and turn in **PART 2** of the application at the interview, or you may file the entire application at one time. We will make a decision on your application within 30 days of the date you turned in **PART 1,** whether or not the rest of the application was turned in with it.

Household interviews are conducted in the Food Stamp Office; however, there are certain instances when home visit interviews or telephone interviews are conducted. If you feel you will have difficulty coming or are unable to come to the office, please tell us why on the bottom of **PART 1** of the application. A determination will be made, and you will be notified of the time and place of the interview.

If you are eligible to receive food stamps, you will be issued a **Food Stamp Identification Card** which you will show when you pick up the stamps and when you buy food. In addition, you will receive an **Authorization to Participate (ATP)** card (either through the mail or directly from the Food Stamp Office). This ATP card will tell you how many stamps you are going to receive.

Take your ATP and your Food Stamp Identification Card to your issuance office to pick up your food stamps. You no longer have to buy stamps so the issuance office will give you the amount on the ATP. The issuance office will keep your ATP card.

You must report to the local office any changes in your income, deductions, salary increases, inheritance, unemployment benefits, etc., as well as any changes in your household, etc. If you do not do this, it could cause you to lose your food stamps, or not get the amount you are entitled to according to your actual income and deductions. Any change must be reported within **ten (10)** calendar days from the date you first know about it.

IF YOU PLAN TO MOVE, you may be able to continue receiving food stamps for 60 days after you arrive at your new home. Report to your current office that you intend to move and ask that your food stamps be continued. If moving means a change in your income or rent, or other changes, be sure to report these also.

IF THE FOOD STAMP OFFICE TURNS YOU DOWN and you think you are eligible, or you believe they made a mistake figuring your income, you can ask for a Fair Hearing. You may also request a Fair Hearing if it takes longer than 30 days for the Food Stamp Office to decide on your application. You will be able to tell your side of the story or point out the mistake. If it is determined in a Fair Hearing that you have been wrongfully denied food stamps, the benefits you lost will be made up to you. You can get a **Request for a Fair Hearing** form at any Food Stamp Office. Contact your local office if you think you did not receive the right amount of food stamps.

You may be able to get independent **LEGAL ASSISTANCE** to either advise or represent you at a Fair Hearing. For help in obtaining legal counsel or other representation, contact your County Welfare Office or call the nearest office of the Montana Legal Services Association.

YOU MAY LOSE YOUR RIGHT TO RECEIVE FOOD STAMPS by giving false information about your income, expenses, or the number of persons in your household. You may also be subject to criminal prosecution.

IT IS A FEDERAL CRIME to obtain, use or transfer food stamps or ATP cards if you are not authorized. Persons convicted of these offenses can be fined up to $10,000 and imprisoned for not more than five years.

The Food Stamp Program is available to all people without regard to sex, race, religion, color, national origin or political beliefs. If you feel you have been treated unfairly, you may file a complaint with the U. S. Department of Agriculture or request a hearing.

For additional information, contact your local County Welfare Office at _____ or call the Citizen Advocate Office at 1–800–332–2272 Toll Free

SRS—EA—4A
(Rev. 11/83)

STATE OF MONTANA
DEPARTMENT OF SOCIAL & REHABILITATION SERVICES
Economic Assistance Division

RELEASE OF CONFIDENTIAL INFORMATION

AUTHORIZATION TO MONTANA SOCIAL & REHABILITATION SERVICES TO OBTAIN PERSONAL INFORMATION

Client's Name:_____ SSN:_____

Address:_____
(STREET) (CITY) (STATE) (ZIP CODE)

I authorize the individual, company or agency shown below to disclose to the _____ County Department of Welfare of the Montana Social and Rehabilitation Services, the information specified below, which relates to my eligiblity to receive Public Assistance benefits. I understand any information obtained will be kept confidential and will be used only for purposes directly connected with the administration of benefits or services. I further understand that any information obtained may be released to a proper governmental agency or court of law enforcement agency for purposes of legal and investigative actions concerning fraud, collection of support or establishment of third party liability.

INFORMATION SOURCE: Landlords, Neighbors, Employers, Social Security Administration, Doctors, Hospitals, Veterans Administration, Bureau of Indian Affairs, Department of Labor and Industry, Assessors, Treasurers, County Clerks of Court, Banks, Credit Unions, Savings and Loans, Buyers of Contracts for Deed/Negotiable Instruments.

INFORMATION TO BE REQUESTED: Family Composition, Earned Wages, Unearned Wages, Checking Accounts, Savings Accounts, Stocks, Bonds, Time Certificates, BIA-IIM Funds, Veterans Benefits, Unemployment Compensation, Workmens Compensation, Loans, Personal Property, Mortgages, Contracts for Deed/Negotiable Instruments, Real Estate, etc. Also, Medical Reports or conditions to exempt participation in employment or County Work Program.

DISCLOSURE: Please provide information requested in space below or on back of sheet.

Signature of applicant or authorized representative:

X_____ Date:_____

SRS—EA—4A
(Rev. 11/83)

STATE OF MONTANA
DEPARTMENT OF SOCIAL & REHABILITATION SERVICES
Economic Assistance Division

RELEASE OF CONFIDENTIAL INFORMATION

AUTHORIZATION TO MONTANA SOCIAL & REHABILITATION SERVICES TO OBTAIN PERSONAL INFORMATION

Client's Name:_____ SSN:_____

Address:_____
(STREET) (CITY) (STATE) (ZIP CODE)

I authorize the individual, company or agency shown below to disclose to the _____ County Department of Welfare of the Montana Social and Rehabilitation Services, the information specified below, which relates to my eligiblity to receive Public Assistance benefits. I understand any information obtained will be kept confidential and will be used only for purposes directly connected with the administration of benefits or services. I further understand that any information obtained may be released to a proper governmental agency or court of law enforcement agency for purposes of legal and investigative actions concerning fraud, collection of support or establishment of third party liability.

INFORMATION SOURCE: Landlords, Neighbors, Employers, Social Security Administration, Doctors, Hospitals, Veterans Administration, Bureau of Indian Affairs, Department of Labor and Industry, Assessors, Treasurers, County Clerks of Court, Banks, Credit Unions, Savings and Loans, Buyers of Contracts for Deed/Negotiable Instruments.

INFORMATION TO BE REQUESTED: Family Composition, Earned Wages, Unearned Wages, Checking Accounts, Savings Accounts, Stocks, Bonds, Time Certificates, BIA-IIM Funds, Veterans Benefits, Unemployment Compensation, Workmens Compensation, Loans, Personal Property, Mortgages, Contracts for Deed/Negotiable Instruments, Real Estate, etc. Also, Medical Reports or conditions to exempt participation in employment or County Work Program.

DISCLOSURE: Please provide information requested in space below or on back of sheet.

Signature of applicant or authorized representative:

X_____ Date:_____

SRS-FS-6
New 10/82

STATE OF MONTANA
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
REPORT OF EMPLOYMENT INCOME

Name of Wage Earner_____

☐ Please supply earnings information for period _____ through _____ below.

The employee is paid (check one):

☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other -- Specify_____

Pay period ending_____						
Date of pay_____						
Gross amount_____						
Amounts withheld from wages:						
Federal withholding_____						
State withholding_____						
FICA_____						
Health insurance_____ ☐ Mandatory ☐ Not Mandatory						
Credit union_____						
Union dues_____						
Special funds (flower, etc.) ☐ Mandatory ☐ Not Mandatory						
Other -- Specify_____ ☐ Mandatory ☐ Not Mandatory						

☐ Please supply the following information:

If the person is employed by you **now**, when was he or she hired?_____

If the person is not employed by you now, please answer the following:

The person was employed from_____ to_____

The usual gross monthly earnings were $_____

The reason the employee left was _____

_____

Is re-employment probable?_____ If so, when?_____

Remarks:_____

☐ Present address of employee is?_____

or last known address is?_____

Name of Employer_____

Address of Employer_____

Signature of Person Preparing Report_____

Date_____

SRS–FS–4
(new 3/79)

MONTANA DEPT. OF SOCIAL & REHABILITATION SERVICES
Economic Assistance Division – Food & Nutrition Bureau

SELF–EMPLOYMENT RECORD

MONTH: _____

DAY OF MO.	DESCRIPTION OF ARTICLES, GOODS, MATERIALS OR SERVICES RENDERED	TOTAL PURCH. & EXPENDITURES	TOTAL SALES & EARNINGS
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			
31			

PARTICIPANT'S NAME: _____ CASE NO: _____

PARTICIPANT'S SIGNATURE: _____ DATE: _____

* County Office will complete the Month, Participant Name and Case Number before giving the form to the household.

SRS-FS-5(New 1/82)

Affidavit of Understanding Regarding Work Registration Requirements

I understand that under the Food Stamp Act, I will not be eligible to receive food stamps if I refuse to follow the requirements to register for work, seek employment, and accept suitable employment. These have been explained to me by my eligibility technician.

Although I may not be required to report to a Job Service Office at this time, I understand that job location services are available to me there. I agree to report to the local Job Service and do a job search if directed to do so at a later time. I will accept an offer of suitable employment whether I receive this offer through a referral from the Job Service Office or through my own contacts.

Failure to comply with the work registration requirements may result in disqualification of the entire household from the Food Stamp Program.

_____
Applicant's Signature

The following are members of the household who are required to register for work: _____, _____, and _____. I understand that they must also meet the work registration requirements described to me by the eligibility technician and summarized above. I will explain to the household members their work registration responsibilities.

We understand that failure to comply with the work registration requirements may result in disqualification of the entire household from the Food Stamp Program.

_____
Applicant's Signature

AFFIDAVIT OF SEPARATE ECONOMIC UNIT

I, the undersigned, certify that the person(s) listed on my application for participation in the Food Stamp Program, customarily purchase, store and prepare food separately from other individuals with whom I (we) share common living quarters.

I authorize the Welfare Division to verify this statement as required. I understand fully that in determining the amount of my benefits that the Welfare Division is relying on my representation herein.

I realize that failure to report the TRUE FACTS of my living arrangements could result in a denial of my application and/or termination of my future participation.

_____ _____

Signature Date

_____ _____

Case Number Witness

Identify name(s) of other unit(s) living at the residence:

Names	Receiving Food Stamps (yes or no)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

If yes, under what name(s) is/are the unit(s) receiving stamps?

_____

_____

_____

_____

SRS—FS—2
(Rev. 3/83)

MONTANA DEPT. OF SOCIAL & REHABILITATION SERVICES

Case Number:_____

CHANGE REPORT FORM

Date:_____

Name:_____

Address:_____

_____

Dear _____

Use this form to report any of the following changes in your household circumstances:

- Changes in your total household income when it goes up or down by $25 or more a month. You don't have to report changes in your AFDC check.
- Changes in any source of income such as getting a new job or changing jobs.
- A car, or other licensed vehicle, if anyone in your household gets one.
- Increases in your household's savings if the total cash and savings of all household members now amounts to $1,500 or more.
- Changes in the number of people in your household.
- Your new address if you move.
- Your new rent or mortgage costs if you move.
- Increases in your utilities and dependent care costs.
- When total medical expenses of household members age 60 or over, and members who receive Supplemental Security (SSI) benefits or Social Security Disability payments, or Veterans benefits because of a total disability, go up or down by $25 or more a month.

You must report these changes **within 10 days** of the time you learn of them. This will help make sure you get the correct amount of food stamps.

If for some reason you can't mail this form, you can report the changes by calling us at:_____.

You can also use this form to report changes in the cost of caring for children or disabled adults, or changes in shelter costs even if you haven't moved. If these expenses go up, you may be eligible for more food stamps. For instance, if you are now using the standard amount for utilities, you should report your actual utility costs whenever they are higher than the standard. The change may make you eligible for more food stamps.

IF YOU PURPOSELY HOLD BACK INFORMATION ABOUT CHANGES IN YOUR HOUSEHOLD, YOU WILL OWE US THE VALUE OF ANY EXTRA FOOD STAMPS YOU RECEIVE AS A RESULT. YOU MAY ALSO BE BARRED FROM THE FOOD STAMP PROGRAM FOR 6 MONTHS OR MORE, AND BE FINED, IMPRISONED, OR BOTH.

Sincerely,

IF YOU DIDN'T GIVE YOUR SOCIAL SECURITY NUMBERS

If you have not given social security numbers for all household members, list their names, ages and social security numbers (SSN) below:

Name	Social Security Number
1.	
2.	
3.	

IF YOU STARTED A JOB OR CHANGED JOBS

You must tell us when a household member starts a new job or changes jobs.

Household Member:_____ ☐ changing jobs ☐ new job

Name of Employer:_____

Expected wage: _____ ☐ weekly ☐ every two weeks ☐ twice a month ☐ monthly

When will first pay check be received?_____

IF INCOME OR ANY SOURCE OF INCOME CHANGES

You must tell us if the total income received by your household goes up or down by $25 or more a month. In figuring the change, use your household's total monthly income before deductions such as taxes, retirement or union dues are taken out. You don't have to report changes in your AFDC check, but you have to report changes in other source of income.

If you have a wage stub or other document which shows what your new income is, please send it in with this form. If you don't have a wage stub at this time, please go ahead and report the change anyway.

Name	Where does income come from	Total New Amount	How often received
1.		$	
2.		$	
3.		$	

IF THE NUMBER OR CARS OR LICENSED VEHICLES CHANGES

Has anyone in your household gotten a car, truck, boat, camper, motorcycle or other licensed vehicle since the last time you told us about the vehicles your household owns?

Make	Model	Year	Make	Model	Year

Has anyone in your household sold or traded in a licensed vehicle since the last time you told us about the cars or other vehicles your household owns? How much did you get for it? $_____

Make	Model	Year	Make	Model	Year

IF YOUR SAVINGS INCREASE

You must tell us if the **total** amount of money that the members of your household have in cash, savings accounts, checking accounts and in stocks and bonds **increases** to more than $1,500. How much does your household now have?
$_____

IF SOMEONE MOVES IN OR OUT

Has any household member moved out or passed away? Are there any new members in your household? If so, please list them and complete the blanks beow. Include newborn children.

Name	Entered household	Left household	If entered household, give age, Social Security Number & any income before deductions
1. _____	☐	☐	_____
2. _____	☐	☐	_____
3. _____	☐	☐	_____

If a new person has entered your household we must verify their social security number. Please show your eligibility tehnician their social security card.

IF YOU MOVED OR YOUR RENT OR MORTGAGE CHANGED

If you moved, what is your new mailing address: City State Zip Code

_____

If you don't have a street address, tell us how to get to your home: Phone no. where you can be reached

_____

If you moved, you must also list your new expenses below. You can also use this section to tell us that your rent or mortgage has gone up.

	Rent or mortgage payment	Insurance on home (if not included in mortgage)	Property taxes (if not included in mortgage
New amount	$_____	$_____	$_____

IF YOUR UTILITIES OR DEPENDENT CARE COSTS GO UP

Have your utility bills (gas, oil, electricity, etc.) gone up? Have you started paying someone to care for a child or dependent adult or have these costs increased? If so, you may be eligible for more food stamps. Use the space below to tell us which costs have gone up, the new amount you are paying and how often you are billed.

Type of Cost	New amount	How often billed
_____	$_____	
_____	$_____	
_____	$_____	
_____	$_____	
_____	$_____	
_____	$_____	

IF HOUSEHOLD MEMBER'S MEDICAL EXPENSES GO UP OR DOWN

List the medical expenses for all household members age 60 or over, and members who receive Supplemental Security Income (SSI) benefits, Social Security Disability Payments, or Veteran's benefits because of a total disability, if the total monthly medical expenses have gone up or down by $25 or more.

	Amount	How often is each payment due?
Medical and dental services	$	
Hospital or nursing care	$	
Health insurance and medical payments	$	
Drugs prescirbed by a doctor	$	
Dentures, hearing aids and eyeglasses	$	
Transportation costs to get medical care	$	
Services of an attendant or nurse	$	
Other (explain)	$	

Please list names of household members who have these expenses:_____

_____

PENALTY WARNING

ANYONE IN YOUR HOUSEHOLD WHO BREAKS ANY OF THE RULES LISTED BELOW ON PURPOSE CAN BE BARRED FROM THE FOOD STAMP PROGRAM FOR 6 MONTHS OR MORE; FINED UP TO $10,000, IMPRISONED UP TO 5 YEARS, OR BOTH; AND SUBJECT TO PROSECUTION UNDER OTHER APPLICABLE STATE OR FEDERAL LAWS:

DO NOT give false information, or hide information, to continue receiving food stamps.

DO NOT trade or sell food stamps or authorization cards to anyone who is not authorized to use them for your household.

DO NOT alter authorization cards to get food stamps you're not entitled to receive.

DO NOT use food stamps to buy ineligible items, such as alcoholic drinks and tobacco.

DO NOT use someone else's food stamps or authorization cards for your household.

YOUR SIGNATURE

I understand the penalty for hiding or giving false information. I also understand I will owe the value of any extra food stamps I receive because I don't fully report changes in my household. I agree to prove any changes I report. I also understand that I am required by state and federal law to report to the county food stamp office any changes in income and medical costs of more than $25 per month; any changes in the source of income; changes in resources if they reach or exceed $1,500; changes in household size; changes in the number of vehicles; any changes in address and any resulting change in shelter costs. I further understand that I must report these changes within 10 days and that the failure to do so may result in a loss of program benefits and in possible criminal prosecution or pentalites as provided by law. My answers on this form are correct and complete to the best of my knowledge.

Do you expect the changes you have reported will remain the same next month? ☐ YES ☐ NO

If you answered no, please explain:_____

Your Signature:_____ Today's Date:_____

IF YOUR BENEFITS CHANGE

We'll use your answers on this form to see if your household's benefits will change. Before we change your benefits, we'll send you a notice explaining what will happen. If you don't agree with our decision, you can have a fair hearing. A hearing officer will decide if you are right.

FS-3a (New 8/83)

DEPARTMENT OF
SOCIAL AND REHABILITATION SERVICES

TED SCHWINDEN, GOVERNOR

P.O. BOX 4210

STATE OF MONTANA

HELENA, MONTANA 59604

MONTHLY REPORTING AND RETROSPECTIVE BUDGETING

Starting September 1, 1983, Montana will begin a new system of determining food stamp benefits. This new system is called, "Monthly Reporting and Retrospective Budgeting". If you are presently receiving benefits, any changes in your income or household expenses will be handled by retrospective budgeting procedures. When retrospective budgeting procedures are used, the food stamp office will base your benefits on your income and expenses two months prior.

Under this new system, households are required to report their circumstances monthly except for households whose members are all over age sixty (60) or permanently disabled and have no earned income.

Your eligibility technician will explain this new system to you before you will be expected to complete monthly reports.

HOW DOES THE FOOD STAMP OFFICE DETERMINE YOUR INCOME?

When you first apply for food stamp benefits, the food stamp office will use prospective budgeting procedures. When prospective budgeting procedures are used, your benefits will be based on the income you have in the current month. To do this, the eligibility technician looks at your past income and asks you whether you expect this income to continue. If you do, this is the amount they will use. But if you are no longer getting this income, or expect income from a new source, then what you have received in the past doesn't matter.

When future income is hard to predict, the food stamp office is allowed to count only the amount of income you are certain will actually be available to you.

Prospective budgeting procedures can only be used in the month you apply for benefits and in the month thereafter. Retrospective budgeting procedures are used in the third and following months in which you receive benefits.

"AN EQUAL OPPORTUNITY EMPLOYER"

HOW IS INCOME DETERMINED UNDER RETROSPECTIVE BUDGETING PROCEDURES?

When the food stamp office uses retrospective budgeting procedures, they will base your benefits on income two months prior. The only exception is that income received in the first two months of application from a source which no longer provides income will not be retrospectively budgeted in the third and fourth month.

IN RETROSPECTIVE BUDGETING, INCOME MUST BE FIGURED ON A MONTHLY BASIS ON INFORMATION THE HOUSEHOLD GIVES THE FOOD STAMP OFFICE ON A MONTHLY REPORT.

In a retrospective budgeting system, the food stamp office will require that certain households report their financial situation each month. The reporting form will provide the food stamp office with information concerning the household composition, income, resources, shelter costs, dependent care costs, and medical expenses. Completing a report form each month is called MONTHLY REPORTING.

The food stamp office will provide households with a monthly report form each month. The report form will usually come with the household's monthly Authorization to Participate (ATP) card or coupons. The monthly report must be returned to the food stamp office by the 8th of the month. If it is not, a household may not receive benefits on time.

IF YOU FAIL TO COMPLETE AND RETURN THE MONTHLY REPORT FORM, YOU WILL BE GIVEN NOTICE THAT YOUR FOOD STAMP CASE WILL BE CLOSED AND YOUR FOOD STAMP BENEFITS WILL STOP.

The food stamp office will consider your monthly report incomplete if:

- it is not signed;
- it is not accompanied by verification of reported earned income and expenses; or
- it omits information the food stamp office needs to determine your eligibility or level of food stamp benefits.

If you fail to complete and return the monthly report form within 10 days of the date the notice of late or incomplete monthly report is mailed, the food stamp office will close your case and stop your food stamp benefits. In order for your household to receive food stamps again, you must reapply for benefits.

EPB5/h

SRS FS-1(e)
New 9/83

STATE OF MONTANA
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

FOOD STAMP PROGRAM
EXPLANATION AND ELECTION
STANDARD UTILITY ALLOWANCE

Food Stamp Program rules allow a household to use its utility expenses as deductible expenses. Deductible expenses reduce your countable income and make you eligible for more benefits. Montana has a year round Standard Utility Allowance which includes utility charges for heat, lights, water, phone, and garbage collection. Your household is eligible to use this standard when you are charged for heating at anytime during the year if the charge is separate and apart from your rent or mortgage payment.

If you are eligible to use the standard utility allowance, you can choose to use either your actual monthly utility bills or the standard allowance. If you choose to use the utility standard, you will not need to furnish the food stamp office with your utility bills each month. You can choose either the Standard Utility Allowance or your actual utility bills, but you must use whichever you choose for twelve (12) months from the date of your certification.

The standard utility allowances are:

Household Size	Monthly, Year Round
1	$100
2	$100
3	$140
4	$145
5+	$163

Please check one block or the other:

[_] I choose to use the Standard Utility Allowance and I understand that I cannot switch from this standard for the next 12 months.

[_] I choose to use my actual utility expenses and I agree to furnish the food stamp office with my utility bills each month. I understand that by not submitting some of my utility bills, I will receive a lower deduction. I understand that in months when my utility bills are lower than the standard allowance, I will not receive as large of a deduction as I would have if I had chosen the Standard Allowance. I understand that I cannot switch to the standard allowance for the next twelve (12) months.

_____
Signed, Head of Household or Responsible Household Member

_____
Date

Office use only: _____
Effective Date

EPB5/i

INTAKE AND PROBLEM

Date of Application
Date of interview

HOUSEHOLD COMPOSITION

EA-P-31

Name

Date of request

RESOURCES

INCOME

Amount & Source

SHELTER

Rent or Mortgage payment
Utility

VERIFICATION

Period _____ to _____
Initial Month Amt. _____
Ongoing Month Amt. _____

FS RUNNING RECORD (CONT'd) NAME_____

DATE_____

Cert. period_____to_____
Amount
_____

DATE_____

Cert. period_____to_____
Amount
_____

DATE_____

Cert. period_____to_____
Amount
_____

DATE_____

Cert. period_____to_____
Amount
_____

DATE_____

Cert. Period_____to_____
Amount
_____

SRS-FS-20 (Rev. 3/83)

Application Worksheet

Food Stamp case number

Case name

Ethnic code

Work Registration

Household Member No.	Are work registration forms necessary?	If yes, give date received If no, give code letter
1	☐ Yes ☐ No	
2	☐ Yes ☐ No	
3	☐ Yes ☐ No	
4	☐ Yes ☐ No	
5	☐ Yes ☐ No	
6	☐ Yes ☐ No	
7	☐ Yes ☐ No	
8	☐ Yes ☐ No	
9	☐ Yes ☐ No	
10	☐ Yes ☐ No	

Work Registration Codes

- **A.** Under age 18 or age 60 or over
- **B.** Mentally or physically disabled
- **C.** Cares for child under age 12 or incapacitated person
- **D.** Cares for child under age 18 and another member is registered or employed
- **E.** Subject to and participating in WIN
- **F.** Receipt of or registration required for unemployment compensation
- **G.** Participates in drug addict or alcoholic treatment program
- **H.** Works at least 30 hrs. per week or receives weekly earnings equal to Federal minimum wage x 30
- **I.** Student exemption

Citizenship (see back page)

Social Security Numbers (All household members must have a #, see back page.)

Students (see back page)

Workspace—Licensed Vehicles

The $4,500 market value limit applies to *all* licensed vehicles except a vehicle used to transport a physically disabled household member, vehicles used as income producers (taxi, tractor, etc.) or as a home.

Equity value is excluded on the first vehicle and on any vehicles used:

- to produce income.
- for transportation to work, or
- for transportation to training or education preparatory to employment. If both excess value and equity apply to the same vehicle, the greater of the two amounts is counted.

Primary Vehicle and Vehicles Used for Work

Make			
Year			
Fair market value	$	$	$
Minus value limit	-$4,500.00	-$4,500.00	-$4,500.00
Excess value	$	$	$

Other Licensed Vehicle

Make			
Year			
Fair market value	$	Fair market value	$
Minus value limit	-$4,500.00	Minus amt. owed	-$
Excess value	$	Equity value	$

If both excess value and equity value apply to the sample vehicle, the greater of the two amounts is counted as a resource.

Resources (do not enter the value of excluded resources)

Verification of resources (if necessary)

Checking accounts	$
Savings accounts (Include IRA's and certain Keough Plans)	$
Cash on hand	$
Stocks, bonds, etc.	$
Real estate (equity value)	$
Countable value of licensed vehicles (use workspace above)	$
Other	$
Total household resources	$

Maximum resources limit for household: ☐ $1,500 ☐ $3,000

Self-Employment Income (Include room and board payments)

Household Member	Source of Income	Gross Monthly Amount	Verification
		$	
		$	
	Total gross self-employment income	$	
	Subtract monthly business costs	$	
	a. List monthly income before taxes	$	add to sum on line "b" wages & salaries, pg. 2

Wages, Salaries or Other Income from Employment (do not count excluded income)

(For members currently on strike, enter income before the strike.)

Household Member	Source of Income	Gross Monthly Amount	Verification
		$	
		$	
		$	
		$	

b. Total gross employment income, include line "a" (self-employment income) pg. 1 $_____ (enter on line 1, pg. 3)

Educational Grants, Scholarships or Loans

		$
		$
Enter monthly income received from educational grants, etc.		$
Less monthly tuition and mandatory fees	−	$
c. Balance	=	$

Unearned Income

(do not count excluded income)

		$
	+	$
	+	$
	+	$
d. Total unearned income (Line c + Line d)	=	$ _____ (enter on line 2, pg. 3)

Medical Expenses

(List medical expenses for any household member who is age 60 or over or who receives Supplemental Security Income (SSI) benefits benefits or Social Security Disability payments or Veteran's Benefits because of a total disability. Do not count reimbursable expenses.)

	Monthly Amount	Verification (if necessary)
Medical and dental services	$	
Hospital or nursing care	$	
Health insurance and medicare payments	$	
Drugs prescribed by a doctor	$	
Other (specify)	$	
Total	$	
Less −	$ 35.00	
e.	$	(enter on line 13, pg. 3)

Dependent Care

Individual receiving care_____. f. Monthly cost $_____ Maximum, if less $_____
(enter lesser amount on line 15, pg. 3.)

Shelter Costs

	Actual Verified Monthly Charge		Monthly Amount Billed
Telephone (basic rate)	$	Rent or Mortgage	$
Electric	$	Lot Rent	$
Gas	$	Taxes	$
Oil	$	Insurance	$
Water and sewerage	$	Verification Notes:	
Garbage and trash	$		
Installation of utilities	$		
Other_____			
Monthly Utility Charge	$	Standard Utility Allowance or Total Verified cost whichever is greater:	$
Total Utility Standard	$		
(Allow utility standard only if there is an obligation to pay a heat bill separate from rent or mortgage.)		Total Shelter Costs	g. $ (Enter on line 17, pg. 3)

MONTH				
HOUSEHOLD SIZE				
GROSS MONTHLY INCOME (GMI) (Do not count excluded income)				
1. Gross Earned Income (Line "b", pg. 2)				
2. Gross Unearned Income + (Line "d", pg. 2)				
3. Total Income (Lines 1 & 2) =				
4. GMI Standard (Does not apply to households with elderly or disabled members)				
5. GMI Eligible		☐ Y ☐ N		☐ Y ☐ N
NET MONTHLY INCOME (NMI)				
6. Gross Earned Income (Line 1)				
7. Less 18% Line 6 −				
8. Balance =				
9. Plus Unearned Income + (Line 2)				
10. Total Income =				
11. Less Standard Deduction −				
12. Balance =				
13. Less Medical over $35 − (Line "e", pg. 2) (Age 60 or Disabled)				
14. Balance =				
15. Less Dependent Care Cost (Line "f", pg. 2) − Not to Exceed Limit				
16. Balance =				
17. Total Shelter Cost (Line "g", pg. 2) =				
18. Less 50% Line 16 −				
19. Balance =				
▶ *If household has a member age 60 or who receives SS or SSI Disability or Veteran's Benefits because of a total disability, Enter Line 19 on Line 23.*				
20. Maximum Combined Shelter & Dependent Care Deduction				
21. Less Dependent Care Cost, − Line 15				
22. Balance =				
23. Enter Line 22 or 19, whichever is less. − Subtract from line 16				
24. Balance (Equals Net Monthly Income) = (If allotment table is used, round **up** to nearest dollar)				
25. NMI Standard				
26. NMI Eligible		☐ Y ☐ N		☐ Y ☐ N
BENEFIT COMPUTATION				
27. Amount Thrifty Food Plan				
28. Less 30% Line 24 − (Round up to nearest dollar)				
29. Monthly Coupon Allotment		$		$
30. Prorate Benefit for Initial Application and **Late** Recertification		$		$

Application filed_____
Recertification filed_____

Disposition (See page 4 when pending or denying application)

Approved ☐ Expedited Service

Certification period from / / to / /

☐ Change Slip Given to Household

Household size

Allotment: Full month $_____ Initial month $_____

Eligibility worker

Date / /

Citizenship

List alien members, type of verification and date provided:

List members whose citizenship is questionable, reason questionable, type of verification and date provided:

Social Security Numbers

For all members enter person's name & how SSN verified, i.e., "SS card viewed". (If this was done previously, check the open blank.) If some problem, give member's name and status, i.e., SSN applied for, SS-5 on file 4-1-83.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Students

Household Member No.	Date Enrolled	Eligible?	Eligible Status Code
		☐ Yes ☐ No	
		☐ Yes ☐ No	
3		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
6		☐ Yes ☐ No	

Student Eligibility Codes

A. Responsible for care of a dependent household member under age 6 or under age 12 when adequate child care is not available.

B. Disabled or under age 18 or over age 60

C. Employed at least 20 hours per week

D. Participate in a federally financed work study program

E. Receives AFDC benefits.

F. Less than half-time student or not attending institution of higher education

Authorized Representatives

Name _____

Address (if non household member)

_____

_____

Name _____

Address (if nonhousehold member)

_____

_____

Is anyone eligible for meals-on-wheels or communal dining? ☐ Yes ☐ No

Disposition (When not approved)

☐ Pended

Reason _____

_____

Eligibility worker _____

Date / /

☐ Denied

Reason _____

_____

Eligibility worker _____

Date / /

Remarks

SRS—FS—20C
(New 1-83)

STATE OF MONTANA
DEPARTMENT OF SOCIAL & REHABILITATION SERVICES

FOOD STAMP MONTHLY COMPUTATION WORKSHEET

Name _____ Date _____

HOUSEHOLD SIZE		PROS		RETRO		VERIFICATION NOTES
GROSS MONTHLY INCOME (GMI) (Do not count excluded income)						
1. Gross Earned Income (Line 4 FS-20)						
2. Gross Unearned Income (Line 8 FS-20)	+					
3. Total Income (Lines 1 & 2)	=					
4. GMI Standard						
5. GMI Eligible			☐ Y ☐ N		☐ Y ☐ N	
NET MONTHLY INCOME (NMI)						
6. Gross Earned Income (Line 1)						
7. Less 18% Line 6	−					
8. Balance	=					
9. Plus Unearned Income (Line 2)	+					
10. Total Income	=					
11. Less Standard Deduction	−					
12. Balance	=					
13. Less Medical over $35 (Age 60 or Disabled)	−					
14. Balance	=					
15. Less Dependent Care Cost Not to Exceed Limit	−					
16. Balance	=					
17. Total Shelter Cost (Line 20 FS-20)	=					
18. Less 50% Line 16	−					
19. Balance	=					
► *If household has a member age 60 or who receives SS or SSI Disability, Enter Line 19 on Line 23.*						
20. Maximum Combined Shelter & Dependent Dare Deduction						
21. Less Dependent Care Cost, Line 15	−					
22. Balance	=					
23. Enter Line 22 or 19, whichever is less. Subtract from line 16	−					
24. Balance	=					
25. NMI Standard						
26. NMI Eligible			☐ Y ☐ N		☐ Y ☐ N	
BENEFIT COMPUTATION						
27. Amount Thrifty Food Plan						
28. Less 30% Line 24	−					
29. Monthly Coupon Allotment						

Effective Date		
Worker		
Date Posted to HPR Card		
Clerical Worker		

SRS—FS—11
(Rev. 11/81)

MONTANA DEPT. OF SOCIAL & REHABILITATION SERVICES

FOOD STAMP NOTICE OF DECISION

Name: _____ Case No: _____

Address: _____ Auth. Rep.: _____

City: _____ State: _____ Zip: _____ App. Date: _____

TYPE OF ACTION: ☐ New Application ☐ Change ☐ Re-Certification

ACTION TAKEN: ☐ Approval ☐ Pended ☐ Denial ☐ Close ☐ Restore or Supp. Benefits

Household size: _____ ☐ AFDC ☐ Non-AFDC Mail Issuance: Effective date: _____

FOR MORE INFORMATION CONTACT:

Worker: _____ Phone: _____ Date: _____

Explanation of Action Taken:

We are writing to tell you about the action which the _____ County Welfare Department has taken on your food stamp case. We have explained the action next to the boxes marked:

☐ You will receive food stamp benefits during the month(s) of _____.

The first month you will receive _____ which covers the month(s) of _____

After this month, you will receive _____.

"Use Only for 30-day or 60-day Certifications Which are Approved After the 15th of the Month

☐ In order to continue to receive food stamp benefits without a break, you need to file a new application by: _____.

(See instructions on the back of this letter about contin uing your food stamp benefits.)

☐ Because you needed food stamps right away, we postponed asking you to give us certain information. Before you receive additional food stamps, you must bring in or mail the following information:

_____

_____

If this information results in a change(s) in your eligibility or benefits, the change(s) will be made without giving you advance notice.

☐ We have found that you are eligible for:

☐ increased ☐ restored or

☐ supplemental benefits for the period _____ _____ in the amount of _____.

☐ Your application has not been approved because:

_____

_____

_____

Legal base for action: _____ **CFR** _____.

Manual Reference: _____

☐ You didn't do everything required for us to find out if you are eligible for food stamps. Here's what you still need to do:

_____

_____

_____

_____

If you do this by _____ you won't need to reapply.

☐ We have found that your household no longer qualifies for the food stamp benefits you have been receiving. Your benefits will be:

☐ Ended on: _____

☐ Reduced to: _____ per month on: _____

This change is being made because: _____

_____

_____

_____

Legal Base for action: _____ **CFR** _____.

Manual Reference: _____

Request for Fair Hearing: You can have a fair hearing on your case if you do not agree with our decision. To request a hearing, fill out & return the request on back of this form.

You can continue to receive food stamps at your current rate if you request a hearing by _____.

You can then receive them until your hearing is decided or your eligibility period ends, whichever comes first. If, however, the hearing finds that our decision was correct, your household will owe us the value of the extra food stamps you received.

Ethnic Group: ☐ B ☐ H ☐ AI ☐ A ☐ W Date posted to HPR: _____ Clerical Worker: _____

DISTRIBUTION: **Original to Clerical Unit and then to case file** **Copies 1 & 2 to household**

CONTINUING FOOD STAMP BENEFITS

To begin the recertification process, complete the first page and as much of the rest of the application as possible and mail or bring it to us. If you can't mail or bring in the first page, someone else can do it for you. If we receive the first page of the application by the date shown on the front of this letter, you complete the certification requirements and are found eligible, you will continue to receive food stamps without a break. Otherwise, your benefits may be late.

Please call and let us know if you cannot send your application on time. If you were sick or have another good reason and qualify, you will get all the food stamps you missed. If we decide you did not have a good reason for applying late, you can appeal our decision by asking for a fair hearing.

- - - - - -

FAIR HEARING REQUEST

You can have a hearing if you do not agree with our decision on the front of this notice. At the hearing you will have a chance to explain why you disagree. A Hearing Officer will decide who is right.

You can still request a hearing after the date written under the hearing clause on the front of this form, but you won't be able to receive food stamps at your current rate. If you want to discuss our decision or ask any questions about how a fair hearing works, call the food stamp office.

If you would like a fair hearing fill out one page of this form and mail to:

Hearing Officer
Montana Dept. of Social & Rehabilitation Services
P.O. Box 4210
Helena, MT 59604

(Use this space to tell us why you want a fair hearing): _____

_____

_____

If you are requesting a hearing because of a reduction in benefits, please check one of the following:

[ ] I want to continue receiving the amount of food stamps I now receive until the hearing.

[ ] I do not want to continue receiving the amount of food stamps I now receive until the hearing.

_____
(Your Signature)

Telephone number where you can be reached: _____

Today's Date: _____

- - - - - -

LEGAL AID

If you are dissatisfied with any decision of the Department affecting benefits you are receiving or have applied to receive, you may be entitled to independent legal assistance. For help in obtaining legal counsel or other representation, contact the Eligibility Technician at your County Welfare Office or call the nearest office of the Montana Legal Services Association.

If this presents some problem, please contact you local County Welfare Office.

- - - - - -

FOR OFFICE USE ONLY:

Date received by Hearing Officer:

SRS–FS–22
(rev. 11/78)

STATE OF MONTANA
DEPARTMENT OF SOCIAL & REHABILITATION SERVICES

NOTICE OF CHANGE TO HOUSEHOLD PARTICIPATION RECORD CARD

NAME: _____ CASE NO: _____

ADDRESS: _____

ACTION TO BE TAKEN: ☐ New Cert. ☐ Change ☐ Close ☐ Restore Lost Benefits or Supp. Benefits

ALLOTMENT: _____ CERTIFICATION PERIOD: _____

(Use Variable Allotments when changes are anticipated within the certification period)

1. Variable Allotment: _____ Month(s) _____
2. Variable Allotment: _____ Month(s) _____

(NOTE: Clerical Worker will enter the Variable Allotment on a separate line on HPR card)

H. H. SIZE	(AFDC or NON–AFDC)	ETHNIC GROUP
		B H AI A W

RESTORATION OF LOST BENEFITS OR SUPPLEMENTAL BENEFITS

Period of Recovery: _____

Amount to be Restored: $ _____

AUTHORIZED REPRESENTATIVE: _____

DATE: _____ ELIGIBILITY WORKER: _____

DATE POSTED: _____ CLERICAL WORKER: _____

DISTRIBUTION: Original to Food Stamp Clerical Unit and Duplicate to Case File.

SRS-FS-71
(New 7/83)

STATE OF MONTANA
DEPARTMENT OF SOCIAL & REHABILITATION SERVICES
Helena, Montana 59604

NOTICE OF LATE OR INCOMPLETE
MONTHLY REPORT, FOOD STAMP PROGRAM

(Name and address of County Welfare Office)

TO: _____ **FROM:**

_____

_____

_____
Eligibility Technician

_____
Date

☐ Your "Monthly Eligibility and Income Report", due the eighth (8th) day of this month, has not been returned to our office. Your case will be closed if you do not return your report by the date shown below. If for some reason you did not receive this report or need help in completing the report, please contact our office.

☐ We have received your "Monthly Eligibility and Income Report" for FOOD STAMPS. However, we still need the following information in order to determine whether you continue to be eligible for benefits:

IF THIS INFORMATION IS NOT RECEIVED BY_____, YOUR CASE WILL BE **CLOSED** EFFECTIVE_____ FOR FAILURE TO COMPLY WITH AGENCY REQUIREMENTS. Once your case is closed you will need to reapply for benefits. There may be a waiting period for your reapplication interview.

Legal Basis for Action:
ARM 46.11.120
7 CFR 273.21

SEE BACK OF NOTICE FOR
FAIR HEARING REQUEST

Distribution: Original to client; copy to case file.

IMPORTANT

If you disagree with the action taken by the County Welfare Office, request a fair hearing immediately. If a fair hearing is requested within ten (10) days of the mailing date of this notice, and if the State Department of Social and Rehabilitation Services determines that the issues concern facts or judgments relating to your individual case, rather than State policy, the action will not be effective until the fair hearing decision is rendered.

You have ninety (90) days from the date your case is closed to request a fair hearing.

Fair hearings are conducted by the Department's Hearing Officer. Decisions by the Hearing Officer are binding on the Department and must conform to Federal and State Law, regulation or policy and must be based exclusively on evidence and other material introduced at the hearing.

The right to a fair hearing on the county's action includes an administrative review of the action and a pre-hearing conference on the action.

The purpose of the administrative review is to permit you to discuss the proposed action with representatives of the Department; to present additional information to the Department concerning the action; and to obtain additional explanations from the Department of the reasons for the action.

The purpose of the pre-hearing conference is to consider simplification of the legal and factual issues in preparation for the fair hearing; to obtain admissions of fact and documents which will avoid unnecessary proof in the fair hearing; to explore any possibility of settlement of the parties' differences; to establish what evidence and witnesses will be presented in the fair hearing; and to discuss any other matters which may aid in the disposition of the fair hearing.

You may be represented by an attorney, or by a relative, friend or other spokesperson, or you may represent yourself. The Eligiblity Technician at your County Welfare Office can tell you where and how to obtain free legal help.

A request for a fair hearing need not be in writing. However, the blank below is provided for your convenience. Fill in, sign and mail to:

Hearing Officer — Box 4210 — Helena, MT 59604

REQUEST FOR FAIR HEARING

CLAIMANT'S NAME:	SOCIAL SECURITY NO:	PHONE:
STREET ADDRESS:	**CITY:**	**ZIP CODE:**

This is to request a fair hearing. I am making this request because: _____

_____

_____

_____

I have an attorney: ☐ **Yes** ☐ **No** . My attorney's name is: _____ .

His/her address is: _____ . His/her phone number is: _____ .

_____ _____

(CLAIMANT OR AUTHORIZED REPRESENTATIVE) **(DATE)**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0066

FORM SS-5 — APPLICATION FOR A SOCIAL SECURITY NUMBER CARD
(Original, Replacement or Correction)

MICROFILM REF. NO. (SSA USE ONLY)

Unless the requested information is provided, we may not be able to issue a Social Security Number (20 CFR 422.103(b))

INSTRUCTIONS TO APPLICANT ▶ Before completing this form, please read the instructions on the opposite page. You can type or print, using pen with dark blue or black ink. Do not use pencil.

NAM	NAME TO BE SHOWN ON CARD	First	Middle	Last
NAB 1	FULL NAME AT BIRTH (IF OTHER THAN ABOVE)	First	Middle	Last
ONA	OTHER NAME(S) USED			
STA 2	MAILING ADDRESS	(Street/Apt. No., P.O. Box, Rural Route No.)		
CTY STE ZIP	CITY	STATE	ZIP CODE	

CSP 3 CITIZENSHIP (Check one only)
- ☐ a. U.S. citizen
- ☐ b. Legal alien allowed to work
- ☐ c. Legal alien not allowed to work
- ☐ d. Other (See instructions on Page 2)

SEX 4 SEX
- ☐ MALE
- ☐ FEMALE

ETB 5 RACE/ETHNIC DESCRIPTION (Check one only) (Voluntary)
- ☐ a. Asian, Asian-American or Pacific Islander (Includes persons of Chinese, Filipino, Japanese, Korean, Samoan, etc., ancestry or descent)
- ☐ b. Hispanic (Includes persons of Chicano, Cuban, Mexican or Mexican-American, Puerto Rican, South or Central American, or other Spanish ancestry or descent)
- ☐ c. Negro or Black (not Hispanic)
- ☐ d. North American Indian or Alaskan Native
- ☐ e. White (not Hispanic)

DOB 6	DATE OF BIRTH ▶	MONTH	DAY	YEAR	AGE 7	PRESENT AGE	PLB 8	PLACE OF BIRTH ▶ CITY	STATE OR FOREIGN COUNTRY	FCI ☐

MNA 9	MOTHER'S NAME AT HER BIRTH	First	Middle	Last (her maiden name)
FNA	FATHER'S NAME	First	Middle	Last

PNO 10
a. Has the person listed in Item 1 above or anyone acting on that person's behalf ever applied for a social security number card before? ☐ YES (2) ☐ NO (1) ☐ Don't know (1) **If yes, when:** MONTH / YEAR

b. Was a card received? ☐ YES (3) ☐ NO (1) ☐ Don't know (1) **If you checked yes to a or b, complete items c through e; otherwise go to Item 11.**

SSN c. Enter Social Security Number ☐☐☐-☐☐-☐☐☐☐

NLC PDB d. Enter the name shown on the most recent social security card

e. Date of birth correction (See Instruction 10 on page 2) ▶ MONTH / DAY / YEAR

DON 11 TODAY'S DATE ▶ MONTH / DAY / YEAR

12 Telephone number where we can reach you during the day. Please include the area code. ▶ HOME / OTHER

ASD 13 **WARNING: Deliberately furnishing (or causing to be furnished) false information on this application is a crime punishable by fine or imprisonment, or both.**

YOUR SIGNATURE

14 YOUR RELATIONSHIP TO PERSON IN ITEM 1
- ☐ Self
- ☐ Other (Specify) _____

WITNESS (Needed only if signed by mark "X")

WITNESS (Needed only if signed by mark "X")

DO NOT WRITE BELOW THIS LINE (FOR SSA USE ONLY)

SSN ASSIGNED ☐☐☐-☐☐-☐☐☐☐

DTC | SSA RECEIPT DATE

NPN

DOC | NTC | CAN | BIC

SIGNATURE AND TITLE OF EMPLOYEE(S) REVIEWING EVIDENCE AND/OR CONDUCTING INTERVIEW

TYPE(S) OF EVIDENCE SUBMITTED

☐ MANDATORY IN PERSON INTERVIEW CONDUCTED

DATE

DATE

IDN | ITV | DCL

DEPARTMENT OF SOCIAL &
REHABILITATION SERVICES
RAVALLI COUNTY OFFICE OF HUMAN SERVICES

TED SCHWINDEN, GOVERNOR

310 NORTH THIRD STREET

STATE OF MONTANA

(406) 363-1944

HAMILTON, MONTANA 59840

MEDICAL-NURSING HOME

_____ has an appointment on _____ at _____ am/pm
The application should be completed before your interview. If you are late it is possible that you will not be seen that day, but will have to have your appointment rescheduled.

To determine eligibility for assistance, we MUST have the following documents as they apply to your case.

I. IDENTIFICATION:
- -Birth certificates
- -Baptismal Certificates
- -Proof of Age from Social Security
- -Social Security Cards (For all family members)

II. INCOME:
- -VA Benefits Verification
- -SS Benefits Verification
- -Any other Determined Benefits Verification
- -Closure Letter from other State or county
- -Escrow Payments
- -Family Contribution
- -Interest Income

III. RESOURCES:
- -Checking Account Statement-Current
- -Savings Account Statement-Current
- -Contracts of Property Transfers
- -Life Insurance Policies
- -Burial Agreement
- -CD Numbers, Face Value, Interest accumulated
- -Vehicle Registrations
- -Stocks, Bonds, Mutual Funds
- -Property Tax Receipts
- -Mineral Rights
- -Lease Agreement
- -Escrow & Trust Funds-Locations of

IV. MEDICAL:
- -Copy of Medicare Card
- -Hospital/Medical Insurance Policy
- -Health Insurance Premium

V. OTHER:
- -Face Sheet
- -Appt. for Safety Deposit Box
- -Power of Attorney, or Other Legal documents

If verification and documentation is not readily available by your appointment date, bring in what you have and additional time will be given to you to obtain the items still needed.

If you fail to keep your appointment without notifying our office (363-1944), we will consider that you are not interested at this time, but will reapply at a later date.

SRS–EA–1(e)
(rev. 9/78)

MONTANA DEPARTMENT OF SOCIAL & REHABILITATION SERVICES
Economic Assistance Division

FACE SHEET

County: _____
H. H. No: _____
Date: _____
Phone: _____

SURNAME: _____ FIRST NAME: _____

CROSS REFERENCES: _____

MEMBERS OF HOUSEHOLD

NAME	BIRTH–DATE	BIRTHPLACE	RELAT.	RACE	RELIGION	EDUC.	SOC. SEC. NO.	VETER. STATUS	CENSUS NUMBER
Man									
Woman									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
Deceased Spouse									

CURRENT ADDRESS

STREET & NUMBER	CITY	COUNTY	STATE	FROM	TO

FAMILY STATUS

☐ Single ☐ Divorced ☐ Married ☐ Deserted ☐ Widowed ☐ Separated ☐ Other

MAIDEN NAME	MARRIAGE			TERMINATION		
	DATE	TOWN	STATE	DATE	TOWN	STATE
Present Marriage:						
Former Husband (name)						
Former Wife (name)						

Court Stipulations (support orders, custody, etc.) _____

Other agencies or persons interested: _____

RELATIVES

NAME	ADDRESS	RELATION.	NAME	ADDRESS	RELATION.

SRS—EA—1A
(Rev. 8/83)

APPLICATION
REDETERMINATION FOR ASSISTANCE

▶ *PLEASE PRINT CLEARLY* ◀ H. H. No. ____

COLUMNS: A	B	C	D	E	F	G
Print the names of all persons who live in your present household: First Middle Initial Last	Birthdate Mo./Day/Yr. and Birthplace	Sex M/F	Relationship to Applicant	Social Security Number and Indian Enrollment Number	Full Time Student? Yes or No	Child Support Code See Item 22 Below
1. (Man)	/ /			SSN / IE		
2. (Woman) (Maiden)	/ /			SSN / IE		
3.	/ /			SSN / IE		
4.	/ /			SSN / IE		
5.	/ /			SSN / IE		
6.	/ /			SSN / IE		
7.	/ /			SSN / IE		
8.	/ /			SSN / IE		
9.	/ /			SSN / IE		

TO LIST ANY ADDITIONAL PERSONS WHO LIVE IN YOUR HOUSEHOLD, ASK FOR PAGE 2A, FORM **EA—1A**

22. COLUMN G ENTRY: Print one of the following code letters that shows the reason why the parent cannot support each Child that is listed above. If both Parents are in the home, pick the code that applies to the Father. If there is an absent parent, choose the code letter that applies to the absent parent.

CODE:
1. Separation (SP)
2. Unemployed Parent (UP)
3. Divorce (DV)
4. Unmarried—Paternity (PE) Established

CODE:
5. Desertion (DS)
6. Incapacity (IC)
7. Medical Institution (MI)
8. Unmarried—Paternity (NE) Not Established

CODE:
9. Jail, or Prison (JP)
10. Death (DE)
11. Armed Forces (AF)
12. Deported (DP)

23. If the parent is absent from the home, how long has he been gone? ..... months

24. Are there any members of your household that do NOT need assistance? ☐ Yes ☐ No
If "YES," list their names here: .....

25. Have you received any money from any other Welfare Agency in the last 4 months? ☐ Yes ☐ No
When: Mo. ..... Day ..... Yr. ..... Where .....

26. Do you intend to make your home in Montana? ☐ Yes ☐ No How long in present county ..... Months
County of Legal Residence ..... Current Address .....

27. *MONTHLY EXPENSES:*

RENT:	$	**MORTGAGE PAYMENT:**	$	**WATER:**	$
LIGHTS:	$	**TAXES:**	$	**SEWER:**	$
HEATING FUEL:	$	**TELEPHONE:**	$	**OTHER:**	$
MEDICAL PAYMENT	$	SUPPORT and ALIMONY	$		

40. Are you currently registered for work at the local employment office? ☐Yes ☐No

41. Have you filed for unemployment, or workmen's compensation? ☐Yes ☐No

42. Have you been out of work for 30 days, or more? ☐Yes ☐No

43. Have you refused a job in the last thirty days? ☐Yes ☐No

44. Are you currently working 100 hours, or more, in a month? ☐Yes ☐No

45. If your answer to 44 was YES, list the details here: .....

46. *EMPLOYMENT HISTORY FOR THE LAST 3 YEARS. (List the most recent employer first.)*

DATA FOR APPLICANT					DATA FOR SPOUSE OF APPLICANT				
Employer's Name	**City**	**State**	**From**	**To**	**Employer's Name**	**City**	**State**	**From**	**To**

50. **LISTING OF ASSETS.** Print the estimated dollar ($) value of the assets listed below that YOU, OR YOUR SPOUSE, OR ANY OTHER MEMBER OF YOUR HOUSEHOLD possess. If YOU, or any member of your household DO NOT HAVE the asset listed below, then place a √ in the column marked "NONE." Personal clothing and household furniture should not be listed below. An entry is required for each asset line.

ASSETS	√NONE	Yours	Spouse	Others	ASSETS	√NONE	Yours	Spouse	Others
Checking Account(s)		$	$	$	Automobile No. 1		$	$	$
Savings Account(s)		$	$	$	Automobile No. 2		$	$	$
Money NOT in a Bank		$	$	$	Truck		$	$	$
Credit Union Shares		$	$	$	Trailer or Camper		$	$	$
Savings Bond(s)		$	$	$	Boat or Snowmobile		$	$	$
Retirement Fund		$	$	$	Motorcycle		$	$	$
Stocks or Bonds		$	$	$	Tools, hand & powered		$	$	$
Burial Funds		$	$	$	Farm/Business Equipmt.		$	$	$
Real Estate Used as Home		$	$	$	Livestock or Poultry		$	$	$
Other Real Estate		$	$	$	Safety DP, CD, etc.		$	$	$

51. Do you, or your spouse, have any life insurance? ☐Yes ☐No Company .....

Face Value $..... Cash Value $..... Policy No. .....

52. In the last 2 years, have you, or any member of your household, sold or given away, a house, building, real estate, or other property to another person(s)? ☐ Yes ☐ No

If your answer is "YES" list the details in item 80, supplemental page.

60. INCOME LISTING. Print the amount of money received by YOU, YOUR SPOUSE, or any other member of your household in the correct column, below. If you DO NOT RECEIVE income from the sources listed below, make a √ in the "NONE" column. For any income that you receive but is not listed in column A, below, print the amount in the line marked "ANY OTHER INCOME."

A	B	C	D	E	F
TYPES OF INCOME	√NONE	YOURS	SPOUSE	OTHERS	How Often Received
UNEMPLOYMENT COMPENSATION		$.	$.	$.	
WORKMEN'S COMPENSATION (IA)		$.	$.	$.	
SOCIAL SECURITY BENEFITS		$.	$.	$.	
RAILROAD RETIREMENT		$.	$.	$.	
VETERANS ADMINISTRATION BENEFITS		$.	$.	$.	
RETIREMENT OR PENSION INCOME		$.	$.	$.	
ARMED FORCES ALLOTMENT		$.	$.	$.	
ALIMONY AND CHILD SUPPORT		$.	$.	$.	
RELATIVE CONTRIBUTIONS		$.	$.	$.	
INCOME FROM MORTGAGE, or Sales Contract		$.	$.	$.	
RENT FROM REAL ESTATE PROPERTY		$.	$.	$.	
INCOME FROM ROOMERS, or Boarders		$.	$.	$.	
INTEREST FROM SAVINGS ACCOUNT		$.	$.	$.	
MONEY FROM INDIAN TRIBAL FUNDS B.I.A., and/or I.I.M.		$.	$.	$.	
OIL OR MINERAL BENEFITS		$.	$.	$.	
ANY OTHER INCOME		$.	$.	$.	

If you expect to receive income from any of the above sources, explain in Block 80.

COMPLETE THIS SECTION IF ANY MEMBER OF HOUSEHOLD IS EMPLOYED

61. GROSS PAY (Before Deductions)		$.	$.	$.	
62. List your **REQUIRED DEDUCTIONS,** but only if you entered Gross Pay above.					
a. Income Taxes (Federal)					
b. State of Montana Taxes					
c. Social Security					
d. Other required deductions; Union Dues, Medical, etc.					
e. Transportation to and from work					
f. Other work deductions, uniforms, etc.					
g. Retirement					

63. If you are self-employed, we will need a copy of your last income tax return.

70. If the Applicant, or Spouse, is *unable* to work, list the reason(s) here: .....

71. If any member of your household is pregnant, list the name of the person: .....
and expected date of birth: .....

72. Is any member of household currently covered by Health, Accident, or Hospital Insurance? If "YES" enter the company name here: ..... ☐ Yes ☐ No

73. Is another person, or company, responsible for medical care that you or any member of your family is receiving, or has received? ☐ Yes ☐ No

74. Do you owe money for medical care that you, or any family member received in the last three months? ☐ Yes ☐ No

75. Do you make regular payments on medical bills, or medical insurance premiums? ☐ Yes ☐ No

If "YES", provide payment information below:

	AMOUNT PAID	PAID HOW OFTEN
a. Medical Bills (Doctor or Hospital)		
b. Health, Accident or Hospital Insurance		
c. Prescribed Medication		
d. Any other medical expense(s)		

76. Responsible relative

NAME	ADDRESS	RELATION

80. Use this block for additional details, or explanation of previous blocks: .....

90. BE SURE THAT YOU HAVE ANSWERED ALL QUESTIONS ON FORM EA-1, AND PAGES 2 TO 5, FORM EA-1A. READ CAREFULLY THE FOLLOWING STATEMENT BEFORE YOU SIGN:

I declare that this statement has been examined and filled out by me, and to the best of my knowledge and belief is true, accurate and complete. I understand that any misstatement will be investigated and prosecuted. I further declare that I will promptly report to the Welfare Department all facts concerning any income or sources received by me and/or my dependents and any change of circumstances whatever of myself and/or dependents for whom I have applied for assistance.

I understand I can appeal for a fair hearing to the State Department of Social Rehabilitation Services if I am not satisfied with the promptness of the action on my application, with the decision, or with the amount of assistance which I receive.

I have been informed of the availability of Family Planning and early screening and may have these services by contacting the County Welfare Office.

I understand that this Declaration of Facts may be investigated by the Department of Public Welfare and I agree to cooperate by signing EA-4 and EA-29 and help in such an investigation by presenting proof of the statements I have made in this Declaration.

I hereby authorize all medical providers to provide and release any medical information pertaining to myself, or any other person for whom I am applying for assistance, to the State Department of Social and Rehabilitation Services, the State Department of Revenue, and their agents, upon their request, and hereby release said medical providers from any liability based on such release.

Benefits and services must be provided without regard to race, color, national origin, religion, political belief, age, handicap, sex or marital status. I understand I may file a complaint with the State Department of Social and Rehabilitation Services if I feel that I have been discriminated against.

(APPLICANT OR GUARDIAN – SIGN HERE)	Date	(SPOUSE OF THE APPLICANT – Sign Name Here)	Date

91. If the applicant CANNOT write, or sign his name above, a Mark will be used instead of a signature; one witness is then required to verify the applicant's Mark and complete 92 below.

92. Witness's Signature (When Required)	Date	Witness Address & Zip Code

Date _____ Worker's Signature _____

SRS—EA—4A
(Rev. 11/83)

STATE OF MONTANA
DEPARTMENT OF SOCIAL & REHABILITATION SERVICES
Economic Assistance Division

RELEASE OF CONFIDENTIAL INFORMATION

AUTHORIZATION TO MONTANA SOCIAL & REHABILITATION SERVICES TO OBTAIN PERSONAL INFORMATION

Client's Name:_____ SSN:_____

Address:_____
(STREET) (CITY) (STATE) (ZIP CODE)

I authorize the individual, company or agency shown below to disclose to the _____ County Department of Welfare of the Montana Social and Rehabilitation Services, the information specified below, which relates to my eligiblity to receive Public Assistance benefits. I understand any information obtained will be kept confidential and will be used only for purposes directly connected with the administration of benefits or services. I further understand that any information obtained may be released to a proper governmental agency or court of law enforcement agency for purposes of legal and investigative actions concerning fraud, collection of support or establishment of third party liability.

INFORMATION SOURCE: Landlords, Neighbors, Employers, Social Security Administration, Doctors, Hospitals, Veterans Administration, Bureau of Indian Affairs, Department of Labor and Industry, Assessors, Treasurers, County Clerks of Court, Banks, Credit Unions, Savings and Loans, Buyers of Contracts for Deed/Negotiable Instruments.

INFORMATION TO BE REQUESTED: Family Composition, Earned Wages, Unearned Wages, Checking Accounts, Savings Accounts, Stocks, Bonds, Time Certificates, BIA-IIM Funds, Veterans Benefits, Unemployment Compensation, Workmens Compensation, Loans, Personal Property, Mortgages, Contracts for Deed/Negotiable Instruments, Real Estate, etc. Also, Medical Reports or conditions to exempt participation in employment or County Work Program.

DISCLOSURE: Please provide information requested in space below or on back of sheet.

Signature of applicant or authorized representative:

X_____ Date:_____

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

TED SCHWINDEN, GOVERNOR

P.O. BOX 4210

STATE OF MONTANA

HELENA, MONTANA 59604

_____ has filed an application for Montana Medicaid. To determine eligibility it will be necessary for you to answer the following questions.

We have enclosed a preaddressed-stamped envelope for your convenience. Please return this form within five (5) days.

1. Client's place of birth _____
   Maiden Name _____
   Date of birth _____
   U.S. Citizenship, if born other than in U.S. _____

2. Residency for 5 years prior to nursing home placement
   _____

3. Client's occupation prior to retirement or entry into nursing home
   _____
   Spouse's Name _____
   Spouse's occupation prior to retirement or entry into nursing home
   _____

4. Is the client a veteran? ( )Yes ( )No If yes, VA claim number
   _____

   Was the client's spouse a veteran? ( )Yes ( )No If yes, VA claim number _____

5. a) Where are the client's savings accounts located?
   _____
   Address _____

   b) Where are the client's checking accounts located?
   _____
   Address _____

c) Where is the client's safety deposit box located?
Address _____

d) Does the client own any mineral rights? ( )Yes ( )No
If yes, where located and address _____
_____

e) Does the client have any contract for deeds or property agreements? ( )Yes ( )No
If yes, please describe _____

f) Does the client own a home? ( )Yes ( )No
If yes, where located _____

g) Does the client own a vehicle? ( )Yes ( )No
If yes, who has the vehicle, where is it licensed, who has the title and describe the vehicle _____
_____

h) Does the client have any stocks or bonds? ( )Yes ( )No
If yes, please describe _____

i) Please list any other liquid resources _____
_____

j) Please list any other real or personal property _____
_____

6. Do you or anyone have any liquid, real, or personal property which belongs to the client? ( )Yes ( )No
If yes, please describe _____

7. Does the client have any money set aside for burial? ( )Yes ( )No
If yes, please describe _____

8. Has the client set aside money for a special purpose or for an emergency? ( ) Yes ( ) No
If yes, please describe _____

9. Does the client's name appear on any accounts or resources which could be considered to be someone elses? ( ) Yes ( ) No
If yes, give the other person's name and the location of the account _____

10. Has any account with the client's name on it been closed in the last 2 years? ( ) Yes ( ) No
If yes, give a brief explanation of what happened to the money which was in the account before it was closed _____
_____

11. Does the client have any medical, accident or nursing home insurance?
( )Yes ( )No
Company Name _____
Company Address _____
Certificate No. _____ Policy No. _____
Effective Date _____ Premium _____

12. Does the client have any life insurance? ( )Yes ( )No
Company Name _____
Company Address _____
Policy No. _____
Face Value of Policy _____
Cash Surrender Value _____

13. What is the client's source(s) of income and amount?

_____

_____

Your cooperation in this review will be greatly appreciated. Thank you for your time.

Sincerely,

_____
Eligibility Technician

SRS-EA-77
(Rev. 5/82)

WORKSHEET
RESOURCE EVALUATION/REVIEW

Start Date:_____ County:_____ E.T._____

Client Name:_____ Social Security No._____

Safety Deposit Box ☐ Yes ☐ No Contents:

RELATED MA MANUAL SECTION	RESOURCE TYPE	CURRENT MARKET VALUE	EQUITY VALUE
204-2A, 204-2B,C,D,E	Real Estate		
204-2B	Burial/Cemetery Plots		
204-2B	Other Real Property		
204-2C	Life Estates		
204-4A,B,C,D,E,F	Automobiles		
204-7	Life Insurance		
204-9	Burial Contracts/Agreements		
204-8	Trusts		
204-10A	Savings Accounts		
204-10A	Checking Accounts		
204-10B	Time Deposits		
204-10C	Stocks		
204-10D	Mutual Funds		
204-10F	Bonds, U.S. Savings		
204-10E	Bonds, Munic., Corp., Govt.		
204-11A	Mineral Rights		
204-1B	Nursing Home Account		
204-3	Items of Unusual Value		
204-10G	Property Agreements		

TOTAL CURRENT MARKET VALUE . . . . . =

a) If CMV is less than $1500, you need not compute equity value.
b) If CMV is more than $1500, you must compute equity value.

NEXT RESOURCE REVIEW DATE:_____

Rationale:

_____ _____
E.T. Signature *Date*

FORM SRS–EA–33

SOCIAL SECURITY NUMBER CONSENT STATEMENT

"I understand that providing my Social Security Number to the State agency of the State government lawfully charged with administering Title XIX (Medicaid) of the Social Services Act is voluntary. The only use of the Social Security Number to be made by the State agency is the administration of Title XIX programs, with no disclosure of such Social Security Number for any other purpose."

"I hereby consent to be issued a Social Security Number by the Social Security Administration and to have my Social Security Number released for the aforementioned purposes only."

_____
Signature

_____
Date

SRS-EA-5(a)
(New 5/82) Department of Social and Rehabilitation Services

IMPORTANT INFORMATION ABOUT FORM SRS-EA-5, "AGREEMENT TO SELL PROPERTY"

I. TIME LIMITS FOR SELLING PROPERTY

The time limit during which you must sell the property is:

Real Property(Houses,Land,etc.)-6 months from the date this agreement is approved.

All Other Property-3 months from the date this agreement is approved.

Notify your welfare office immediately if you find you are unable to sell the property within this time limit.

II. CURRENT MARKET VALUE

When you sign Form SRS-EA-5, you agree to sell the resources described on the form for their current market value. This means the highest amount you can get by offering it on the open market.

If you knowingly dispose of an agreed-upon resource for less then its current market value, the welfare office will determine what the current market value was at the time of disposition and determine the amount of your overpayment accordingly.

III. NOTIFYING YOUR WELFARE OFFICE

Notify your welfare office as soon as you sell the property. Also notify your welfare office immediately if you encounter difficulty in selling the property or if you decide not to sell the property.

SRS-EA-6
(New 5/82)

MEDICAL INSTITUTIONAL BUDGET

ient Name: _____ SS No. _____

DATE						
Earned Income						
+ Unearned Income						
– Personal Needs						
– Spouse/Family Maint.						
– Medical Insur. Premium						
– Home Maintenance						
Gross Available Income						
1. SSI/BASICALLY NEEDY						
Cost of Care						
– Gross Available Income						
Eligibility	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Effective Date						
Worker						
2. PRIVATE PAY						
Gross Available Income						
– Cost of Care						
Obligation						
X 3 Months						
Quarterly Obligation						
– Medical Expense						
Deficit						
Eligibility	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Effective Date						
Worker						

[redacted] 526-34-[redacted]

INTAKE AND PROBLEM 07-24-84:

Application for MA-Nursing Home for [redacted] age 76. Interview with [redacted] daughter-in-law. Previously on MA, February, 1981 through March, 1984. Closed due to over resources. (See inactive file, Fair Hearing data, etc..).

Excess resources, mineral acres, were purchased by son, [redacted] and recorded May, 1984 for $3,366.36, considered fair market value due to inappropriatness of an exact title search, (see lawyers letter). Money used to pay May, June and July nursing home charges, statement and receipt copied.

HOUSEHOLD COMPOSITION:

[redacted] 01-09-08, 526-[redacted]
Social Security and Medicare cards copied.
Son, [redacted] has power of attorney, copied.

THIRD PARTY LIABILITY:

Medicare only.

RESIDENCE:

North Valley Nursing Home, Stevensville, Montana.

DEPRIVATION:

Aged.

INCOME:

Social Security, $294.00 monthly including $14.60 Medicare premium.
Verified June 18, 1984 Bendex and copy of January, 1984 S.S. check.

RESOURCES:

Checking account	$ 60.48,	August 1, 1984, First State Bank, Stevensville, EA-4.
Stocks	184.50,	Dallea Petroleum Corporation, Inc., 123 shares at $1.50 each.
Cash value	588.09,	Glacier Life Insurance Company, $1,650.00 face value.
Nursing Home acct.	86.44	
Total	$919.51.	

RECOMMENDATIONS:

Approve Medical Assistance Nursing Home effective August 1, 1984.

GB:td

E 1 (7/15/82)

1 Name of Applicant First/Initial/Last	2 Case No.	3 Dep	4 Date of Birth	5 Sex M___ F___	6 AFDC___ MA___ FS___ GA___ COM___	7 Race	8 Tribe	9 Enr	10W

11 Street – RR – Box No.	12 Second Address Line	13 Medicare No.	14 Ins.	15 Mar

16 City	17 State	18 Zip

20 Prog	21 A	22 App Date	23 Open Date	24 State Start	25 Amt	26 Date (Deny/Clo)	27 Rea	28 Pay Inc	29 Client	30 Done (Redeter)	31 Due
FS COM	a	d	f	i	l			☐ y ☐ n			
AFDC	b		g	j				☐ y ☐ n			
MA GA	c	e	h	k				☐ y ☐ n			

40 Name	41 Client ID	42 Sex M___ F___	44 Prog	45 A	46 Open	47 Close	48 Rea
			FS COM		a	d	g
49 Date of Birth / 50 Dep / 51 Tribe / 52 Enr / 53 WIN / 54 Medicare No. / 55 Ins / 56 Rela			AFDC		b	e	h
			MA GA		c	f	i

40 Name	41 Client ID	42 Sex M___ F___	44 Prog	45 A	46 Open	47 Close	48 Rea
			FS COM		a	d	g
49 Date of Birth / 50 Dep / 51 Tribe / 52 Enr / 53 WIN / 54 Medicare No. / 55 Ins / 56 Rela			AFDC		b	e	h
			MA GA		c	f	i

40 Name	41 Client ID	42 Sex M___ F___	44 Prog	45 A	46 Open	47 Close	48 Rea
			FS COM		a	d	g
49 Date of Birth / 50 Dep / 51 Tribe / 52 Enr / 53 WIN / 54 Medicare No. / 55 Ins / 56 Rela			AFDC		b	e	h
			MA GA		c	f	i

Current			Change To
________	Countable Earned Income	a	________
________	Plus EIC	b	________
________	Less 75 (Prorate)	c	________
________	Less Day Care	d	________
________	Less 30 & 1/3	e	________
________	Less Adult Disregards	f	________
________	Balance 2nd Person	g	________
________	Social Security	h	________
________	SSI	i	________
________	Other Unearned	j	________
________	Net Monthly Income	k	________

Budget Type: SSI ☐ AFDC ☐ MN ☐ Child Only ☐ Shelter ☐

________	Benefit Standard	l	________
________	Medically Needy Standard	m	________
________	Less Net Monthly Income	n	________
________	Grant Amount	o	________
________	Less Recovery	p	________
________	Check Amount	q	________
________	Incurrment Amount	r	________

No. in Day Care

30 & 1/3 Admin.

61 Ineligible due to lump sum until

62 Nursing Home Care

Began ________

Ended ________

63 Nursing Home Resources

Month	Amount
________	________
________	________

64 Persons name that received mail if different from applicant

Future Months ________

HEALTH INSURANCE

Ident	70 Act	71 Co No.	72 Policy No.	73 Type Cov	74 From	75 To
1	a	d	g	j	m	p
2	b	e	h	k	n	q
3	c	f	i	l	o	r

90 Worker No.	91 County Off.	Certified By	92 Month/Day/Year	Date Last Action	Form Date	Last Worker	Run/Batch

DEPARTMENT OF SOCIAL & REHABILITATION SERVICES

RAVALLI COUNTY OFFICE OF HUMAN SERVICES

TED SCHWINDEN, GOVERNOR

310 NORTH THIRD STREET

STATE OF MONTANA

(406) 363-1944

HAMILTON, MONTANA 59840

STATE MEDICAL

_____ has an appointment on _____ at _____ am/pm

The application should be completed before your interview. If you are late it is possible that you will not be seen that day, but will have to have your appointment rescheduled.

To determine eligibility for assistance, we MUST have the following documents as they apply to your case.

I. IDENTIFICATION:
- -Drivers License
- -Birth Certificates
- -Social Security Cards (For all Family members)

II. INCOME:
- -Child Support Verification
- -VA Benefits Verification
- -SS Benefits Verification
- -Any other Determined Benefits Verification
- -Wage Slips or Statement from Employer
- -UC Verification Unemployment Benefits
- -Closure Letter from Other State or County
- -Escrow Payments
- -Family Contribution

III. RESOURCES:
- -Equity Value on vehicles
- -Checking Account Statement-Current
- -Savings Account Statement-Current
- -Life Insurance Policies
- -CD Numbers, Face Value, Interest accumulated
- -Vehicle Registrations
- -Stocks, Bonds, Mutual Funds
- -Mineral Rights

IV. MARITAL STATUS:
- -Separation Statements
- -Marriage Licenses
- -Divorce Decrees
- -Other

V. EXPENSES:
- -Rent Receipts or Statement
- -Mortgage Payments
- -Child Care Receipts

VI. MEDICAL:
- -Proof of Disability or Doctor Referral
- -Pregnancy Verification
- -Hospital/Medical Insurance Policy
- -All Medical Bills Owing

If verification and documentation is not readily available by your appointment date, bring in what you have and additional time will be given to you to obtain the items still needed.

If you fail to keep your appointment without notifying our office (363-1944/45), we will consider that you are not interested at this time, but will reapply at a later date.

SRS–EA–1(e)
(rev. 9/78)

MONTANA DEPARTMENT OF SOCIAL & REHABILITATION SERVICES
Economic Assistance Division

FACE SHEET

County: _____
H. H. No: _____
Date: _____
Phone: _____

SURNAME: _____ FIRST NAME: _____

CROSS REFERENCES: _____

MEMBERS OF HOUSEHOLD

NAME	BIRTH–DATE	BIRTHPLACE	RELAT.	RACE	RELIGION	EDUC.	SOC. SEC. NO.	VETER. STATUS	CENSUS NUMBER
Man									
Woman									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
Deceased Spouse									

CURRENT ADDRESS

STREET & NUMBER	CITY	COUNTY	STATE	FROM	TO

FAMILY STATUS

☐ Single ☐ Divorced ☐ Married ☐ Deserted ☐ Widowed ☐ Separated ☐ Other

MAIDEN NAME	MARRIAGE			TERMINATION		
	DATE	TOWN	STATE	DATE	TOWN	STATE
Present Marriage:						
Former Husband (name)						
Former Wife (name)						

Court Stipulations (support orders, custody, etc.) _____

Other agencies or persons interested: _____

RELATIVES

NAME	ADDRESS	RELATION.	NAME	ADDRESS	RELATION.

SRS—EA—1A
(Rev. 8/83)

APPLICATION
REDETERMINATION FOR ASSISTANCE

▶ *PLEASE PRINT CLEARLY* ◀ H. H. No. ____

COLUMNS: A	B	C	D	E	F	G
Print the names of all persons who live in your present household: First Middle Initial Last	Birthdate Mo./Day/Yr. and Birthplace	Sex M/F	Relationship to Applicant	Social Security Number and Indian Enrollment Number	Full Time Student? Yes or No	Child Support Code See Item 22 Below
1. (Man)	/ /			SSN / IE		
2. (Woman) (Maiden)	/ /			SSN / IE		
3.	/ /			SSN / IE		
4.	/ /			SSN / IE		
5.	/ /			SSN / IE		
6.	/ /			SSN / IE		
7.	/ /			SSN / IE		
8.	/ /			SSN / IE		
9.	/ /			SSN / IE		

TO LIST ANY ADDITIONAL PERSONS WHO LIVE IN YOUR HOUSEHOLD, ASK FOR PAGE 2A, FORM **EA—1A**

22. COLUMN G ENTRY: Print one of the following code letters that shows the reason why the parent cannot support each Child that is listed above. If both Parents are in the home, pick the code that applies to the Father. If there is an absent parent, choose the code letter that applies to the absent parent.

CODE:
1. Separation (SP)
2. Unemployed Parent (UP)
3. Divorce (DV)
4. Unmarried—Paternity (PE) Established

CODE:
5. Desertion (DS)
6. Incapacity (IC)
7. Medical Institution (MI)
8. Unmarried—Paternity (NE) Not Established

CODE:
9. Jail, or Prison (JP)
10. Death (DE)
11. Armed Forces (AF)
12. Deported (DP)

23. If the parent is absent from the home, how long has he been gone? ..... months

24. Are there any members of your household that do NOT need assistance? ☐ Yes ☐ No
If "YES," list their names here: .....

.....

25. Have you received any money from any other Welfare Agency in the last 4 months? ☐ Yes ☐ No
When: Mo. ..... Day ..... Yr. ..... Where .....

26. Do you intend to make your home in Montana? ☐ Yes ☐ No How long in present county ..... Months
County of Legal Residence ..... Current Address .....

27. MONTHLY EXPENSES:

RENT:	$	**MORTGAGE PAYMENT:**	$	**WATER:**	$
LIGHTS:	$	**TAXES:**	$	**SEWER:**	$
HEATING FUEL:	$	**TELEPHONE:**	$	**OTHER:**	$
MEDICAL PAYMENT	$	SUPPORT and ALIMONY	$		

40. Are you currently registered for work at the local employment office? ☐Yes ☐No

41. Have you filed for unemployment, or workmen's compensation? ☐Yes ☐No

42. Have you been out of work for 30 days, or more? ☐Yes ☐No

43. Have you refused a job in the last thirty days? ☐Yes ☐No

44. Are you currently working 100 hours, or more, in a month? ☐Yes ☐No

45. If your answer to 44 was YES, list the details here: .....

46. *EMPLOYMENT HISTORY FOR THE LAST 3 YEARS. (List the most recent employer first.)*

DATA FOR APPLICANT					DATA FOR SPOUSE OF APPLICANT				
Employer's Name	**City**	**State**	**From**	**To**	**Employer's Name**	**City**	**State**	**From**	**To**

50. **LISTING OF ASSETS.** Print the estimated dollar ($) value of the assets listed below that YOU, OR YOUR SPOUSE, OR ANY OTHER MEMBER OF YOUR HOUSEHOLD possess. If YOU, or any member of your household DO NOT HAVE the asset listed below, then place a ✓ in the column marked "NONE." Personal clothing and household furniture should not be listed below. An entry is required for each asset line.

ASSETS	✓NONE	Yours	Spouse	Others	ASSETS	✓NONE	Yours	Spouse	Others
Checking Account(s)		$	$	$	Automobile No. 1		$	$	$
Savings Account(s)		$	$	$	Automobile No. 2		$	$	$
Money NOT in a Bank		$	$	$	Truck		$	$	$
Credit Union Shares		$	$	$	Trailer or Camper		$	$	$
Savings Bond(s)		$	$	$	Boat or Snowmobile		$	$	$
Retirement Fund		$	$	$	Motorcycle		$	$	$
Stocks or Bonds		$	$	$	Tools, hand & powered		$	$	$
Burial Funds		$	$	$	Farm/Business Equipmt.		$	$	$
Real Estate Used as Home		$	$	$	Livestock or Poultry		$	$	$
Other Real Estate		$	$	$	Safety DP, CD, etc.		$	$	$

51. Do you, or your spouse, have any life insurance? ☐Yes ☐No Company .....

Face Value $..... Cash Value $..... Policy No. .....

52. In the last 2 years, have you, or any member of your household, sold or given away, a house, building, real estate, or other property to another person(s)? ☐ Yes ☐ No

If your answer is "YES" list the details in item 80, supplemental page.

60. INCOME LISTING. Print the amount of money received by YOU, YOUR SPOUSE, or any other member of your household in the correct column, below. If you DO NOT RECEIVE income from the sources listed below, make a ✓ in the "NONE" column. For any income that you receive but is not listed in column A, below, print the amount in the line marked "ANY OTHER INCOME."

A	B	C	D	E	F
TYPES OF INCOME	✓NONE	YOURS	SPOUSE	OTHERS	How Often Received
UNEMPLOYMENT COMPENSATION		$.	$.	$.	
WORKMEN'S COMPENSATION (IA)		$.	$.	$.	
SOCIAL SECURITY BENEFITS		$.	$.	$.	
RAILROAD RETIREMENT		$.	$.	$.	
VETERANS ADMINISTRATION BENEFITS		$.	$.	$.	
RETIREMENT OR PENSION INCOME		$.	$.	$.	
ARMED FORCES ALLOTMENT		$.	$.	$.	
ALIMONY AND CHILD SUPPORT		$.	$.	$.	
RELATIVE CONTRIBUTIONS		$.	$.	$.	
INCOME FROM MORTGAGE, or Sales Contract		$.	$.	$.	
RENT FROM REAL ESTATE PROPERTY		$.	$.	$.	
INCOME FROM ROOMERS, or Boarders		$.	$.	$.	
INTEREST FROM SAVINGS ACCOUNT		$.	$.	$.	
MONEY FROM INDIAN TRIBAL FUNDS B.I.A., and/or I.I.M.		$.	$.	$.	
OIL OR MINERAL BENEFITS		$.	$.	$.	
ANY OTHER INCOME		$.	$.	$.	

If you expect to receive income from any of the above sources, explain in Block 80.

COMPLETE THIS SECTION IF ANY MEMBER OF HOUSEHOLD IS EMPLOYED

61. GROSS PAY (Before Deductions)		$.	$.	$.	
62. List your **REQUIRED DEDUCTIONS,** but only if you entered Gross Pay above.					
a. Income Taxes (Federal)					
b. State of Montana Taxes					
c. Social Security					
d. Other required deductions; Union Dues, Medical, etc.					
e. Transportation to and from work					
f. Other work deductions, uniforms, etc.					
g. Retirement					

63. If you are self-employed, we will need a copy of your last income tax return.

70. If the Applicant, or Spouse, is *unable* to work, list the reason(s) here: .....

71. If any member of your household is pregnant, list the name of the person: .....
and expected date of birth: .....

72. Is any member of household currently covered by Health, Accident, or Hospital Insurance? If "YES" enter the company name here: ☐ Yes ☐ No

73. Is another person, or company, responsible for medical care that you or any member of your family is receiving, or has received? ☐ Yes ☐ No

74. Do you owe money for medical care that you, or any family member received in the last three months? ☐ Yes ☐ No

75. Do you make regular payments on medical bills, or medical insurance premiums? ☐ Yes ☐ No

If "YES", provide payment information below:

	AMOUNT PAID	PAID HOW OFTEN
a. Medical Bills (Doctor or Hospital)		
b. Health, Accident or Hospital Insurance		
c. Prescribed Medication		
d. Any other medical expense(s)		

76. Responsible relative

NAME	ADDRESS	RELATION

80. Use this block for additional details, or explanation of previous blocks: .....

90. BE SURE THAT YOU HAVE ANSWERED ALL QUESTIONS ON FORM EA-1, AND PAGES 2 TO 5, FORM EA-1A. READ CAREFULLY THE FOLLOWING STATEMENT BEFORE YOU SIGN:

I declare that this statement has been examined and filled out by me, and to the best of my knowledge and belief is true, accurate and complete. I understand that any misstatement will be investigated and prosecuted. I further declare that I will promptly report to the Welfare Department all facts concerning any income or sources received by me and/or my dependents and any change of circumstances whatever of myself and/or dependents for whom I have applied for assistance.

I understand I can appeal for a fair hearing to the State Department of Social Rehabilitation Services if I am not satisfied with the promptness of the action on my application, with the decision, or with the amount of assistance which I receive.

I have been informed of the availability of Family Planning and early screening and may have these services by contacting the County Welfare Office.

I understand that this Declaration of Facts may be investigated by the Department of Public Welfare and I agree to cooperate by signing EA-4 and EA-29 and help in such an investigation by presenting proof of the statements I have made in this Declaration.

I hereby authorize all medical providers to provide and release any medical information pertaining to myself, or any other person for whom I am applying for assistance, to the State Department of Social and Rehabilitation Services, the State Department of Revenue, and their agents, upon their request, and hereby release said medical providers from any liability based on such release.

Benefits and services must be provided without regard to race, color, national origin, religion, political belief, age, handicap, sex or marital status. I understand I may file a complaint with the State Department of Social and Rehabilitation Services if I feel that I have been discriminated against.

(APPLICANT OR GUARDIAN – SIGN HERE)	Date	(SPOUSE OF THE APPLICANT – Sign Name Here)	Date

91. If the applicant CANNOT write, or sign his name above, a Mark will be used instead of a signature; one witness is then required to verify the applicant's Mark and complete 92 below.

92. Witness's Signature (When Required)	Date	Witness Address & Zip Code

Date _____ Worker's Signature _____

SRS—EA—4A
(Rev. 11/83)

STATE OF MONTANA
DEPARTMENT OF SOCIAL & REHABILITATION SERVICES
Economic Assistance Division

RELEASE OF CONFIDENTIAL INFORMATION

AUTHORIZATION TO MONTANA SOCIAL & REHABILITATION SERVICES TO OBTAIN PERSONAL INFORMATION

Client's Name:_____ SSN:_____

Address:_____
(STREET) (CITY) (STATE) (ZIP CODE)

I authorize the individual, company or agency shown below to disclose to the _____ County Department of Welfare of the Montana Social and Rehabilitation Services, the information specified below, which relates to my eligiblity to receive Public Assistance benefits. I understand any information obtained will be kept confidential and will be used only for purposes directly connected with the administration of benefits or services. I further understand that any information obtained may be released to a proper governmental agency or court of law enforcement agency for purposes of legal and investigative actions concerning fraud, collection of support or establishment of third party liability.

INFORMATION SOURCE: Landlords, Neighbors, Employers, Social Security Administration, Doctors, Hospitals, Veterans Administration, Bureau of Indian Affairs, Department of Labor and Industry, Assessors, Treasurers, County Clerks of Court, Banks, Credit Unions, Savings and Loans, Buyers of Contracts for Deed/Negotiable Instruments.

INFORMATION TO BE REQUESTED: Family Composition, Earned Wages, Unearned Wages, Checking Accounts, Savings Accounts, Stocks, Bonds, Time Certificates, BIA-IIM Funds, Veterans Benefits, Unemployment Compensation, Workmens Compensation, Loans, Personal Property, Mortgages, Contracts for Deed/Negotiable Instruments, Real Estate, etc. Also, Medical Reports or conditions to exempt participation in employment or County Work Program.

DISCLOSURE: Please provide information requested in space below or on back of sheet.

Signature of applicant or authorized representative:

X_____ Date:_____

G.A.
Name _____

Date _____

INTAKE AND PROBLEM:

HOUSEHOLD COMPOSITION:

RESIDENCE:

DEPRIVATION:

INCOME:

RESOURCES:

RECOMMENDATIONS:

STATE MEDICAL BUDGET

Date of APPLICATION:_____ H.H. COMP._____

Period of Coverage Requested:_____ CASE NAME:_____

MONTH:						
A. Gross Earned Income:						
B. Less FICA, SS, Fed. Tax						
C. Net Earned Income						
D Gross Unearned Income						
E Total Income Per Month						

MAXIMUM INCOME LEVEL:
1-314
2-375
3-400
4-425
5-501
6-564

GA STD:
1-212
2-279
3-332
4-425
5-501
6-564

F Total Income _____

If Line F is more than Line G, deny due to income exceeds standards.ARM 46.25.739.(2)(b)

If Line F is less than Line G, finish Budget Line H.

G Maximum Income Limit: $ (Std.X6)

H. Countable Income (Line F)_____
Less GA Std. X 6 -_____

Equals Spenddown =_____

Plus Excess Resources +_____

TOTAL CLIENT RESPONSIBLE TO PAY _____

If amount client responsible to pay is more than total medical bills, deny due to no medical need. ARM 46.25.739(3)

RECOMMEND:

E.T. _____ DATE _____

DEPARTMENT OF SOCIAL & REHABILITATION SERVICES

RAVALLI COUNTY OFFICE OF HUMAN SERVICES

TED SCHWINDEN, GOVERNOR

310 NORTH THIRD STREET

STATE OF MONTANA

(406) 363-1944

HAMILTON, MONTANA 59840

DATE:

We have received an Indigency Notice for _____

on _____ from _____

If you need help with medical bills it will be necessary for you to come into the department office within ten days to fill out an application. It will be necessary for you to have an appointment with an Eligibility Technician and provide information as to your income and resources. The Eligibility Technician, at the time of your appointment, will explain eligibility criteria and the application process.

Sincerely,

SRS-EA-27
(Rev. 8/83)

MONTANA DEPARTMENT OF SOCIAL & REHABILITATION SERVICES

LETTER OF NOTIFICATION

TO:		FROM:	
Name of Applicant or Recipient:		Organizational Unit:	RAVALLI COUNTY HUMAN SERVICES
Street Address:		Street Address:	310 NORTH 3RD
City and Zip Code:		City and Zip Code:	HAMILTON, MT 59840 Phone: 363-1944

1. **PROGRAM:** ☐ AFDC ☐ MED. ASSIST. ☐ GEN. ASSIST. ☐ CO. MED. ☐ FOOD STAMPS
☐ OTHER:_____

2. **ACTION:**

Since your have not responded to our correspondence of _____, the Ravalli County Human Services is denying your need for help with medical bills of_____. This means you are personally responsible to pay all the bills incurred during the above confinement.

Legal Basis for Action:

ARM 46.10.202,204 & 205

45 CFR 233.10.206.10,233.20

_____ MCA

If you have any questions regarding this action or if there are additional facts relating to your circumstances which you have not reported to us, please write or telephone. We will answer your questions or make an appointment to see you in person. Please remember that this action pertains only to the circumstances you reported to us. **(PLEASE READ THE REVERSE SIDE OF THIS NOTICE FOR YOUR FAIR HEARING RIGHTS).**

_____
(NAME & TITLE)

_____
(DATE)

REQUEST FOR FAIR HEARING

This is to request a fair hearing. I am making this request because:_____

_____

I understand that the right to a fair hearing includes an administrative review and a pre-hearing conference. If my reasons for a fair hearing have not been resolved during the administrative review and/or pre-hearing conference, I understand that a fair hearing will be scheduled.

I have an attorney: ☐ **Yes** ☐ **No.** My attorney's name is:_____

His/her address is:_____. His/her phone number is:_____.

_____ _____ _____
(CLAIMANT OR AUTHORIZED REPRESENTATIVE) (PHONE) (DATE)

***TO REQUEST A FAIR HEARING COMPLETE, SIGN AND MAIL THE WHITE COPY OF THIS NOTICE TO: HEARINGS OFFICER, BOX 4210, HELENA, MT 59604.**

Distribution: White — Household; Yellow — Household; Pink — County File

"Benefits and services must be provided without regard to race, color, national origin, religion, political belief, age, handicap, sex or marital status.

You may file a complaint with the State Department of Social and Rehabilitation Services if you feel that you have been discriminated against."

IMPORTANT

If you disagree with the action taken by the County Welfare Office, request a fair hearing immediately. If a fair hearing is requested within 10 days of the mailing date of this notice, and if the State Department of Social and Rehabilitation Services determines that the issues concern facts or judgments relating to your individual case, rather than State policy, the action will not be effective until the fair hearing decision is rendered.

Unless you ask for a fair hearing within 90 days of having your benefits reduced, suspended, terminated or denied, you will not usually be granted a hearing.

Fair hearings are conducted by the Department's Hearing Officer. Decisions by the Hearing Officer are binding on the Department and must conform to Federal and State law, regulation or policy and must be based exclusively on evidence and other material introduced at the hearing.

The right to a fair hearing on the county's action includes an administrative review of the action and a pre-hearing conference on the action.

The purpose of the administrative review is to permit you to discuss the proposed action with representatives of the Department; to present additional information to the Department concerning the action; and to obtain additional explanations from the Department of the reasons for the action.

The purpose of the pre-hearing conference is to consider simplification of the legal and factual issues in preparation for the fair hearing; to obtain admissions of fact and documents which will avoid unnecessary proof in the fair hearing; to explore any possiblity of settlement of the parties' differences; to establish what evidence and witnesses will be presented in the fair hearing; and to discuss any other matters which may aid in the disposition of the fair hearing.

The opportunity for you to have an administrative review or pre-hearing conference may not be used by the Department to diminish, delay or avoid a fair hearing.

You may be represented by an attorney, or by a relative, friend or other spokesman, or you may represent yourself. The Eligibility Technician at your County Welfare Office can tell you where and how to obtain free legal help.

You may request a hearing orally or in writing. However, if you make an oral request, you will be asked to complete the written request on the front section of this notice. If you need help completing the written request, the county office can assist you.

Hearing Officer — Box 4210 — Helena, MT 59601

FOR AFDC RECIPIENTS ONLY

Family Planning Services — As an AFDC recipient, you may be eligible for family planning services. Please ask about them at your County Welfare Office.

EPSDT — All Medicaid recipients under 21 years of age are eligible for Early, Periodic Screening, Diagnosis and Treatment (EPSDT). Emphasizing pevention, this program offers a comprehensive mental health and physical examiniation to determine whether you have any health problems. This examination includes height and weight measurement, a blood pressure test, a hematocrit (blood) test, urinalysis, a hearing test, a speech/language test, growth assessment, a Denver Developmental Test (for children under 6), an immunization survey, a dental assessment and a vision test. The EPSDT program also offers follow-up diagnosis and treatment for any problems found. If you want to participate in this program, ask at your County Welfare Office.

FORM SRS–EA–28
(Revised July 1976)

REPAYMENT AUTHORIZATION FOR SSI ASSISTANCE

(STATE OR COUNTY)

BY

Name	Social Security Number

AND

Spouse, if any	Social Security Number

Street	City	Zip

AND

Parent, Guardian or Vendor	Street	City	Zip

FOR AND IN CONSIDERATION of the prompt payment of _____ (State or County) interim assistance (assistance furnished to or on behalf of applicants for supplemental security income financed from State or local funds for basic needs during the period in which applications are pending), I/we hereby authorize the Secretary of Health, Education and Welfare to make the first payment of supplemental security income benefits to which I/we are determined to be eligible to receive, for and on my/our behalf, to _____ (County or State of Montana).

I/We further authorize the _____ (State or County) to deduct from such first payment an amount sufficient as reimbursement for interim assistance paid to me/us; and after making such deduction, the _____ (State or County) shall promptly pay the balance, if any, to me/us.

It is understood that in the event of disagreement, I/we shall have the right to a hearing from the State with respect to such appointment of such first payment.

Date	Signature
Date	Signature of Parent, Guardian or Vendor

Repayment Should Be Made To:

☐ State SRS, Helena

☐ _____ County

SRS–EA–23
(rev. 4/80)

MONTANA DEPT. OF SOCIAL & REHABILITATION SERVICES

ASSESSMENT FOR MEDICAL ASSISTANCE APPLICATION
BLIND OR DISABLED

PART I – TO BE COMPLETED BY THE APPLICANT:

This is to express my intent to apply for Medical Assistance if I am denied SSI due to excess income and/or resources; or, am denied SSDIB due to insufficient work record, but meet the disability criteria.

This intent becomes void if I do not make an application within 30 days after receiving denial notices from the Social Security Administration.

Please bring your denial notice when you apply to us for Medical Assistance.

1. _____
(Name of Applicant) (Date of Birth) (Social Security No.)

_____
(Address) (City) (State) (Zip Code)

2. Applied for SSI: ☐ Yes ☐ No Applied for SSDIB: ☐ Yes ☐ No

Signature: **Date:**

PART II – TO BE COMPLETED BY THE COUNTY:

3. Did the applicant receive Aid to the Disabled or Blind prior to July 1, 1973? ☐ Yes ☐ No
If **yes**, check appropriate program and where received:
☐ Aid to the Needy Blind ☐ Aid to the Disabled
County: _____
State (if other than Montana): _____

4. Receiving Social Security Disability Title II Benefits: ☐ Yes ☐ No
If **yes**, attach verification. ☐ Verification Required

5. If applicant is deceased, give date of death: _____

6. Medical Reexamination: ☐ Yes ☐ No

Eligibility Technician: _____ **Date:** _____

County: _____ **Address:** _____

PART III – TO BE COMPLETED BY THE DISABILITY DETERMINATION BUREAU:

Status of Application:

☐ **Approved:** Effective: _____ (Date) Medical Reexamination: _____ (Date)

☐ **Denied:** Reason: _____

☐ Receiving SSDIB (Title II): _____ (Date of Onset)

☐ This disability is of such a nature that disability existed 90 days prior to the date of onset above.

☐ This disability is of such a nature that disability existed beginning: _____ (Date).

Disability Examiner: _____ **Date:** _____

orm SRS–EA/SA–5
New (7/83)

STATE OF MONTANA — SOCIAL and REHABILITATION SERVICES

FOR USE BY PHARMACIES

NAME & ADDRESS OF PROVIDER OF SERVICES	PROV. NO.	MAIL TO: RAVALLI COUNTY OFFICE OF HUMAN SERVICES 310 NORTH 3rd St. HAMILTON, MT.59840

PATIENT: Last Name	First	Mid. Init.	Sex M ☐ F ☐	Date of Birth Mo Day Yr	County	Client I.D.

The individual named above is eligible for State Medical from _____ (MM/DD/YY) to _____ (MM/DD/YY).

This form authorizes the following services:

_____

_____

_____

If additional services are needed, the provider must obtain authorization from the county prior to provision of services.

By: _____
eligibility worker *date*

Payment Authorization:

_____
Signature *date*

	Rx NUMBER	DRUG NAME	DRUG NUMBER	DATE WRITTEN	DATE FILLED
	PRESCRIBING PHYSICIAN'S NAME	PHYSICIAN CODE	DAYS SUPPLY	NEW Rx or Refill	No. Units Dispensed	AMT. Charged
2.	Rx NUMBER	DRUG NAME	DRUG NUMBER	DATE WRITTEN	DATE FILLED
	PRESCRIBING PHYSICIAN'S NAME	PHYSICIAN CODE	DAYS SUPPLY	NEW Rx or Refill	No Units Dispensed	AMT. Charged
3.	Rx NUMBER	DRUG NAME	DRUG NUMBER	DATE WRITTEN	DATE FILLED
	PRESCRIBING PHYSICIAN'S NAME	PHYSICIAN CODE	DAYS SUPPLY	NEW Rx or Refill	No. Units Dispensed	AMT. Charged
4.	Rx NUMBER	DRUG NAME	DRUG NUMBER	DATE WRITTEN	DATE FILLED
	PRESCRIBING PHYSICIAN'S NAME	PHYSICIAN CODE	DAYS SUPPLY	NEW Rx or Refill	No. Units Dispensed	AMT. Charged

ereby certify that the care, services and supplies itemized have been furnished, the amounts listed are e and, except as noted, no part thereof has been paid; payment of fees made in accordance with estab- ished medicaid schedules is accepted as payment in full. I further certify that the service(s) indicated above has/have been provided without regard to race, color, national origin, creed, sex, religion, political ideas, marital status, age or handicap. I hereby agree to maintain and furnish on request to the Depart- ent or any of their duly authorized agents or representatives such records as are necessary to disclose ly the extent of care, services, and supplies provided to individuals under the state Medical Program. . UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM STATE FUNDS, AND T ANY FALSIFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED U R STATE LAWS.

ROVIDER'S SIGNATURE: _____ DATE: _____

Pay Code	
TOTAL CHARGES	Coder
AMT. TO BE PAID BY RECIPIENT	Adjuster
AMT. TO BE PAID BY STATE MEDICAL	

RETAIN LAST COPY FOR YOUR RECORDS.

orm SRS-EA/SA-1
New (7/83)

STATE OF MONTANA — SOCIAL and REHABILITATION SERVICES

FOR USE BY PHYSICIANS AND ALL OTHERS EXCEPT DENTISTS AND INSTITUTIONS.

NAME & ADDRESS OF PROVIDER OF SERVICES | PROV. NO.

MAIL TO: RAVALLI COUNTY OFFICE OF HUMAN SERVICES
310 NORTH 3rd St.
HAMILTON, MT. 59840

PATIENT: Last Name | First | Mid. Init. | Sex M ☐ F ☐ | Date of Birth Mo Day Yr | County | Client I.D.

DIAGNOSIS AND CONCURRENT CONDITIONS:

SIGNS AND SYMPTOMS

SYM 1 | SYM 2 | SYM 3

PRIMARY DIAG.

SECONDARY DIAG.

Diag. 1

Diag. 2

The individual named above is eligible for State Medical from _____ to _____.
MM/DD/YY MM/DD/YY

This form authorizes the following services:

_____

_____

_____

If additional services are needed, the provider must obtain authorization from the county prior to provision of services.

By: _____
eligibility worker *date*

Payment Authorization:

_____
Signature *date*

PLACE OF SERVICE CODES: 1. Office 2. Home 3. Inpatient Hospital 4. Outpatient Hospital 5. Nursing Home 6. Other

DATE OF SERVICE	PROCEDURE NUMBER	Plc.of Serv.	DESCRIBE EACH SERVICE, SUPPLY OR APPLIANCE SEPARATELY	No. of Services	CHARGES	PAY

PAY CODE

TOTAL SERVICES

AMOUNT OF PAYMENT FROM OTHER SOURCES (ENTER AS "CREDIT")

NAME _____ ($ _____)

NAME _____ ($ _____)

TOTAL CHARGES		
TOTAL CREDITS		
NET CHARGES		

Codes

I hereby certify that the care, services and supplies itemized have been furnished, the amounts listed are due and, except as noted, no part thereof has been paid; payment of fees made in accordance with established medicaid schedules is accepted as payment in full. I further certify that the service(s) indicated above has/have been provided without regard to race, color, national origin, creed, sex, religion, political ideas, marital status, age or handicap. I hereby agree to maintain and furnish on request to the Department or any of their duly authorized agents or representatives such records as are necessary to disclose fully the extent of the care, services, and supplies provided to individuals under the State Medical Program. **I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE MADE FROM STATE FUNDS, AND THAT ANY FALSIFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER STATE LAWS.**

PROVIDER'S SIGNATURE: _____ *DATE:* _____

RETAIN LAST COPY FOR YOUR RECORDS.

orm SRS–EA/SA–2
New (7/83)

STATE OF MONTANA — SOCIAL and REHABILITATION SERVICES

FOR USE BY HOSPITALS

NAME & ADDRESS OF PROVIDER OF SERVICES | PROV. NO.

MAIL TO: RAVALLI COUNTY OFFICE OF HUMAN SERVICES
310 NORTH 3rd St.
HAMILTON, MT. 59840

PATIENT: Last Name | First | Mid. Init. | Sex M ☐ F ☐ | Date of Birth Mo. Day Yr | County | Client I.D.

The individual named above is eligible for State Medical from _____ (MM/DD/YY) to _____ (MM/DD/YY).

This form authorizes the following services.

_____

_____

Date Admitted Mo. Day Yr | Time Admitted | Attending or Referring Physician | Phy. No.

PATIENT STATUS: 1 Date Discharge Mo. Day Yr | 2 Date Expired Mo. Day Yr | 3 Still in Hospital ☐ YES

STATEMENT PERIOD: FROM Mo. Day Yr | TO Mo. Day Yr

SIGNS AND SYMPTOMS — Sym 1 / Sym 2 / Sym 3

PRIMARY DIAG.

SECONDARY DIAG. — Diag 1 / Diag 2

SURGICAL PROCEDURES; AND DATE(S)

If additional services are needed, the provider must obtain authorization from the county prior to provision of services.

By: _____ *eligibility worker* *date*

Payment Authorization: _____ *Signature* *date*

SERVICES RENDERED

	Accommodations	No. Day	Rate	Charges	Pay
14	1-BED				
21	2-3-4 BED				
35	5 OR MORE BED				
42	ICU - CCU				
63	NURSERY				
	TOTAL NO. OF DAYS				
77	OPERATING ROOM				
84	PHARMACY				
91	LABORATORY				
106	RADIOLOGY				
112	MEDICAL SURGICAL CENT. SUPP.				
126	ANESTHESIA				
133	INHALATION THERAPY				
147	PHYSICAL THERAPY				
154	OCCUPATIONAL THERAPY				
161	SPEECH THERAPY				
175	EMERGENCY DEPT./ROOM				
182	OTHER				

PATIENT ONLY

Date of Serv.	Procedure No.	Itemized Services Outpatient Only	No. Serv.	Charges	Pay Code
		TOTAL SERVICES			

AMOUNT OF PAYMENT FROM OTHER SOURCES (ENTER AS "CREDIT")

NAME _____ ($ _____)

NAME _____ ($ _____)

TOTAL CHARGES			Code
TOTAL CREDITS			Adj.
NET CHARGES			

I hereby certify that the care, services and supplies itemized have been furnished, the amounts listed are due and, except as noted, no part thereof has been paid; payment of fees made in accordance with established medicaid schedules is accepted as payment in full. I further certify that the service(s) indicated above has/have been provided without regard to race, color, national origin, creed, sex, religion, political ideas, marital status, age or handicap. I hereby agree to maintain and furnish on request to the Department or any of their duly authorized agents or representatives such records as are necessary to disclose fully the extent of care, services, and supplies provided to individuals under the State Medical Program. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM STATE FUNDS, AND THAT ANY FALSIFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER STATE LAWS.

PROVIDER'S SIGNATURE _____ *DATE:* _____

RETAIN LAST COPY FOR YOUR RECORDS.

orm SRS–EA/SA–4
New (7/83)

STATE OF MONTANA — SOCIAL and REHABILITATION SERVICES

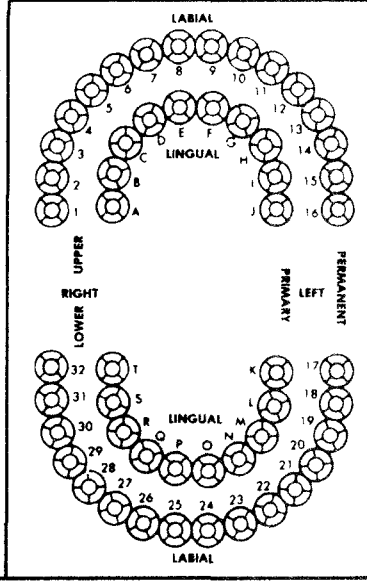
FOR USE BY DENTISTS

NAME & ADDRESS OF PROVIDER OF SERVICES	PROV. NO.	MAIL TO: RAVALLI COUNTY OFFICE OF HUMAN SERVICES 310 NORTH 3rd St. HAMILTON, MT.59840

PATIENT: Last Name	First	Mid. Init.	Sex M ☐ F ☐	Date of Birth Mo. Day Yr	County	Client I.D.

SIGNS AND SYMPTOMS — **SYM**

REASON FOR REQUESTED PROSTHESIS



The individual named above is eligible for State Medical from _____ (MM/DD/YY) to _____ (MM/DD/YY).

This form authorizes the following services:

_____

_____

_____

If additional services are needed, the provider must obtain authorization from the county prior to provision of services.

By: _____
eligibility worker *date*

Payment Authorization:

_____
Signature *date*

☐ CHECK HERE IF THIS IS A REQUEST FOR AUTHORIZATION.

_____
Signature of Provider if Requesting Authorization *Date*

DENTAL APPROVAL ☐ Yes ☐ No

Approved By: _____ *Date:* _____

EXAMINATION AND TREATMENT RECORD

Date of Service	Surface No.	Tooth No.	Procedure Number	Description of Service *(Including X-Rays, Prophylaxis, Material Used, Etc.)*	No. Service	Charges	Payment	▼
				TOTAL SERVICES ▶				Pay Code
				TOTAL CHARGES				Coder
				TOTAL CREDITS				Adjuster
				NET CHARGES				

AMOUNT OF PAYMENT FROM OTHER SOURCES (ENTER AS "CREDIT")

NAME _____ ($ _____)

NAME _____ ($ _____)

hereby certify that the care, services and supplies itemized have been furnished, the amounts ted are due and, except as noted, no part thereof has been paid; payment of fees made in cordance with established medicaid schedules is accepted as payment in full. I further certify the service(s) indicated above has/have been provided without regard to race, color, national origin, creed, sex, religion, political ideas, marital status, age or cap. I hereby agree to maintain and furnish on request to the Department or any of their duly authorized agents or representatives such records as are necessary disclose fully the extent of care, services, and supplies provided to individuals under the State Medical Program. **I UNDERSTAND THAT PAYMENT F THIS CLAIM WILL BE FROM STATE FUNDS, AND THAT ANY FALSIFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED NDER STATE LAWS.**

☐ CHECK HERE IF A CLAIM STATEMENT

_____
Signature of Provider (Sign here if a Claim Statement)

_____
Date

RETAIN LAST COPY FOR YOUR RECORDS.

G.A.
Name _____

Date _____

INTAKE AND PROBLEM:

HOUSEHOLD COMPOSITION:

RESIDENCE:

DEPRIVATION:

INCOME:

RESOURCES:

RECOMMENDATIONS:

SRS EA-27
(Rev. 8/83)

MONTANA DEPARTMENT OF SOCIAL & REHABILITATION SERVICES

LETTER OF NOTIFICATION

TO:		FROM:	
Name of Applicant or Recipient: [redacted]		Organizational Unit:	
Street Address: P.O. Box [redacted]		Street Address:	
City and Zip Code: Hamilton, MT. 59840		City and Zip Code:	Phone: 363 1944

1. PROGRAM: ☐ AFDC ☒ MED. ASSIST. ☐ GEN. ASSIST. ☐ CO. MED. ☐ FOOD STAMPS
☐ OTHER:_____

2. ACTION:

Your application for Medical Assistance is being processed and is pending Social Security Disability determination.

Tentative State Medical has been approved for you to see a neurologist for an initial evaluation only.

Please contact me when you have scheduled the appointment and I will issue you a payment authorization to present to the physicians office.

Legal Basis for Action:

ARM_____

_____ CFR_____

_____ MCA

If you have any questions regarding this action or if there are additional facts relating to your circumstances which you have not reported to us, please write or telephone. We will answer your questions or make an appointment to see you in person. Please remember that this action pertains only to the circumstances you reported to us. **(PLEASE READ THE REVERSE SIDE OF THIS NOTICE FOR YOUR FAIR HEARING RIGHTS).**

Gayle Baard,
Eligibility Technician II
Carole A. Graham,
County Director
cc: Peggy Verburg

Laura Lutzenhiser, E.T. Supervisor
_____
(NAME & TITLE)

February 1, 1985
_____
(DATE)

REQUEST FOR FAIR HEARING

This is to request a fair hearing. I am making this request because:_____

_____

I understand that the right to a fair hearing includes an administrative review and a pre-hearing conference. If my reasons for a fair hearing have not been resolved during the administrative review and/or pre-hearing conference, I understand that a fair hearing will be scheduled.

I have an attorney: ☐ Yes ☐ No. My attorney's name is:_____

His/her address is:_____. His/her phone number is:_____.

_____ (CLAIMANT OR AUTHORIZED REPRESENTATIVE) _____ (PHONE) _____ (DATE)

*TO REQUEST A FAIR HEARING COMPLETE, SIGN AND MAIL THE WHITE COPY OF THIS NOTICE TO: HEARINGS OFFICER, BOX 4210, HELENA, MT 59604.

White — Household; Yellow — Household; Pink — County File

DEPARTMENT OF SOCIAL & REHABILITATION SERVICES

RAVALLI COUNTY OFFICE OF HUMAN SERVICES

TED SCHWINDEN, GOVERNOR

310 NORTH THIRD STREET

STATE OF MONTANA

(406) 363-1944

HAMILTON, MONTANA 59840

FOOD STAMPS & GENERAL ASSISTANCE

_____ has an appointment on _____ at _____ am/pm

The application should be completed before your interview. If you are late it is possible that you will not be seen that day, but will have to have your appointment rescheduled.

To determine eligibility for assistance, we MUST have the following documents as they apply to your case.

1. IDENTIFICATION:
   - -Drivers License
   - -Birth Certificates
   - -Social Security Cards (for all family members)
   - -Alien

2. INCOME:
   - -Child Support Verification
   - -VA Benefits Verification
   - -SS Benefits Verification
   - -Any other determined benefits verification
   - -Wage Slips or Statements from employer
   - -UC Verification-Unemployment Benefits
   - -Closure letter from Other State or County
   - -Escrow Income
   - -Family Contribution

III. RESOURCES:
   - -Equity Value on vehicles
   - -Checking Account Statement-Current
   - -Current Savings Account Statement
   - -Life Insurance Policies
   - -CD Numbers, Face Value, Interest accumulated
   - -Vehicle Registrations
   - -Stocks, Bonds, Mutual Funds
   - -Mineral Rights
   - -Lease Agreements
   - -Escrow & Trust Funds-locations of

IV. EXPENSES:
   - -Rent Receipts or Statement
   - -Utilities Receipts
   - -Telephone Bill
   - -Mortgage Payments
   - -Taxes-Property
   - -Insurance-Property
   - -Child Care Receipts

V. OTHER:
   - -Job Service Registration Card
   - -Lay off statement

If Verification and documentation is not readily available by your appointment date, bring in what you have and additional time will be given to you to obtain the items still needed.

If you fail to keep your appointment without notifying our office (363-1944/45), we will consider that you are not interested at this time, but will reapply at later date.

SRS—EA—1A
(Rev. 8/83)

YA.

APPLICATION
REDETERMINATION FOR ASSISTANCE

▶ *PLEASE PRINT CLEARLY* ◀ H. H. No. ____

COLUMNS: A	B	C	D	E	F	G
Print the names of all persons who live in your present household: First Middle Initial Last	Birthdate Mo./Day/Yr. and Birthplace	Sex M/F	Relationship to Applicant	Social Security Number and Indian Enrollment Number	Full Time Student? Yes or No	Child Support Code See Item 22 Below
1. (Man)	/ /			SSN / IE		
2. (Woman) (Maiden)	/ /			SSN / IE		
3.	/ /			SSN / IE		
4.	/ /			SSN / IE		
5.	/ /			SSN / IE		
6.	/ /			SSN / IE		
7.	/ /			SSN / IE		
8.	/ /			SSN / IE		
9.	/ /			SSN / IE		

TO LIST ANY ADDITIONAL PERSONS WHO LIVE IN YOUR HOUSEHOLD, ASK FOR PAGE 2A, FORM **EA—1A**

22. COLUMN G ENTRY: Print one of the following code letters that shows the reason why the parent cannot support each Child that is listed above. If both Parents are in the home, pick the code that applies to the Father. If there is an absent parent, choose the code letter that applies to the absent parent.

CODE:
1. **Separation (SP)**
2. **Unemployed Parent (UP)**
3. **Divorce (DV)**
4. Unmarried—Paternity (PE) Established

CODE:
5. Desertion (DS)
6. Incapacity (IC)
7. Medical Institution (MI)
8. Unmarried—Paternity (NE) Not Established

CODE:
9. Jail, or Prison (JP)
10. Death (DE)
11. Armed Forces (AF)
12. Deported (DP)

23. If the parent is absent from the home, how long has he been gone? ..... months

24. Are there any members of your household that do NOT need assistance? ☐ Yes ☐ No
If "YES," list their names here: .....

.....

25. Have you received any money from any other Welfare Agency in the last 4 months? ☐ Yes ☐ No
When: Mo. ..... Day ..... Yr. ..... Where .....

26. Do you intend to make your home in Montana? ☐ Yes ☐ No How long in present county ..... Months
County of Legal Residence ..... Current Address .....

27. MONTHLY EXPENSES:

RENT:	$	**MORTGAGE PAYMENT:**	$	**WATER:**	$
LIGHTS:	$	**TAXES:**	$	**SEWER:**	$
HEATING FUEL:	$	**TELEPHONE:**	$	**OTHER:**	$
MEDICAL PAYMENT	$	SUPPORT and ALIMONY	$		

40. Are you currently registered for work at the local employment office? ☐Yes ☐No

41. Have you filed for unemployment, or workmen's compensation? ☐Yes ☐No

42. Have you been out of work for 30 days, or more? ☐Yes ☐No

43. Have you refused a job in the last thirty days? ☐Yes ☐No

44. Are you currently working 100 hours, or more, in a month? ☐Yes ☐No

45. If your answer to 44 was YES, list the details here: .....

46. *EMPLOYMENT HISTORY FOR THE LAST 3 YEARS. (List the most recent employer first.)*

DATA FOR APPLICANT					DATA FOR SPOUSE OF APPLICANT				
Employer's Name	**City**	**State**	**From**	**To**	**Employer's Name**	**City**	**State**	**From**	**To**

50. **LISTING OF ASSETS.** Print the estimated dollar ($) value of the assets listed below that YOU, OR YOUR SPOUSE, OR ANY OTHER MEMBER OF YOUR HOUSEHOLD possess. If YOU, or any member of your household DO NOT HAVE the asset listed below, then place a ✓ in the column marked "NONE." Personal clothing and household furniture should not be listed below. An entry is required for each asset line.

ASSETS	✓NONE	Yours	Spouse	Others	ASSETS	✓NONE	Yours	Spouse	Others
Checking Account(s)		$	$	$	Automobile No. 1		$	$	$
Savings Account(s)		$	$	$	Automobile No. 2		$	$	$
Money NOT in a Bank		$	$	$	Truck		$	$	$
Credit Union Shares		$	$	$	Trailer or Camper		$	$	$
Savings Bond(s)		$	$	$	Boat or Snowmobile		$	$	$
Retirement Fund		$	$	$	Motorcycle		$	$	$
Stocks or Bonds		$	$	$	Tools, hand & powered		$	$	$
Burial Funds		$	$	$	Farm/Business Equipmt.		$	$	$
Real Estate Used as Home		$	$	$	Livestock or Poultry		$	$	$
Other Real Estate		$	$	$	Safety DP, CD, etc.		$	$	$

51. Do you, or your spouse, have any life insurance? ☐Yes ☐No Company .....

Face Value $..... Cash Value $..... Policy No. .....

52. In the last 2 years, have you, or any member of your household, sold or given away, a house, building, real estate, or other property to another person(s)? ☐ Yes ☐ No

If your answer is "YES" list the details in item 80, supplemental page.

60. INCOME LISTING. Print the amount of money received by YOU, YOUR SPOUSE, or any other member of your household in the correct column, below. If you DO NOT RECEIVE income from the sources listed below, make a ✓ in the "NONE" column. For any income that you receive but is not listed in column A, below, print the amount in the line marked "ANY OTHER INCOME."

A	B	C	D	E	F
TYPES OF INCOME	✓NONE	YOURS	SPOUSE	OTHERS	How Often Received
UNEMPLOYMENT COMPENSATION		$.	$.	$.	
WORKMEN'S COMPENSATION (IA)		$.	$.	$.	
SOCIAL SECURITY BENEFITS		$.	$.	$.	
RAILROAD RETIREMENT		$.	$.	$.	
VETERANS ADMINISTRATION BENEFITS		$.	$.	$.	
RETIREMENT OR PENSION INCOME		$.	$.	$.	
ARMED FORCES ALLOTMENT		$.	$.	$.	
ALIMONY AND CHILD SUPPORT		$.	$.	$.	
RELATIVE CONTRIBUTIONS		$.	$.	$.	
INCOME FROM MORTGAGE, or Sales Contract		$.	$.	$.	
RENT FROM REAL ESTATE PROPERTY		$.	$.	$.	
INCOME FROM ROOMERS, or Boarders		$.	$.	$.	
INTEREST FROM SAVINGS ACCOUNT		$.	$.	$.	
MONEY FROM INDIAN TRIBAL FUNDS B.I.A., and/or I.I.M.		$.	$.	$.	
OIL OR MINERAL BENEFITS		$.	$.	$.	
ANY OTHER INCOME		$.	$.	$.	

If you expect to receive income from any of the above sources, explain in Block 80.

COMPLETE THIS SECTION IF ANY MEMBER OF HOUSEHOLD IS EMPLOYED

61. GROSS PAY (Before Deductions)		$.	$.	$.	
62. List your REQUIRED DEDUCTIONS, but only if you entered Gross Pay above.					
a. Income Taxes (Federal)					
b. State of Montana Taxes					
c. Social Security					
d. Other required deductions; Union Dues, Medical, etc.					
e. Transportation to and from work					
f. Other work deductions, uniforms, etc.					
g. Retirement					

63. If you are self-employed, we will need a copy of your last income tax return.

70. If the Applicant, or Spouse, is *unable* to work, list the reason(s) here: .....

71. If any member of your household is pregnant, list the name of the person: .....
and expected date of birth: .....

72. Is any member of household currently covered by Health, Accident, or Hospital Insurance? If "YES" enter the company name here: ☐ Yes ☐ No

73. Is another person, or company, responsible for medical care that you or any member of your family is receiving, or has received? ☐ Yes ☐ No

74. Do you owe money for medical care that you, or any family member received in the last three months? ☐ Yes ☐ No

75. Do you make regular payments on medical bills, or medical insurance premiums? ☐ Yes ☐ No

If "YES", provide payment information below:

	AMOUNT PAID	PAID HOW OFTEN
a. Medical Bills (Doctor or Hospital)		
b. Health, Accident or Hospital Insurance		
c. Prescribed Medication		
d. Any other medical expense(s)		

76. Responsible relative

NAME	ADDRESS	RELATION

80. Use this block for additional details, or explanation of previous blocks: .....

90. BE SURE THAT YOU HAVE ANSWERED ALL QUESTIONS ON FORM EA-1, AND PAGES 2 TO 5, FORM EA-1A. READ CAREFULLY THE FOLLOWING STATEMENT BEFORE YOU SIGN:

I declare that this statement has been examined and filled out by me, and to the best of my knowledge and belief is true, accurate and complete. I understand that any misstatement will be investigated and prosecuted. I further declare that I will promptly report to the Welfare Department all facts concerning any income or sources received by me and/or my dependents and any change of circumstances whatever of myself and/or dependents for whom I have applied for assistance.

I understand I can appeal for a fair hearing to the State Department of Social Rehabilitation Services if I am not satisfied with the promptness of the action on my application, with the decision, or with the amount of assistance which I receive.

I have been informed of the availability of Family Planning and early screening and may have these services by contacting the County Welfare Office.

I understand that this Declaration of Facts may be investigated by the Department of Public Welfare and I agree to cooperate by signing EA-4 and EA-29 and help in such an investigation by presenting proof of the statements I have made in this Declaration.

I hereby authorize all medical providers to provide and release any medical information pertaining to myself, or any other person for whom I am applying for assistance, to the State Department of Social and Rehabilitation Services, the State Department of Revenue, and their agents, upon their request, and hereby release said medical providers from any liability based on such release.

Benefits and services must be provided without regard to race, color, national origin, religion, political belief, age, handicap, sex or marital status. I understand I may file a complaint with the State Department of Social and Rehabilitation Services if I feel that I have been discriminated against.

(APPLICANT OR GUARDIAN – SIGN HERE)	Date	(SPOUSE OF THE APPLICANT – Sign Name Here)	Date

91. If the applicant CANNOT write, or sign his name above, a Mark will be used instead of a signature; one witness is then required to verify the applicant's Mark and complete 92 below.

92. Witness's Signature (When Required)	Date	Witness Address & Zip Code

Date _____ Worker's Signature _____

SRS—EA—4A
(Rev. 11/83)

STATE OF MONTANA
DEPARTMENT OF SOCIAL & REHABILITATION SERVICES
Economic Assistance Division

RELEASE OF CONFIDENTIAL INFORMATION

AUTHORIZATION TO MONTANA SOCIAL & REHABILITATION SERVICES TO OBTAIN PERSONAL INFORMATION

Client's Name:_____ SSN:_____

Address:_____
(STREET) (CITY) (STATE) (ZIP CODE)

I authorize the individual, company or agency shown below to disclose to the _____ County Department of Welfare of the Montana Social and Rehabilitation Services, the information specified below, which relates to my eligiblity to receive Public Assistance benefits. I understand any information obtained will be kept confidential and will be used only for purposes directly connected with the administration of benefits or services. I further understand that any information obtained may be released to a proper governmental agency or court of law enforcement agency for purposes of legal and investigative actions concerning fraud, collection of support or establishment of third party liability.

INFORMATION SOURCE: Landlords, Neighbors, Employers, Social Security Administration, Doctors, Hospitals, Veterans Administration, Bureau of Indian Affairs, Department of Labor and Industry, Assessors, Treasurers, County Clerks of Court, Banks, Credit Unions, Savings and Loans, Buyers of Contracts for Deed/Negotiable Instruments.

INFORMATION TO BE REQUESTED: Family Composition, Earned Wages, Unearned Wages, Checking Accounts, Savings Accounts, Stocks, Bonds, Time Certificates, BIA-IIM Funds, Veterans Benefits, Unemployment Compensation, Workmens Compensation, Loans, Personal Property, Mortgages, Contracts for Deed/Negotiable Instruments, Real Estate, etc. Also, Medical Reports or conditions to exempt participation in employment or County Work Program.

DISCLOSURE: Please provide information requested in space below or on back of sheet.

Signature of applicant or authorized representative:

X _____ Date: _____

EA/SA-7
(11/84)

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
ECONOMIC ASSISTANCE DIVISION

ADDENDUM TO APPLICATION FOR GENERAL ASSISTANCE

YOU MUST RETURN THIS FORM BY THE END OF THIS MONTH. IF THIS REPORT IS NOT RECEIVED, YOUR ASSISTANCE WILL BE CLOSED AS OF THE LAST DAY OF THE MONTH.

Please list below the needs of your household for each category. It will be necessary to bring in your rent and utility receipts. The total of all your needs cannot exceed the maximum standards for household size. Refer to the table below for the maximum amount allowable in each category.

Rent	$_____
House Payment	$_____
Home Property Taxes	$_____
Home Insurance	$_____
Utilities	$_____
Food	$_____
Personal Needs	$_____
Transportation	$_____
What type of Transportation (public, car, etc.)	_____
How many miles per mo.	_____

FOR OFFICE USE ONLY

Rent	$_____
House Payment	$_____
Home Property Taxes	$_____
Home Insurance	$_____
Utilities	$_____
Food	$_____
Personal Needs	$_____
Transportation	$_____

No. of Persons in Household	Shelter	Utilities	Food	Personal Needs	Trans-portation	Maximum Standard
1	$120	$ 75	$ 79	$ 50	$ 50	$212
2	160	98	145	67	67	279
3	190	116	208	80	80	332
4	242	149	264	102	102	425
5	285	178	313	120	120	501
6	321	197	376	135	135	564
7	355	218	416	150	150	624
8	390	240	475	165	165	685

$59 Each Additional

If you are a family of 9 or more, ask your worker for the table of standards.

THE AMOUNT YOU RECEIVE FOR SHELTER AND UTILITIES MAY EXCEED THE TOTAL OF THE TWO (SHELTER AND UTILITIES) CATEGORIES UP TO A MAXIMUM STANDARD.

_____ _____
Recipient Signature Date

_____ _____
Eligibility Technician Signature Date

RECIPIENT RIGHTS:

- To make application without delay.
- To inquire and be informed orally and in writing about coverage, conditions of eligibility, scope of program and other services available.
- To be determined eligible or ineligible within 30 days of application.
- To be informed of fair hearing rights.
- To continuation of benefits during the fair hearing process.
- To have immediate needs satisfied.
- To receive timely written notice of denial, reduction or termination of assistance or all or part of assistance requested.

FS-74 (Rev. 11/83)
MONTANA DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Report Month:_____

Due Date:_____

MONTHLY ELIGIBILITY AND INCOME REPORT

Sign and return this form to your local county welfare department by the the 8th of this month. If this report is not received, your food stamps, AFDC grant and /or Medicaid may be closed as of the last date of this month.

The information that you put on this report will be used by your eligibility technician to decide if you continue to be eligible for food stamp benefits, AFDC and/or Medicaid. If you have any questions about completing this form, please contact your local County Welfare Office.

THE INFORMATION PROVIDED ON THIS FORM WILL BE SUBJECT TO VERIFICATION BY FEDERAL, STATE AND LOCAL OFFICIALS. IF INACCURATE OR INCOMPLETE, YOU MAY BE DENIED FOOD STAMPS AND/OR BE SUBJECT TO CRIMINAL PROSECUTION FOR KNOWINGLY PROVIDING FALSE INFORMATION.

IF YOUR HOUSEHOLD RECEIVES FOOD STAMPS, IT MUST FOLLOW THE RULES LISTED BELOW. ANY MEMBER OF YOUR HOUSEHOLD WHO INTENTIONALLY BREAKS ANY OF THE FOLLOWING RULES CAN BE BARRED FROM THE FOOD STAMP PROGRAM FOR 6 MONTHS AFTER THE FIRST VIOLATION, 12 MONTHS AFTER THE SECOND VIOLATION, AND PERMANENTLY AFTER THE THIRD VIOLATION. THE INDIVIDUAL WOULD ALSO BE SUBJECT TO A FINE OF UP TO $10,000, IMPRISONMENT OF UP TO FIVE YEARS, OR BOTH, IN ADDITION TO SUSPENSION FROM THE FOOD STAMP PROGRAM OF UP TO 18 MONTHS CONSECUTIVE TO THE ORIGINAL SUSPENSION, AS WELL AS FURTHER PROSECUTION UNDER OTHER APPLICABLE STATE AND FEDERAL LAWS.

DO NOT give false information, or hide information, to receive or continue to receive food stamps.
DO NOT trade or sell food stamps or authorization cards.
DO NOT alter authorization to participate (ATP) cards to receive food stamps to which you're not entitled.
DO NOT use food stamps to buy ineligible items, such as alcoholic drinks and tobacco.
DO NOT use someone else's food stamps or ATP cards for your household.

1. Please print your name_____
(Head of Household)

Social Security Number_____

2. ADDRESS CHANGE

Has your address changed since your last report? ☐ **YES** ☐ **NO**
If yes, give your new address below:

_____

_____

3. PEOPLE IN YOUR HOME

Instructions: List the names and relationship to you, of the people who live and eat with you at this time. (include yourself)

Name	Relation	Name	Relation
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

4. CHANGES IN YOUR HOUSEHOLD LAST MONTH

Did anyone move into or out of your household last month? ☐ YES ☐ NO

If 'yes', write the change below. If you answered 'no', go on to 5.

Name	Date Moved Out	Date Moved In	Birthdate	Social Security Number
_____	___/___/___	___/___/___	_____	
_____	___/___/___	___/___/___	_____	
_____	___/___/___	___/___/___	_____	
_____	___/___/___	___/___/___	_____	

The Social Security card of a new member(s) must be provided to your Eligibility Technician. Always include any new member's resources and income in this report.

5. EXPECTED CHANGES

Do you expect any changes in your circumstances in the next month, such as:

- someone starting a job, starting to receive unemployment compensation or other income or receiving a lease or royalty payment; or
- someone moving into or out of your household?

☐ YES (If Yes, Explain) ☐ NO

6. WAGES

Did anyone in your household receive wages last month? ☐ YES ☐ NO

Instructions: 1. Report the earning of anyone who received wages LAST MONTH;
2. Attach verification of earnings (paystubs) or loss of earnings (lay-off slip).

Wage Earner's Name			Did This Person's Income ☐ Start ☐ Continue ☐ Stop		Will Income Continue Next Month: ☐ Yes ☐ No
Employer's Name & Address					
Date Paid	**Earned Before Tax**	**Tips**	**Date Paid**	**Earned Before Tax**	**Tips**
1st payday			4th payday		
2nd payday			5th payday		
3rd payday					

Wage Earner's Name			Did This Person's Income ☐ Start ☐ Continue ☐ Stop		Will Income Continue Next Month? ☐ Yes ☐ No
Employer's Name & Address					
Date Paid	**Earned Before Tax**	**Tips**	**Date Paid**	**Earned Before Tax**	**Tips**
1st payday			4th payday		
2nd payday			5th payday		
3rd payday					

(If you have earned income and your report is turned in late you will not be allowed the $30 + ⅓, child care or work expenses. If you receive AFDC the Department must add an amount for advance Earned Income Tax Credit (EITC) payments to earnings.)

7. SELF-EMPLOYMENT

Did your household have income from self-employment last month? ☐ YES ☐ NO

Instructions: If you answered yes, enter the gross self-employment income below and list your operating expenses on a separate sheet. Attach verification of income and expenses or bring in your books.

$_____
Gross Income

8. OTHER INCOME

Did your household have income other than from work last month? ☐ YES ☐ NO

Instructions: 1. Report **any other money** your household received last month. 2. Examples of income which MUST be reported are: Social Security benefits, Veteran's benefits, unemployment benefits, strike pay, worker's compensation, disability insurance, pensions, military allotments, income from property and rental property; lump sum payments, such as past social security, an insurance or court settlement, income tax refunds, general assistance, ADC and INDIAN INCOME including BIA General Assistance, Per Capita Payments, sale of land, or mineral right payments; educational grants/loans; 3. Attach verification of income if it has changed.

Person Receiving Income	Amount	Date Received	Type of Income	Did Person's Income Start, Change, or Stop			Will Income Continue Next Month (Mark X)	
	$			☐	☐	☐	☐ Yes	☐ No
	$			☐	☐	☐	☐ Yes	☐ No
	$			☐	☐	☐	☐ Yes	☐ No
	$			☐	☐	☐	☐ Yes	☐ No

9. CHECKING OR SAVINGS ACCOUNTS (If zero, please enter zero.)

For all household members: $_____ Savings $_____ Checking
Amount (current) Amount (current)

Name of Bank(s) _____ Address _____

10. RESOURCES AND ASSETS

Did anyone in your household buy, sell, or receive a resource or asset last month? ☐ YES ☐ NO

Resources or assets could include:

- Cash
- Stocks, bonds, securities, trust fund or deed
- Land contract, house, or property
- Car, truck, camper, boat, snowmobile, motorcycle
- Recreation property, cottages, buildings
- Life insurance (cash value)

Instructions: If anyone in your household has bought sold or received resources/assets, please list them and contact your eligibility technician. Verification may be required.

Resource/Asset	(Bought, Sold or Received)	Date	Price/Value
			$
			$

11. COST OF CARE FOR CHILDREN, ILL OR DISABLED PERSONS:

Did your household have a child care, ill or disabled person care expense last month? ☐ YES ☐ NO

Instructions: 1. Attach verification of your costs.
2. If reason for care is education or training, send verification of the number of hours spent in the classroom or in training.

Name of Person Receiving Care	Monthly Cost	Who Provides Care? (Name and Address)	How Many Hours Per Month Was Care Provided	Reason For Care
	$			
	$			
	$			

12. HOUSING COSTS

Was there a change in housing costs? ☐ **YES** ☐ **NO** Examples of housing cost changes would be:

• House Payment • House Rent •House Insurance • Property Taxes • Utilities (lights, water, sewage, etc.)

Instructions: If yes, explain the change and attach verification of the change.

What Was the Change(s)?_____

13. MEDICAL COSTS

Did anyone in your household over 60 years of age or older, receiving SSI, social security disability or Veteran's benefits because of a total disability have a medical expense last month? ☐ **YES** ☐ **NO**

Instructions: If yes, list expense below and attach verification of medical expense.

Person's Name	Type of Medical Cost	Amount

14. RIGHTS

If you fail to complete this report correctly and/or verify needed information your case may be closed. If that happens, you would not receive any benefits for the month this report covers. You have the right, however, to furnish a completed report and reapply for benefits.

This is an equal opportunity program. If you believe you have been discriminated against because of race, color, national origin, age, sex, handicap, political beliefs or religion, write immediately to: Eligibility Policy Bureau Chief, Dept. of S.R.S., P.O. Box 4210, Helena, Montana 59604.

AUTHORITY TO REQUIRE SOCIAL SECURITY NUMBERS

The submission of the Social Security Number (SSN) for all household members is mandatory under the Food Stamp Act of 1977 as amended by PL 97-98. Your SSN will be used in the administration of the food stamp program to check the identity of household members, prevent duplicate participation and to facilitate making mass changes. Your SSN will also be used in computer matching and program reviews or audits to make sure your household is eligible for food stamps. This may result in criminal or civil action to administrative claims against persons fraudulently participating in the Food Stamp Program.

HEARING RIGHTS

If you disagree with any action taken as a result of this notice (subject to an additional notification), you have the right to request a fair hearing. If a fair hearing is requested within 10 days of the mailing dates of the additional notice of adverse action, and if the State Department of Social and Rehabilitation Services determines that the issues concern facts of judgements relating to your individual case rather than State policy, the action will not be effective until the fair hearing decision is rendered. Unless you request a fair hearing within 60 days of having your benefits reduced, suspended, terminated or denied, you will not usually be granted a hearing.

Fair hearings are conducted by the Department's Hearing Officer. Decisions by the Hearing Officer are binding on the Department and must conform to Federal and State law, regulation or policy and must be based exclusively on evidence and material introduced at the hearing.

This information is given to advise you of your right to a fair hearing in the event that your grant is reduced or terminated as a result of noncooperation in returning this monthly reporting form or because of information that you have reported on this form. A HEARING NEED NOT BE GRANTED WHEN EITHER STATE OR FEDERAL LAW REQUIRES AUTOMATIC GRANT ADJUSTMENTS FOR CLASSES OF RECIPIENTS UNLESS THE REASON FOR AN INDIVIDUAL APPEAL IS INCORRECT GRANT COMPUTATION.

I understand that the information I provide on this report may result in changes in my assistance, including reducing the amount of my checks, food stamps, and medicaid, or closing my case. I understand that such changes may be made without advance notice. **I AM AWARE THAT THE LAWS OF MONTANA PROVIDE FOR A FINE AND/OR IMPRISONMENT OF ANY PERSON WHO ATTEMPTS TO RECEIVE, OR RECEIVES, ASSISTANCE TO WHICH HE/SHE IS NOT ENTITLED. I HAVE ALSO READ THE PENALTY WARNING FOR FOOD STAMPS.**

SIGNATURE:_____ **DATE:**_____

Before you mail this form, have you:

( ) Signed the form. ( ) Enclosed wage stubs or other information to verify your income.

( ) Enclosed bills for day care, shelter expenses and so on.

If you have questions about this report call 1-800-332-2272, Toll Free.

GENERAL ASSISTANCE check list:

- signed application
- signed addendum
- signed EA-4
- good address (residency) except transient
- S.S. cards and I.D., drivers license
- Job Service card
- verification of shelter expenses, etc.
- wage verification, if any
- Workfare Handout
- workfare assignment - 2 copies to school
  1 file copy
- explain penalty (one week or 1/4 benefit for each refusal to work or failure to comply with workfare instructions)
- explain client responsibility to provide rent receipt and utility bill with addendum.
- landlord agreement
- repayment agreement

- EA-45 Interstate Transient - transportation/medical

G.A.
Name _____

Date _____

INTAKE AND PROBLEM:

HOUSEHOLD COMPOSITION:

RESIDENCE:

DEPRIVATION:

INCOME:

RESOURCES:

RECOMMENDATIONS:

BUDGET COMPUTATION

I. Computation of Earned Income Date:					
1. Gross Earnings					Directions to Home:
2 Earned Income Disregard					
3. Mandatory Deductions					
4. Personal Employment Expense					
5. Child Care Expense					
6. Total Deductions					
7. Net Earned Income (Subtract Line 6 from Line 1 to Determine Line 7)					
II. Other Income Social Security, Veterans, i.a., UC Compensation, etc. (Specify)					
1.					
2.					
3.					
4.					
5.					
6.					
III. Basic Requirement					ET - Notes:
Rent					
Utilities					
Food					
Personal Needs					
Transportation					
IV. Date:					
Max. Std. H.H.of 1	2/2				
Total Need					
- Income/Resources					
GA Amount					
Workfare? ___ Y ___ N					
Action:					
Closure Date:					
ET's Signature:					

DEPARTMENT OF SOCIAL &
REHABILITATION SERVICES
RAVALLI COUNTY OFFICE OF HUMAN SERVICES

TED SCHWINDEN, GOVERNOR

310 NORTH THIRD STREET

STATE OF MONTANA

(406) 363-1944

HAMILTON, MONTANA 59840

LANDLORD AGREEMENT

TO LANDLORDS OF GENERAL ASSISTANCE RECIPIENTS

I agree to accept General Assistance Authorization for payment of rent for_____

This is with the knowledge that rent paid by General Assistance, with the exception of the first months, is paid in arrears and only after compliance with the Workfare Program.

Monthly Rent Amount:_____

Are Utilities included:_____ _____

(yes) (no)

Signature:_____

Date:_____

Address:_____

Phone Number:_____

DEPARTMENT OF SOCIAL & REHABILITATION SERVICES

RAVALLI COUNTY OFFICE OF HUMAN SERVICES

TED SCHWINDEN, GOVERNOR

310 NORTH THIRD STREET

STATE OF MONTANA

(406) 363-1944

HAMILTON, MONTANA 59840

WORKFARE ASSIGNMENT

Date _____

_____ is eligible for General Assistance and has elected to receive assistance through the Workfare Program. The following work assignment for the month of _____ is:

Work Site: _____ Date to Report: _____

No. of Hours: _____

_____
Eligibility Technician

It is the client's responsibility to return the completed work assignment sheet to the Human Services Office.

Any recipient who refuses to participate in the County Work Program will lose eligibility for General Assistance for one week for each refusal. Good cause for refusal to participate will be determined by the County Director.

CERTIFICATION OF WORK BY SUPERVISOR

I hereby certify that _____ did report for and satisfactorily completed _____ hours of work on each day as follows:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____
Signature of Work Supervisor

"AN EQUAL OPPORTUNITY EMPLOYER"

SRS-EA-27
(Rev. 8/83)

MONTANA DEPARTMENT OF SOCIAL & REHABILITATION SERVICES

LETTER OF NOTIFICATION

TO:		FROM:	
Name of Applicant or Recipient:		Organizational Unit:	RAVALLI COUNTY HUMAN SERVICES
Street Address:		Street Address:	310 NORTH 3RD
City and Zip Code:		City and Zip Code:	HAMILTON, MT 59840 Phone: 363-1944

1. **PROGRAM:** ☐ AFDC ☐ MED. ASSIST. ☐ GEN. ASSIST. ☐ CO. MED. ☐ FOOD STAMPS
☐ OTHER:_____

2. **ACTION:** Your General Assistance application has been approved for_____

	_____	_____
Shelter, taxes & insurance	$	$
Utilities	$	$
Personal Needs	$	$
Transportation	$	$

You have been determined exempt from the Workfare Program for the months of_____

You will not be required to file a new application until_____ if you submit a food stamp monthly report and a new General Assistance Addendum by the 8th of each month. All changes in your circumstances must be reported within 10 days. Late reporting could affect the follwing month's benefits.

County check is enclosed_____Yes_____No Amount$_____

You received a county check for $_____.

Vouchers have been sent to _____

Legal Basis for Action:

ARM_____

_____.CFR_____

_____ MCA

If you have any questions regarding this action or if there are additional facts relating to your circumstances which you have not reported to us, please write or telephone. We will answer your questions or make an appointment to see you in person. Please remember that this action pertains only to the circumstances you reported to us. **(PLEASE READ THE REVERSE SIDE OF THIS NOTICE FOR YOUR FAIR HEARING RIGHTS).**

_____
(NAME & TITLE)

_____
(DATE)

REQUEST FOR FAIR HEARING

This is to request a fair hearing. I am making this request because:_____

_____

I understand that the right to a fair hearing includes an administrative review and a pre-hearing conference. If my reasons for a fair hearing have not been resolved during the administrative review and/or pre-hearing conference, I understand that a fair hearing will be scheduled.

I have an attorney: ☐ **Yes** ☐ **No.** My attorney's name is:_____

His/her address is:_____. His/her phone number is:_____.

_____ _____ _____
(CLAIMANT OR AUTHORIZED REPRESENTATIVE) (PHONE) (DATE)

***TO REQUEST A FAIR HEARING COMPLETE, SIGN AND MAIL THE WHITE COPY OF THIS NOTICE TO: HEARINGS OFFICER, BOX 4210, HELENA, MT 59604.**

Distribution: White — Household; Yellow — Household; Pink — County File

Form SRS–EA/SA–6
New (7/83)

STATE OF MONTANA
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

GENERAL ASSISTANCE AUTHORIZATION and INVOICE

VENDOR

DATE ISSUED ▶

NAME:

STREET ADDRESS

CITY | STATE | ZIP

ISSUED BY AND RETURN TO:

RAVALLI COUNTY OFFICE OF HUMAN SERVICES
310 NORTH 3rd St.
HAMILTON, MT 59840

VALID ONLY From _____ To _____ For _____
Name of Client or Family

WORKFARE: YES_____ NO_____ SS#_____

Services Authorized: _____

NO SUBSTITUTES ARE AUTHORIZED.

Return this form to the issuing office with the bottom portion complete. Retain the copy for your records.

_____
Authorized Official

DATES OF DELIVERY OF SERVICE OR ITEMS	DESCRIPTION OF ARTICLES OR SERVICES (Enter complete description and any other applicable information)	UNIT	QUANTITY	UNIT COST	AMOUNT
				TOTAL ▶	

I CERTIFY THAT THIS CLAIM IS CORRECT AND JUST IN ALL RESPECTS, AND THAT PAYMENT OR CREDIT HAS NOT BEEN RECEIVED.

SIGNED: _____ *TITLE:* _____

DATE: _____

▼ FOR SRS USE ONLY ▼

APPROVED FOR PAYMENT: _____ *DATE:* _____

SRS—EA—12
(Rev. 5/84)

MONTANA DEPT. OF SOCIAL & REHABILITATION SERVICES
Economic Assistance Division

REPAYMENT AGREEMENT

(PLEASE TYPE)

For State Use Only:	
Category Code	
Recovery Method Code	
Number of Accounts	
Frequency	
Fiscal _____ (Date)	

(1) County:_____
(2) Case Name:_____
(3) Address:_____
_____ Zip_____
(4) Social Security Number:_____
(5) Repayment By: ☐ Grant Reduction (ADC only)
☐ Cash ☐ Coupon Payment ☐ Monthly Allotment Reduction ☐ Restored Benefits ☐ Other

(6) AFDC Overpayment ☐ Regular ☐ Ward $_____
(7) Food Stamp Overissuance $_____
(8) Medicaid Overpayment $_____
(9) AFDC Period of Overpayment From:__/__/__ To:__/__/__
(10) Medicaid Period of Overpayment From:__/__/__ To:__/__/__

---

(11) I/WE, _____ HEREBY AGREE TO PAY TO THE STATE OF MONTANA THE SUM OF _____ AT THE RATE OF _____ PER _____ (Frequency) FOR: _____ (Reason for Overpayment)

(ATTACH EITHER EA-16F OR FS-27, WHICHEVER IS APPROPRIATE)

PAYMENTS SHALL BEGIN ON OR BEFORE _____ (first of month) AND CONTINUE ON A REGULAR _____ (frequency) BASIS FOR _____ (years/months)

WITH A FINAL PAYMENT OF: _____

IN THE EVENT THAT DEFAULT IS MADE IN ANY OF THE ABOVE PAYMENTS AS THEY BECOME DUE, THEN THE ENTIRE AMOUNT OF THE UNPAID BALANCE SHALL BECOME IMMEDIATELY DUE & PAYABLE WITHOUT FURTHER DEMAND.

ALL STATUTES OF LIMITATION APPLICABLE TO THIS AGREEMENT ARE HEREBY FOREVER WAIVED.

I/WE HAVE ENTERED INTO THIS AGREEMENT VOLUNTARILY.

_____ (Date) _____ (Signature)

_____ (Date) _____ (Signature)

_____ (Address)

Money orders and cashiers checks are to be made payable to the Department of Social & Rehabilitation Servcies and mailed to the Fiscal Bureau, P.O. Box 4210, Helena, MT 59604.

ORIGINAL (White) — Program Integrity Bureau
DUPLICATE (Yellow) — Program Integrity Bureau
TRIPLICATE (Pink) — Originating County
QUADRUPLICATE (Gold) — Recipient

(See EA Manual, 201-2, and AFDC Manual, 503—2B, for purpose and use of this form)

Dept. of Revenue Use Only	
For Accounting Purposes Only:	
AFDC	$_____
Food Stamps	$_____
Medicaid	$_____
Penalty/Interest	$_____
Other _____	$_____
Total	$_____
CODE _____	Other ☐

DEPARTMENT OF SOCIAL & REHABILITATION SERVICES

RAVALLI COUNTY OFFICE OF HUMAN SERVICES

TED SCHWINDEN, GOVERNOR

310 NORTH THIRD STREET

STATE OF MONTANA

(406) 363-1944

HAMILTON, MONTANA 59840

WORK PROGRAM HANDOUT

The General Assistance Work Program which you are applying for is a program designed to assist you on a temporary basis in an emergency situation when you are unable to find other work.

If you are found eligible for the General Assistance Work Program, you will be assigned manual labor to compensate for the amount of assistance given to you. If you do not work your assigned days, you will lose eligibility for one week for each refusal.

While you are on this program, you will be expected to comply with the following:

1. Register at Job Service within 3 working days of application for General Assistance.

2. Bring in verification of all earned and unearned income from any and all employment in month of requested certification.

3. If physically unable to work, provide a doctor's statement to that effect.

4. If you refuse a job, you will be determined ineligible for any further General Assistance for a period of thirty days.

SRS—EA—45
(Rev. 11/83)

STATE OF MONTANA
DEPARTMENT OF SOCIAL & REHABILITATION SERVICES

AFFADAVIT
NON-RESIDENT AND INTERSTATE TRANSIENT

DECLARATION FOR TRANSPORTATION

State of Montana

County of _____

_____ County Office of Human Services

I, _____, declare that I am unable to pay for my own basic needs or transporation for return to my state of origin/residence. I am not a resident nor do I intend to reside in the State of Montana. I am en route to my state of origin/residence, but because of unexpected hardship I am unable to reach that destination.

_____
Signature/Date

DECLARATION FOR MEDICAL

I, _____, declare that while traveling in the State of Montana I have been accidently injured. I am not a resident of the State of Montana nor do I intend to become a resident. I am en route to my state of residence/origin.

I am unable to pay in part or in full for the medical expenses resulting from said accidental injury. I have no other resources (medical insurance, worker's compensation or other liable third party) that can pay for these expenses.

_____
Signature/Date

Exhibit 3
2-6-85

Family Service, Inc.

2201 4th Avenue North Phone 259-2269
BILLINGS, MONTANA 59101

TRAVELERS AID
REPRESENTATIVE

LINDA ROBBINS
EXECUTIVE DIRECTOR

February 1, 1985

Mr. Cal Winslow, Chairman
Human Services Appropriations Committee

Dear Mr. Winslow,

Family Service, Inc. is a United Way Agency set up to help families in emergency situations with groceries, clothing, small prescriptions, small cash loans, gasoline to get to jobs or job interviews, etc. We are entirely United Way supported, and supplement that with donations and repayments. We are also a designated County Welfare vendor and Montana Medicaid vendor.

We are in constant contact with Yellowstone County Resource Department, verifying situations and checking on when Food Stamps and ADC are due on our clients. If they've already received their allocations, we are able to find that out to avoid duplication of services.

In 1984, we experienced a 37% overall increase in the number of families asking us for assistance, over 1983. Much of this increase is directly attributable to the understaffing at County Welfare. When a client goes there to set up an appointment, more often than not, they are needing help right then. Today is February 4th - I just called County Welfare and they are scheduling appointments for March 4th. Then, of course, they have 30 days to process the application. If the client is needing assistance right now, they are automatically sent here to Family Service. The longest we are able to help any one family is a week at a time. We know when we see a family for assistance today that we're looking at giving them assistance once per week for up to 2 months.

We have budgetted $50,000.00 for direct assistance to clients for 1985. In January, we spent just over $4,500.00 <u>just</u> for groceries. That means we are already over-budget for 1985! If there is no relief at County Welfare soon, I'm afraid there will be no help available in Billings for many families before this year is over.

Each case-worker is so overburdened that it <u>is</u> taking the full 30 days to process their applications. The strain of such a heavy work-load is being felt in this office, and I can tell, if not by voice alone, that the strain at County Welfare is getting too great. On the other side is the client. In many cases, just going in to apply was the hardest thing they've ever had to do and it took quite awhile just to decide that there were no more alternatives. Then, to be put off for such a long time, they become angry and frustrated. If they've never had to ask for any type of assistance before, having to come here too is very difficult.

This cannot go on - there has got to be some relief. The understaffing, over-burdening and long delays in applications and processing are causing problems for which soon there will be no solutions. Please, if there is anything you can do to help alleviate these problems, we would be most appreciative.

Thank you for any consideration you may give to this situation.

Sincerely,

Linda Robbins

Linda Robbins
Executive Director

Gunman

From Page One

to talk to his mother, Greer said, but by then Hansen had returned.

Greer and Brun said Mrs. Hansen told them her husband was a Vietnam veteran suffering from emotional problems related to his service in the war.

Greer said he thinks Hansen had been unemployed off and on. Welfare workers have known the Hansen family for several years, he said.

Minutes after police had hauled off Hansen, the welfare office was still buzzing with excitement. Welfare employees were willing to talk about the incident, but declined to give their names, saying they did not want to advertise who they were to other angry clients.

"Everybody ran out," one woman said. "I thought it was going to be another one of those McDonald's massacres."

On July 18 a recently fired security guard opened fire on a McDonald's restaurant in San Ysidro, Calif., killing 21 people and injuring 20 others. The gunman was shot and killed by a police sharpshooter.

"We ran to the back," another welfare employee said. "I thought 'Oh my God.' My worst fear was that he'd shoot someone."

When Hansen came in with his gun, one of the receptionists said she took about five clients who were in the waiting room into an office behind a brick wall. Employees, she said, took off running to the back of the building.

"We get threats like this all the time," she said. "But nothing ever happens."

One woman who was behind the counter near the door Hansen entered said she was very frightened.

"There's no protection here," she said. "What if it would have been real busy and there would have been a lot of people in the waiting room?"

Rifleman storms welfare office

By ROBIN BULMAN
Of The Gazette Staff

Frightened welfare workers herded clients into offices while others fled the building Friday afternoon when a disgruntled food stamp recipient followed through on his threat to seek satisfaction with a gun.

Minutes after entering the Yellowstone County welfare office, located at 3021 Third Ave. N., the man was subdued by a city police detective, who happened to be there on an unrelated matter, and two uniformed officers.

He was identified as Charles Hansen, 39, of 905 Bench Blvd.

Detective Frank Brun said he disarmed Hansen from behind about 3:30 p.m.. The rifle, he said, had no bullets in the chamber, but four live rounds in the magazine.

"By the time I got the cartridges out, the uniformed officers were still fighting him on the floor," Brun said.

No shots were fired throughout the incident, he said, which lasted no more than two or three minutes.

Hansen was arrested on misdemeanor disorderly conduct charges and booked into the Yellowstone County Jail about 4:40 p.m., police said. He was released several hours later and give a notice to appear in court. Hansen has no prior arrests, police said.

An office worker who asked not to be identified estimated that about 60 people were in the building at the time.

According to welfare director Jim Greer, Hansen had come to the office with his wife to resolve a question about his food stamp eligibility. Greer said that before he could talk to Hansen or locate his file, Hansen left, saying he would return with a gun.

"His wife said when he left we'd better call the police," Greer said.

But the police did not respond immediately, according to the receptionist who made the call. "They asked me my life history," she said. "They asked me how long it would take him to get here. I said about eight minutes."

Brun, who was in an office in the rear of the building, said that Greer told him of the potentially volatile situation when Hansen first left. Brun said Greer also told him that police headquarters had been notified, but had said no one could respond immediately.

When Greer returned to say Hansen had arrived with a rifle, Brun said he told Greer to notify police again.

FRANK BRUN
disarms rifleman

"I walked out and the guy was coming through the door," Brun recalled. "He was very irate, upset and screaming and hollering about food stamps. He said he wanted the guy in charge. I told him I was more or less in charge, but he said that wasn't good enough."

Brun said he could not grab the rifle then because he was holding his own pistol out of Hansen's sight.

Hansen turned when two uniformed officers arrived and told him to put down the gun, Brun said. At that point, Brun said he grabbed the rifle from Hansen.

Hansen's wife remained there during the incident, Brun said. A welfare employee said Mrs. Hansen told several people who walked into the office during the incident to leave.

"She tried to tell him to calm down," Brun said. "I was trying to calm him down because he was so irrational. His replies were a lot of yelling and screaming."

According to Greer, Mrs. Hansen tried to telephone her husband to defuse the situation when he first left the office, but could not reach him. Hansen's son then called the welfare office

(More on Gunman, Page 8A)

2/4/85

To Whom It May Concern:

As an eligibility technician in Yellowstone County I see an urgent need for more technicians. The majority of people I see daily are destitute. They are out of money, out of food, and possibly facing eviction and/or utility shut-off. Because of the number of these clients each technician is required to see because of caseload size, we are unable to process these clients in a timely manner. The clients become frustrated and rightly so. What they don't realize is that we are doing to very best we can. They are not concerned with numbers only with their own situation.

They become angry and sometimes threatening. As a technician it is hard to tell people that we understand their position and that we are doing our very best but it may be 30 days or so before they receive assistance. That is the situation. The reason is because we are short staffed. We desparately need more FTEs. Currently in Yellowstone County we are fully staffed with eligibility technicians but caseloads are unmanageable because of their size.

The benefit of more FTEs would not be only to the clients and the current staff but also to the community. Currently service organizations such as The Salvation Army, Saint Vincent DePaul and Family Services are having to help a number of our clients because of the delay in our services. Landlords become upset because clients are not receiving assistance and so are not paying their rent.

We are doing the very best we can but we are becoming frustrated and worn out. This is shown by the amount of turn over we have in our office in the eligibility division. A greater number of technicians would allow us the time to process cases in a more expedient manner. It would also allow us more job satisfaction rather than frustration.

Thank you for your consideration. Any help would be greatly appreciated.

Judy Augenbright, E.T.

Moore than 200 new people are coming to our office each -month to apply for AFDC related programs. Most of them will return to pursue eligibility.

We have people who apply for these assistance programs who are not elibible for any assistance e but will slip through and will be approved for a money grant, medical or food stamps, simply because they are experts at deception. We do not have the time to do more than a quick evaluation of the circumstances they present to us.

Additional staff would truly reduce the number of people who are being approved for assistance they are not eligible for. And would also reduce the number of people who are receiving assistance now that are not eligible.

Janet Schweigert. E.T.

Costly training programs have been set up to stay off federal sanctions for high error rates in the welfare and food stamp programs. Yet, no matter how well trained or highly skilled the workers are, if her she does not have the time to keep up with the paper flow and keep case records current errors will occur.

It would seem that it is, "penny wise and pound foolish," to economize on personnel and spend the dollars trying to appease the federal government with programs or lose the dollars thru lost reimbursement.

Freida Hicks
Elig. Tech. I

Lyn VAN Arsdale E.T. Yellowstone County

As a "rookie" eligibility Technician I felt I was going to be doing a job that meant serving the public, and being in a position to be the arm extended in helping the truly needy.

Shortly thereafter I found the volumn of work so great that I could not keep up with it, let alone meet deadlines, and ~~later~~ literally had nothing left for the client.

Stress is not just the volumn of paper work for an Elig. Tech. Job burn out begins to be apparent due to the frantic pace. There are people who come into the office the day after they've exhausted all resources, only to be told it will take 30 days to process their application. Knowing their need and being unable to meet that need adds additional pressure. Having a smaller caseload would benefit the people in need and the state of Montana as a more thorough work performance would evolve, less errors would be made and deserving people would be helped in a timely manner.

Saturday
2-2-85

I was jolted awake this morning from a deep sleep. My morning to sleep late was interrupted by a group of angry clients who had gathered at my front door. I told them I deeply resented their coming to my home, whereupon the young lady in the group silently turned around, picked up a rifle and shot me point-blank. I awoke from this nightmare but the fear remains.

The clients are angry. Since an armed rifleman barged into our office in January there have been numerous threats. There is not adequate staff to perform the work quickly and accurately. Frustrations build up with the clients as well as for us.

Changes in the various programs have come about so rapidly in the past 2 years that it is difficult to keep abreast. Our office has been understaffed the past 2 years placing an unsurmountable burden on those who remain.

So much emphasis is placed on clients rights. Don't we, as state employees, have the right to an adequate staff so that our work can be performed in a timely manner to the satisfaction of the clients as well as personal satisfaction to ourselves?

Bette Bratsol

County of Yellowstone

RESOURCE DEPARTMENT
JAMES C. GREER, JR., DIRECTOR

3021 3RD AVENUE N
Phone 248-1691
BILLINGS, MONTANA
59101

February 4, 1985

Cal Winslow, Chairman
Human Services Appropriations Subcommittee

Dear Mr. Winslow:

We are writing this letter in hopes that you will realize the workload situation of the Eligibility Technicians at the County level.

We realize that determining the SRS budget needs is not an easy task and thought that any input we could provide would be of help to you.

There are currently 1,426 households on non-assistance Food Stamps in our county. Approximately 1300 of these cases must be reviewed and the allotments changed monthly. We, here at the Yellowstone County Resource Department, have a total of four personnel to complete this task. This amounts to 325 changes, per worker, per month.

These figures do not include the 122 new food stamp interviews, we have weekly, between the four of us. It also doesn't include the monthly food stamp recipients, whom are on County General Assistance, within our unit. The General Assistance cases must also be reviewed and changed monthly. Those cases total approximately 25 per month.

We have enclosed a copy of a study which we compiled and presented to the Legislative Candidates in early November 1984, which we hope will show some justification in allowing additional full-time employees.

We thank you for your consideration in allowing our input.

Sincerely,

Betty Vogel	Pat West	Gail Toney	Barb Harvey	Gwen Stone
E.T. Supr.	E.T.II'	E.T.I	E.T.I	E.T.I

I. FOOD STAMP DENIAL

Forms required & Purpose of Each:

SRS FS-1 FOOD STAMP APPLICATION Client completes this form. Eligibility Technician (ET) assists client if necessary and fills in any blank sections of the form with verbal information received from the client.

SRS FS-20 APPLICATION WORKSHEET This is the form which the ET uses to record verifications and documentation the client submits in order to establish eligibility for Food Stamps. The ET also uses this form in order to compute the client's eligibility amount.

SRS FS-26 NEGATIVE ACTION REPORT This is a report the ET must send to the State SRS office, on a monthly basis, in order to report that a denial was done on the case. It must also include the basis for the denial.

County Form RUNNING RECORD This is a form kept in the front of the client's file so that the next ET that works on the case can tell what the last action on the case was. It also records the basis for the action taken.

FS-11 FOOD STAMP NOTICE OF DECISION This is the letter to the client informing them of the decision which was made on their application.

County Form FOOD STAMP MASTER CARD This form enables the ET to glance at the card file to tell the last action taken on the Food Stamp portion of the file. The card includes the client's address, number of members in the household, phone number, net income, and most recent Food Stamp allotment. It also enables ET to see if closure or denial has been done and the reason for it.

TOTAL FORMS FOR FOOD STAMP DENIAL	6
AVERAGE TIME FOR THIS PROCESS (FORMS ONLY)	10 min.
AVERAGE TIME FOR THIS PROCESS (INTERVIEW ONLY)	15 min.
TOTAL TIME FOR THE FOOD STAMP DENIAL PROCESS	25 min.

II. FOOD STAMP APPROVAL

Forms Required & Purpose of Each:

SRS FS-1 FOOD STAMP APPLICATION Client completes this form. Eligibility Technician (ET) assists client if necessary and fills in any blank sections of the form with verbal information received from the client.

SRS FS-20 APPLICATION WORKSHEET This is the form which the ET uses to record verifications and documentation the client submits in order to establish eligibility for Food Stamps. The ET also uses this form in order to compute the client's eligibility amount.

(continued on page 2)

FOOD STAMP APPROVAL (cont.)

FS-11 FOOD STAMP NOTICE OF DECISION This is the letter to the client informing them of the decision which was made on their applicatio

County Form FOOD STAMP MASTER CARD This form enables the ET to glance at the card file to tell the last action taken on the Food Stamp portion of the file. The card includes the client's address, number of members in the household, phone number, net income, and most recent Food Stamp allotment. It also enables ET to see if closure or denial has been done and the reason for it.

SRS FS-18 NOTICE OF EXPIRATION OF BENEFITS Notice to the client informing them that their certification has expired and that they must submit a new application and set up another interview with technician.

SRS EA-4a RELEASE OF CONFIDENTIAL INFORMATION This is a form that the client must sign in order to receive assistance. This form, once signed, enables the County Welfare office to investigate Family Composition, Earned Wages, Unearned wages & income, Checking and Savings Accounts, Stocks, Bonds, Time Certificates, BIA Funds, VA Benefits, Unemployment Compensation, Workmens Compensation, Loans, Personal Property, Mortgages, Contracts for Deed/Negotiable Instruments, Real Estate, etc. Also, Medical Reports or conditions to exempt participation in employment or County Work Program. All of this must be explained to the client prior to them signing it.

SRS FS-53 JOB SEARCH REFERRAL This form is used to schedule applicant for and inform them of their appointment for Job Search. Job Search is a program which is run by the Employment Security Division through the local Job Service office. A Job Service Placement Counselor attempts to find them work, while at the same time, the client must apply for a certain number of jobs. This program last 8 weeks.

SRS FS-5 AFFIDAVIT OF UNDERSTANDING This form must be signed by the Head of Household showing that they understand that the members of the household, whose names appear on the form, must be registered at the Job Service and accept any employment offered to them.

SRS FS-1e STANDARD UTILITY FORM This form explains to the client that they have the option of either using their actual utility bills to determine the Food Stamp allotment, or using the State standard for utilities. In order to qualify for the Standard Utility amount, the client must be responsible for paying their own heat expenses. The client must sign this form showing which they have chosen.

CO. 31 This is a County form which is sent to the American Indian client's BIA Headquarters requesting information on the client's tribal accounts and land lease income.

County Form RUNNING RECORD This is a form kept in the front of the client's file so that the next ET that works on the case can tell what the last action on the case was and the basis for the action taken.

(cont. Page 3)

EA-1a — COMPUTER FORM which must be filled out and mailed into the State SRS Data Processing Unit so that the client and all members of the household can be entered onto the SRS computer. This form includes all members of the household's Social Security Numbers, Birthdates, Sex, and date of eligibility.

EA-2 — COMPUTER FORM which is a supplement to form listed above. This supplemental form is used when there are more than 4 members in the household.

SRS FS-8 — MAIL ISSUANCE REQUEST This is a form which must be completed if the client requests that the Food Stamps be sent directly to their address, rather than picking them up at the Courthouse.

FS-74 — MONTHLY REPORT FORM Even though this form doesn't have to be completed at the time of the interview, the ET must go over this form with the client to ensure that the client knows what is required on the form,the month that the form inquires about, date due, and which verifications must be submitted with it.

County Form — MRRB (Monthly Reporting Retrospective Budgeting) NOTEBOOK PAGE Each client must have one of these written up on them. The only households that are exempt from this are those on Social Security, Supplemental Security Income, Social Security Disability, or any other fixed income. This is a page which the technician keeps in a notebook with information regarding the case on it.It must include Name, Address, Phone, Application date, Interview date, Ethnic code, Social Security Number, Job status, Names of all members of the household, Income and Income Source, Resources, Day Care Expenses, Name of Landlord, Rent amount, Utility Amounts, Certification Period and Amount Issued. This form is used so the ET doesn't have to refer to the file every time a question regarding the case comes up.

EA P-31 — REQUEST FOR INFORMATION ON UNEMPLOYMENT COMPENSATION & WAGES This form is sent weekly to the State SRS office. The Data Processing Unit then returns computer readouts on each client, showing any Unemployment Benefits or wages received in the last 6 months.

Copies of Identification, Social Security Cards, Vehicle registrations, tax, and Insurance on residence, must be taken and attached to this batch of forms.

TOTAL FORMS FOR FOOD STAMP APPROVAL	17
TOTAL AVERAGE INTERVIEW TIME	29 Min.
TOTAL AVERAGE PAPERWORK TIME	21 Min.
TOTAL AVERAGE TIME FOR COMPLETION OF CASE	50 Min.

Average Number of these per day, per worker	8
Total time per day, if all were completed	6½ - 7 hrs.

III. MRRB (MONTHLY REPORT CHANGES)

Forms required & Purpose of Each:

FS-74	MRRB FORM (MONTHLY REPORT FORM) This is the form that the client submits monthly to report any changes in address, number of household members, expected changes, wages, self employment income, unearned income, checking and savings account balances, resources, day care expenses, housing costs and medical costs. This form must be accompanied by verification of all information.
FS-71	NOTICE OF LATE OR INCOMPLETE MONTHLY REPORT This is a notice the ET must send to the client telling them that their monthly report is past due, or incomplete.
SRS FS-20c	FOOD STAMP MONTHLY COMPUTATION WORKSHEET This is the worksheet which the ET uses to compute the new allotment, based on the monthly report submitted by the client.
FS-11	FOOD STAMP NOTICE OF DECISION This is a letter to the client informing them of the change which was made on their coupon allotment.
County Form	RUNNING RECORD This is the form kept at the front of client's case file so that the next ET that works on the case can tell what the last action taken on the case was.
County Form	MRRB NOTEBOOK PAGE This is the page which the ET keeps in a notebook for quick reference regarding the case. All changed information must be updated on this form, so that there is always the most current information on the case available.
County Form	FOOD STAMP MASTER CARD This form enables the ET to glance at the card file to tell most recent action taken on the case, and allotment amounts. This form must be updates monthly so that all current information regarding the case is available.
EA-1a	COMPUTER FORM which must be updated monthly and resubmitted so that all current information regarding the case is entered into the SRS computer.
EA-2	COMPUTER FORM used when there are more than 4 members in the household. This form must be updated when information must be changed.

TOTAL POSSIBLE FORMS	9
* TOTAL HOUSEHOLDS ON MONTHLY REPORTING	750
TOTAL TIME PER MONTHLY REVIEW WHEN NO CHANGES REQUIRED	8 min.
TOTAL TIME PER MONTHLY REVIEWS WHICH REQUIRE CHANGES	20 min.
TOTAL WHICH MUST BE COMPLETED DAILY IN ORDER TO MEET DEADLINES	9
TOTAL DAILY TIME REQUIRED FOR COMPLETION OF MONTHLY CHANGES	3 Hrs.

*

IV. COUNTY GENERAL ASSISTANCE (WORK PROGRAM)

Forms Required & Purpose of Each:

SRS EA-1A — APPLICATION FOR ASSISTANCE This form is used for all programs, other than Food Stamps. It is to be completed by the client; however, the technician must also double check the form and make sure that it is completed correctly. The date that the form is received in the Welfare office is then used as the applicant's date of application.

EA-79 — DECLARATION OF RESOURCES This form must accompany the application form. The client must list on this form any resources not covered under the questions on the application form. The client must list anything they have more than 1 of, e.g. TV, stereo, washer/dryer, etc.

County Form — WORK PROGRAM QUESTIONNAIRE This form also accompanies the application form. It saves time for the ET so that the ET doesn't have to ask the questions verbally.

SRS EA-1e — FACE SHEET This is an informational form which the ET completes. It contains names, birthdates, birthplaces, relationships to the applicant (for additional members), race, educational background, Social Security numbers, Veteran status, address, martial status and background as well as the client's next of kin. This form is kept in the file for informational purposes.

SRS EA WS1 — ELIGIBILITY INTAKE CHECKLIST This form covers the rights and responsibilities of the client. The ET must go over each item with the client to assure that they understand their rights and responsibilities. The ET and the client must sign this form.

SRS EA-4a (two) — RELEASE OF CONFIDENTIAL INFORMATION This is a form that the client must sign in order to receive assistance. This form, once signed, enables the County Welfare office to investigate Family Composition, Earned Wages, Unearned wages & income, Checking and Savings Accounts, Stocks, Bonds, Time Certificates, BIA Funds, VA Benefits, Unemployment Compensation, Workmens Compensation, Loans, Personal Property, Mortgages, Contracts for Deed/Negotiable Instruments, Real Estate, etc. Also, Medical Reports or conditions to exempt participation in the County Work Program. All of this must be explained to the client prior to them signing it. The client must sign 2 of these forms. One is used for the Food Stamp portion of the application; one for the General Assistance portion.

Co. 22 — This is a County Form which is given to the client. The ET must go over this form with them. It is an informational form on which some of the County Work Program requirements are explained.

Co. 39 — This is also a County Form which is given to the client. This form accompanies the above form (Co. 22) and covers more of the County Work Program requirements for eligibility.

Co. 25 — Also a County Form. This is a form that the client's Landlord must complete. It is used for informational purposes only, to verify address, rent amount, and to whom the rent check should be issued. This form must also be signed by the client,which gives the ET the right to release information to the landlord regarding rent situation only.

(cont. Page 6)

COUNTY GENERAL ASSISTANCE (WORK PROGRAM) cont.

JTPA Form — JOB SERVICE OF MONTANA JTPA APPOINTMENT & REGISTRATION VERIFICATIO This form is used to set up appointment for and verify registration with the Job Training Partnership Act (JTPA) program through the Job Service.

SRS FS-1a — PUBLIC ASSISTANCE AFFIDAVIT REQUEST FOR FOOD STAMP BENEFITS This form is used as a food stamp application for the Public Assistance applicants. This form is completed by the client and double-checked for accuracy by the technician.

Co.26 — EMPLOYMENT RECORD This is a County form used by the client to report any income received. If the client received no other income, this form is not required. If the client works part-time, they would have to submit one of these weekly.

Co. 23 — WORK RELIEF ORDER This is a County form used for informing the client of dates, times, and the place they will be working, on the County Work Program. It is given to the client, generally the day before they are required to report for work. They must first complete all other requirements of the County Work Program prior to being scheduled for work. The client receives one of these schedules monthly.

County Form — CASE PROGRESS RECORD This is a form used for ET to make dictation regarding the client, e.g. if they are cooperating, special situations, etc... This is used basically to document the client's situation for the case record.

Co. 31 — This is a County form letter sent to the American Indian client's BIA headquarters requesting information on their tribal accounts and land lease income.

SRS FS-20 — APPLICATION WORKSHEET Technician's worksheet and computation form which must include all documentation and verification of information used to compute Food Stamp allotment.

EA P-31 — REQUEST FOR INFORMATION ON UNEMPLOYMENT COMPENSATION BENEFITS & WAGES This form is sent weekly to the State SRS office. The Data Processing Unit then returns computer readouts on each client, showing any Unemployment Benefits or wages received in the last 6 months.

SRS FS 18 — NOTICE OF EXPIRATION OF BENEFITS Notice to the client informing them that their certification has expired and that they must submit a new application and set up another interview with technician.

County Form — RUNNING RECORD This is a form kept in the front of the client's file so that the next ET that works on the case can tell what the last action on the case was. It also records the basis for the action taken.

(cont. Pg. 7)

COUNTY GENERAL ASSISTANCE (WORK PROGRAM) cont.

SRS FS-5 AFFIDAVIT OF UNDERSTANDING This form must be signed by the Head of Household showing that they understand that the members of the household, whose names appear on the form, must be registered at the Job Service and accept any employment offered to them.

SRS FS-53 JOB SEARCH REFERRAL This form is used to schedule applicant for and inform them of their appointment for Job Search. Job Search is a program which is run by the Employment Security Division through the local Job Service office. A Job Service Placement Counselor attempts to find them work, while at the same time the client must apply for a certain number of jobs. This program lasts 8 weeks.

SRS FS-1e STANDARD UTILITY FORM This form explains to the client that they have the option of either using their actual utility bills to determine the Food Stamp allotment, or using the State standard for utilities. In order to qualify for the Standard Utility amount, the client must be responsible for paying their own heat expenses. The client must sign this form showing which they have chosen.

Co. 24 JOB APPLICATION VERIFICATION This is a County form used to verify where the client has applied for work. The employer, to whom the client has applied for work, must complete the form. The client must complete 10 of these forms each week. The Technician must then put each one of these into a log book. NOTE: The Technician must transfer, by hand, the information on these forms into a log book. The original form, which was filled out by the employer, is then destroyed.

FS-74 MONTHLY REPORT FORM Even though this form doesn't have to be completed at the time of application, the ET must to over this form with the client to ensure that the client knows what is required on the form, the month that the form inquires about, date due, and which verifications must be submitted with it. This form is used for food stamps only.

EA-1a COMPUTER FORM which must be filled out and mailed into the State SRS Data Processing Unit so that the client and all members of the household can be entered onto the SRS computer. This form includes all members of the household's Social Security Numbers, Birthdates, Sex, and date of eligibility.

EA-2 COMPUTER FORM This form is used as a supplement to form listed above (EA-1a). This supplemental form is used when there are more than 4 members in the household.

County Form BUDGET SHEET This form is used to notify the County Board and clerical staff what action is being taken on the case e.g. approval, denial, closure, etc.

SRS EA-27 LETTER OF NOTIFICATION This letter is used to inform a client as to whether their application has been approved or denied or closed. It would also indicate to the client any special requirements of the program which would be required prior to the

(cont. pg.8)

assistance being rendered to them.

For each County Work Program application approved, the ET must have a notebook page with the person's name, Social Security Number, Birthdate, Resource Information, Landlord and Landlords address & phone, Rent amount, Utility Coverage, and any representative the client may have appointed to represent him. The ET uses this page to keep track of dates of Job Service visits & Dates and amounts of assistance given to him by the County.

Since we have recently made the initial application process into a group meeting, the ET is able to see up to 20 new applicants at one time. This process takes 45-60 minutes for each meeting held. Currently, there is only 1 meeting per week.

The County Work Program client is required to report to the ET at least one time each week. The hour of 8:00 a.m. to 9:00 a.m. is set aside for this purpose. Any person who has already been through the initial application process, may "drop in" at this time and will be seen by the technician. No appointment is necessary, therefore, the ET is subject to seeing 1 to unknown number of clients between the hour of 8 & 9:00 a.m., Monday through Friday. NOTE: Some clients do come in more than once each week.

AVERAGE NUMBER OF CLIENTS SEEN BETWEEN 8-9 a.m. daily	6
AVERAGE TIME PER CLIENT DAILY	8 min.
# OF FORMS REQUIRED FROM APPLICATION TO APPROVAL/DENIAL	30
AVERAGE TIME FOR APPROVAL/DENIAL ACTION	21 min.

V. MISCELLANEOUS DUTIES

MAIL	12 min/day
CREDIT REPORTS (REVIEW INFORMATION)	5 min/day
BILLINGS TIMES (REVIEW INFORMATION)	5 min/day
INDIAN LIST (LIST OF THOSE ON COMMODITIES-MUST REVIEW INFORMATION	5 min/day
VOUCHERS (WRITTEN FOR ITEMS REQUIRED BY GENERAL ASSISTANCE WORKERS)	7 min/day
VERIFICATION OF THOSE THAT SHOWED UP FOR WORK	5 min/day
CONSULTATION WITH SUPERVISOR	12 min/day
PREPARING FOR GROUP MEETINGS (GATHERING PACKETS FOR APPLICATIONS)	30 min/wk
CHECKING APPLICATIONS TO SEE IF THEY QUALIFY FOR EMERGENCY ASSISTANCE	10 min/day
HELPING CO-WORKERS ON CASES (QUESTIONS)	11 min/day
LETTERS TO CLIENTS (MISCELLANEOUS REMINDER LETTERS)	6 min/day
GATHERING FILES AND/OR FORMS	11 min/day
ASSISTING AND INSTRUCTING GENERAL ASSISTANCE WORKERS	6 min/day
HANDLING IRRATE CLIENTS @ THE FRONT DESK	15 min/da
CHECKING COMPUTER READOUTS RE: REPAYMENTS, UNEMPLOYMENT, WORKMEN'S COMPENSATION, POSSIBLE DUPLICATE APPLICATIONS	20 min/day
FILING & UPDATING COMPUTER FORMS AND MONTHLY REPORTER PAGES & CARDS	15 min/day
CHECKING & SORTING COMPUTER READOUTS (EA P-31)	15 min/wk

(cont. page 9)

ORGANIZATIONAL TIME	12 min/day
SIGNING LETTERS AFTER TYPING BY THE CLERICAL STAFF	.4 min/day
JOB SEARCH WARNING & CLOSURE LETTERS	10 min/day
NOTATING OVERISSUANCES WE HAVE NO TIME TO DO	5 min/day
PHONE CALLS FROM CLIENTS & RETURNING PHONE MESSAGES	32 min/day
REVIEWING QUALITY CONTROL FINDINGS	10 min/day
CHANGING CLIENT ADDRESSES	5 min/day
SEARCHING FOR LOST FILES & CARDS	11 min/day
NOTATING WHAT HAS BEEN PAID ON OVERPAYMENTS & CURRENT BALANCES OWING	2 min/day
UPDATE MANUAL MATERIAL	10 min.
OVERPAYMENT COMPUTATIONS AND WORKUPS	1-4 hrs each
REVIEWING NEW POLICY	45 min. time
ATTENDING WORKSHOPS	1-5 days tim
DENIALS OF APPLICANTS WHOM DID NOT KEEP THEIR APPOINTMENTS	2 hrs./mo
CLOSURES OF CASES WHERE NO MONTHLY REPORT WAS SUBMITTED	1 hr./mo
LOGGING COUNTY GENERAL ASSISTANCE WORKERS JOB APPLICATIONS	32 hrs/mo

Exhibit 4
2-6-85

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE: MY NAME IS SUE STEPHENS. I AM AN ELIGIBILITY TECHNICIAN FROM THE MISSOULA COUNTY OFFICE OF HUMAN SERVICES. I AM HERE TO TELL YOU OF THE NEED FOR MORE ELIGIBILITY STAFF.

Our job is to determine eligibility for all catagories of assistance for our clients in a timely manner. The catagories of assistance are: immediate needs, Medicaid, Medically Needy, Medicaid Waiver, Food Stamps, Aid to Families with Dependant Children, General Assistance, State Medical, and Nursing Homes. There are different requirements and paper work for each program. Our job is becoming impossible to do. The last time our staff was increased wasiin 1981 and then only slightly. Since that time caseloads have increased and the number of required forms has increased significantly. For example, we now have 38 food stamp forms compared to 20 several years ago. There are now 55 ADC forms compared to 44; and these are just 2 of the programs that we deal with. The rules and regulations continually change, increase and become more complex. Combined with the increased paper work, this causes delays and errors in trying to serve the public in a timely manner with the same staff of 4 years ago.

Our clients are becoming frustrated and angry with the system that is intended to serve their needs. The elderly and disabled and Medicaid Waiver clients who are less vocal groups may have their benefits delayed for several months due to the priority currently being placed on General Assistance and immediate need cases.

There is also a shortage of clerical positions in our office. As a result, more pressure is put on the eligibility workers to do their own clerical work in order to meet deadlines. In addition, clerical workers are rotated to cover duties for which we need more workers. This affects the flow of work in the entire office.

The pressure for timely and accurate eligibility determination ~~with~~ with our present staff has caused staff burn out leading to missed time from work due to job stress. This in turn creates additional pressure on the remaining staff who has to cover for the absent workers. I believe the recent increase in our error rate, and possible monetary sanctions from the Federal Government against Montana, are a direct result of understaffing.

If you ~~came~~ went to Missoula today to apply for food stamps, the first available appointment would be on February 25th. The first appointment available for ADC would be on February 20th. At times it has taken weeks to get an appointment. That results in an application not being processed with in the 30 day requirement. Federal and State laws require that assistance be provided to those in need and that assistance be provided within required time limits. PLEASE GIVE US THE STAFF WE NEED TO CARRY OUT MONTANA'S OBLIGATION TO SERVE IT'S NEEDY CITIZENS EFFECTIVELY AND EFFICIENTLY.

Exhibit 5
2-6-85

CASCADE COUNTY OFFICE OF HUMAN SERVICES

Eligibility Determination Workload Information

I. Authorized FTE's by work area:

18.0 FTE Eligibility Technicians
2.0 FTE Eligibility Technician Supervisors
1.0 FTE Administrative Officer
3.0 FTE Typists
1.6 FTE Clerical Supervisors
1.0 FTE Food Stamp Issuer
1.8 FTE Accounting Clerks
.8 FTE @ County Director, Receptionist, Telephone Operator, Supply Clerk, Secretary, Word Processor.
33.2 Total FTE for Eligibility Determination

II. Eligibility Technician work activity:

A. Maintenance of open and continuing cases.

1. Continuing households as of 1/1/85 (household = 1 or more persons living together and receiving benefits).

917 households receiving only Food Stamp benefits
166 households receiving only AFDC benefits
24 households receiving only General Assistance benefits
522 households receiving only Medical benefits (322 in nursing homes)
1992 households receiving multiple benefits
3621 total households represents average of 201 per Eligibility Technician

2. Summarized description of work tasks.

-Redetermination/recomputation per monthly reports (GA, AFDC, FS).
-Changes per information from clients & other sources.
-Other changes (address, members)
-Requesting information (SSA, Labor, financial institutions, etc.).
-Records and reports (case files, transmittals).
-Coordination (other agencies, WIN, Job Search).

B. Intake - the receiving and disposition of new applications.

1. Volume = 583 Intakes were initiated in January, 1985 representing an average of 32 1/3 per Eligibility Technician.

2. Summarized description of work tasks.

-One or more face to face interviews.
-Examine and evaluate information presented.
-Identify and aquire necessary additional information.
-Explain and interpret programs, procedures, rights and responsibilities.
-Make eligibility determination and provide written notice of decision.
-Compute benefits; retoractive, current and future.
-Establish records and complete reports.

III. Administrative & Clerical Support Activity in January, 1985:

A. Delivering benefits.

1. 2618 Food Stamp Allotments issued (1529 by mail, 1089 in office).

2. 1227 checks for General Assistance, AFDC, LIEAP, etc. were issued.

B. Other client related activity.

1. 1801 people were welcomed and served by the Receptionist.

2. 600 to 800+ daily incoming calls handled and routed by Telephone Operator.

IV. Coordination Between Eligibility Determination and Social Service Units:

A. Social Service funded positions.

21.0 FTE professional Social Worker and Social Worker Supervisor positions.
10.0 FTE Home Attendant positions (provision of in-home personal & support serv.
6.8 FTE Administrative and clerical positions.
37.8 Total FTE for Social Services.

"Separation" (FFP) prohibits eligibility determination by Social Workers.

Procedures in place for internal referral leading to counselling and referral.

V. Problems and Responses:

A. Open Intakes to Appointments.
-Abuses, multiple returns, appointments exceeding 40%
-Appointments now at 15 work days after contact.

B. Uneven Work Flow to Greater use of mail.
-Calendar v.s. fiscal month.

C. Immediate Needs Mandate to Reorganization.
-Specialized work assignment; terminated hospital service; reassigned workloads.

VI. Summary - Personal Judgements:

A. Heavy workloads diminish efficiency (150 cases = error free work standard).

B. Heavy workloads lead to employee dissatisfaction (classification appeals) .

C. Heavy workloads create client dissatisfaction (inability to respond to new and changing needs).

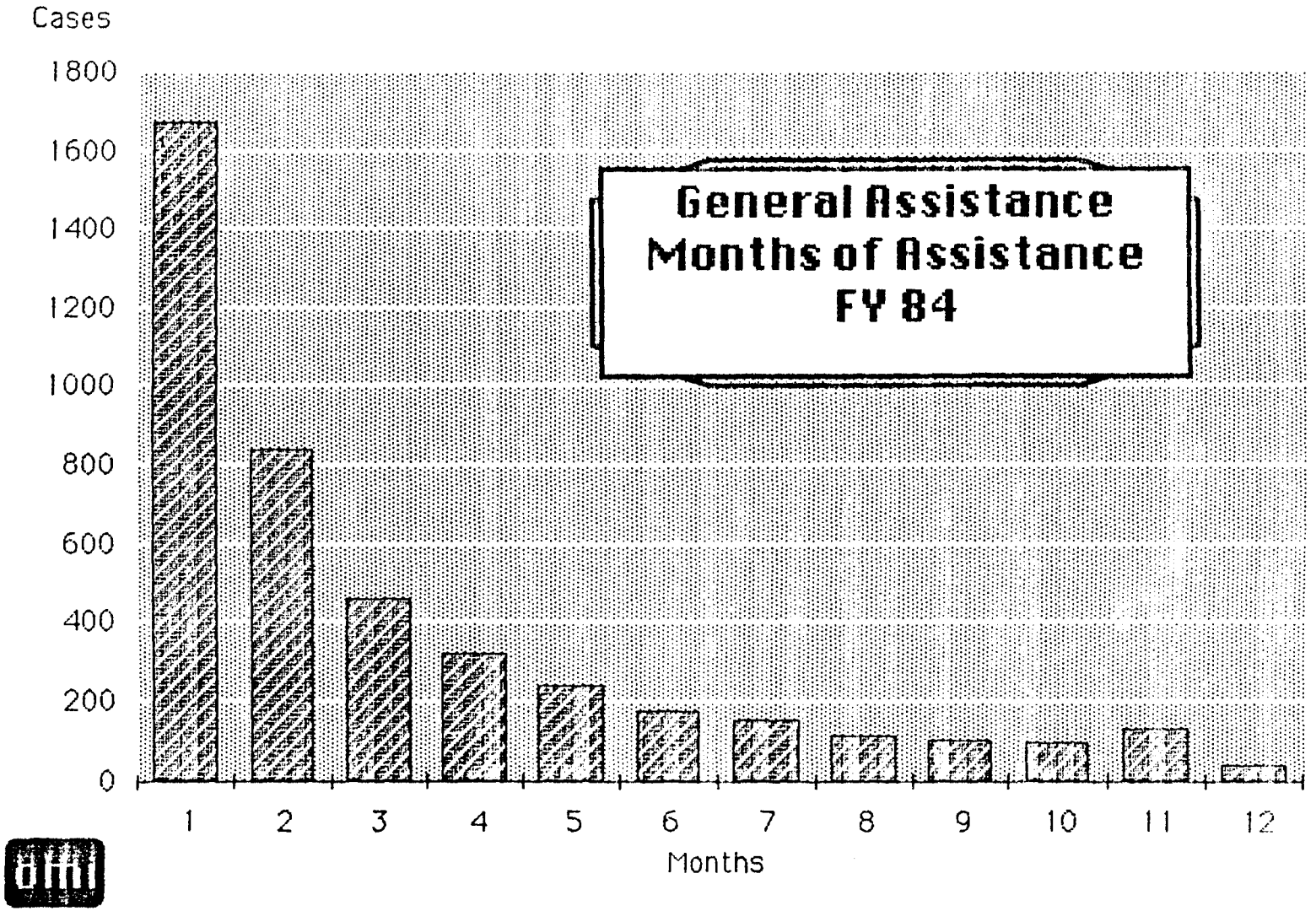


Exhibit 6
2-6-85

	1	2	3	4	5	6
1						
2						
3						
4						
5						
6	county	cases	18-30	30-40	40-50	50+
7						
8	Cascade	390	156	97.5	39	97
9	Deer Lodge	134	50	38	30	16
10	Lake	25	8	5	7	6
11	L & C	260	94	65	57	44
12	Lincoln	54	29	12	9	4
13	Mineral	8	4	2	1	1
14	Park	39	24	7	4	4
15	Powell	27	10	6	6	5
16	Ravalli	28	13	7	4	4
17						
18		965	388	239.5	157	181
19			40.2%	24.8%	16.3%	18.8%
20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
31						
32						
33						
34						
35						
36						
37						
38						
39						

	1	2	3	4	5	6
1		non-work				estimated
2		fare w/out				cases
3		kids- cases	amount	case %	dollar %	under35
4	1	809	96,034	34.7%	9.3%	445
5	2	468	116,660	20.1%	11.2%	257
6	3	266	103,091	11.4%	9.9%	146
7	4	193	94,974	8.3%	9.2%	106
8	5	144	98,298	6.2%	9.5%	79
9	6	100	83,845	4.3%	8.1%	55
10	7	90	89,855	3.9%	8.7%	50
11	8	64	75,373	2.7%	7.3%	35
12	9	55	71,662	2.4%	6.9%	30
13	10	53	73,881	2.3%	7.1%	29
14	11	72	106,433	3.1%	10.3%	40
15	12	20	27,420	0.9%	2.6%	11
16						
17		2,334	1,037,526			1,284

	7	8	9	10	11	12
1	estimated					
2	payments	avg $				
3	under35	per mo.				
4	52,819	$118.71				
5	64,163	$124.64				
6	56,700	$129.19				
7	52,236	$123.02				
8	54,064	$136.53				
9	46,115	$139.74				
10	49,420	$142.63				
11	41,455	$147.21				
12	39,414	$144.77				
13	40,635	$139.40				
14	58,538	$134.39				
15	15,081	$114.25				
16						
17	570,639					
18						

M-MONTH	OTHERCASES	OTHERAMT	WKFARECASESKIDS	WKFAREAMTKIDS	WKFARECASESSINGLES	WKFAREAMTSINGLES	TOTCASES	GA-
1	617	$79,384.39	249	$34,574.55	809	$96,034.25	1,675	$209,993.19
2	227	$61,597.52	147	$45,636.97	468	$116,659.78	842	$223,894.27
3	120	$56,222.14	74	$36,042.59	266	$103,091.49	460	$195,356.22
4	68	$43,853.34	62	$46,590.15	193	$94,974.07	323	$185,417.56
5	50	$31,873.40	48	$42,356.76	144	$98,297.74	242	$172,527.90
6	31	$27,831.46	45	$45,683.11	100	$83,845.92	176	$157,360.49
7	25	$27,445.78	37	$48,119.08	90	$89,855.08	152	$165,419.94
8	20	$27,623.98	28	$39,809.07	64	$75,373.57	112	$142,806.62
9	19	$29,132.83	26	$47,003.99	55	$71,661.75	100	$147,798.57
10	19	$27,443.69	23	$42,175.19	53	$73,880.99	95	$143,499.87
11	28	$47,267.51	33	$64,225.65	72	$106,433.36	133	$217,926.52
12	6	$9,866.73	13	$64,987.32	20	$27,420.18	39	$102,274.23
TOTAL	1,230	$469,542.77	785	$557,204.43	2,334	$1,037,528.18	4,349	$2,064,275.38

,54

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VISITORS' REGISTER

Human Services Sub- COMMITTEE

BILL NO. ____________ DATE 2-6-85

SPONSOR ____________

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
Harold McLaughlin	Great Falls		
Terry Frisch	Helena		
Sue Stephens	Missoula		
Dave Depew	MPEA		
[illegible]	Helena		
Jim Adams	Helena		
Judy Carlson	NASW - Helena		
Kathy McGowan	Helena		
B. [illegible]	"		
Charlotte [illegible]son	"		
Jean C. Johnston	Missoula		
[illegible]	Polson		
James C. [illegible]	Yellowstone Co/Billings		
[illegible]	Ravalli Co/Hamilton		

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

CS-33